Minor Patient Registration

How did you hear about Railyard Urgent Care?

□ Word of Mouth □ SF Reporter □ SF New Mexican □ Public Radio
□ Yahoo! □ Bing □ Facebook □ Google □ Yelp □ Driving by

Last Name: First: Middle Initial:					Date of Birth:
Social Security #:		Gender:	Race:		Ethnicity:
Mailing Address:			City:	State:	Zip Code:
Home Telephone #:			Mobile Telephone #:		
Emergency Contact: Name:			Phone #: Relationship to patient:		
Email:	Preferred Language:		Do you need an Interpreter?		
Preferred Pharmacy:	Pharmacy Location:		Primary Care Physician:		

Reason for today's visit:

Vaccines & Medical History

Any foreign travel in the last 60 days? **Y/N** If yes, where?
Zika/Ébola exposure? **Y/N**

Surgeries:		
Hospitalizations: **Y/N**	Reason:	When:
Family's Medical History: Parents, Siblings and Grandparents		
Are vaccines up to date?		
History of upper respiratory infection where antibiotic was given:		

Current Medications including all supplements

Current Medication Name	Dose and Frequency	Reason for Use

Any type of Allergies:	**Reaction to Allergies:**

Social History

Living arrangements:		
Do you have a disability? **Y/N**	If yes please specify:	
Do you feel safe in your environment? **Y/N**		
Any exposure to second hand smoke? **Y/N**		
Tobacco Use: Chew/Snuff: Never Current Use per day: #of yrs: Quit: When?	**Alcohol Consumption:** How Often? How Many? Exposure to alcoholic in household? **Y/N**	**Recreational Drug use: Y/N** Type?
Are you sexually active? **Y/N** □Heterosexual □Bisexual □Homosexual	Contraception/Protection Use? **Y/N** Type: Sexually transmitted disease:	

Female Patients Only

Have you started having menstrual cycles? **Y/ N**	When was your last menstrual cycle? / /

Thank you for your time and patience in completing this form. This information you provided will assist us with diagnosis and determining proper medical treatment. Please sign below to indicate that you have filled out the form to the best of your ability.

Parent/Guardian Signature:_____ Date:_____

Relationship to Patient:_____

Consent for treatment of minor patient

I, _____, legal guardian of _____, born on ____/____/____, do hereby consent to any medical care determined by the physician to be necessary for the welfare of the child while said child is under the care of Railyard Urgent Care.

Name	Relationship	Phone #

Please name any one else that could bring patient in for a visit, if legal guardian is not available,

I understand:

● I may revoke this authorization at any time by providing written request to the address of Railyard Urgent Care listed above. My revocation will not apply to information already retained/used/or disclosed in response to this authorization. Unless sooner revoked, this authorization expires one year (12 months) from date of signature

Parent/Guardian Signature: _____Date: _____

Relationship to Patient: _____

***Please request additional release as needed.**

Patient Financial Responsibility

Thank you for choosing Railyard Urgent Care for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

• The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
• We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
• Patients are responsible for payment of co pays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
• Co-pays are due at the time of service.
• Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.
• Patient may incur, and are responsible for payment of additional charges, if applicable. These charges may include.
◦ Charge for returned checks **$30.00**
• You may become responsible for medical cost of treatment for illness or condition with the provider listed below if

(1) You fail to pursue the claim for workers' compensation or

(2) It is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or

(3) If an agreement is executed by you and approved pursuant to Workers' Compensation Law 32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/ services performed after the date that agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

• By my signature below, I hereby authorize assignment of financial benefits directly to Railyard Urgent Care and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Parent/Guardian Signature:_____ Date:_____

Relationship to Patient:_____

Patient Rights Acknowledgment

Patient Name (Please Print):_____Date:_____

As required by the privacy regulations created because of the Health Insurance Portability and Accountability Act of 1996 (HIPAA): This notice describes how health care information about you, as a patient of Railyard Urgent Care, may be used and disclosed, and how you may have access to your individual records. Please review this notice carefully. You may request a copy of our most current notice at any time. The following is a brief summary of how we may use and disclose your information:

Treatment: To complete your treatment, such as laboratory testing; to pharmacies when we write prescriptions; to other healthcare providers when we make referrals; to your PCP to advise of treatment given you at this clinic; or other healthcare providers for purposes related to your treatment; to inform you of potential treatment options or alternatives; to inform you of health-related benefits or services that may be of interest to you.

Payment: To bill and collect for services rendered, such as insurance companies, third parties that may be responsible for payments, and to bill you directly, if needed, for services and items; to other healthcare providers and entities to assist in their billing and collection efforts.

Health Care Operations: To assist us in evaluating the quality of care you received; to conduct cost/loss analysis and business planning.

Release of Information: With your written permission, we may release your information to others involved in your care, such as family members, caretakers, guardians. A separate form will be provided to you if you wish to sign a Release of Information for a specific person.

Disclosures by Law: For public health risks such as maintaining vital records; reporting abuse of any kind; preventing or controlling disease, injury or disability; notifying persons of communicable disease; reactions to drugs or problems with devices or products; workman's compensation for coverage of work related injuries.

Health Oversight Activities: Can include audits by insurance companies; inspections; licensure or disciplinary actions; compliance with the civil rights law and health care systems in general

Lawsuits/Law enforcement: in response to court order or subpoena, attorneys (with signed release of information) if you are involved in a lawsuit; regarding a crime victim in certain situations; concerning death from criminal conduct; crimes committed on our property; in an emergency; to medical examiner; for organ or tissue donation directives; serious threats to health or safety; to correctional institutions or law enforcement if you are an inmate.

You have rights regarding your Protected Health Information:
1. You have the right to request restrictions:
2. You have the right to a copy of our Full Privacy Practices
3. You have the right to submit a written request for your medical records
4. You have the right to request an amendment to your health information
5. You have the right to request an accounting of disclosures of your health information
6. You have the right to file a complaint
7. You have the right to provide authorization for other use and disclosures

I have had the opportunity to review/receive a copy of this office's Notice of Privacy Practices. I understand my health information may be disclosed or used for treatment purposes, payments, or health care operations. I understand I may request a copy of this clinic's privacy notice at any time. I understand I have the right to restrict information, but the practice does not have to agree with those restrictions. I understand I may revoke my consents in writing at any time. The practice may condition receipt of treatment based on the execution of this consent.

If you have questions or concerns regarding this notice, please contact the Practice Manager 505-501-7791

Parent/Guardian Signature:_____Date:_____

Relationship to Patient:_____

Authorization to Release/Request for Individual's Health Information/Treatment Records

Last Name: _____ First: _____ Middle Initial: _____ DOB: _____

Mailing Address: _____

City: _____State: _____Zip Code: _____

Home Phone: _____ Cell Phone: _____

I hereby release specified health records from Railyard Urgent Care for the duration of

Date: _____ to Date: _____

□ Entire Health Record
□ Immunization Records
□ X-ray Reports/Discs
□ Discharge Summaries
□ Billing Records
□ Progress Notes/Transcription
□ Pathology/Lab Reports
□ Physical Results
□ Drug Screen Results
□ Other_____

maintained or created by the provider named below to the recipient named below:

Release Records From:	Release Records To:
Railyard Urgent Care	Name:
831 So. St. Francis Drive	
Santa Fe, New Mexico, 87505	
Phone: 505-501-7791	Phone:
Fax: 505-501-7792	Fax:

Purpose of Request:

□ Patient Request □ Continuation of Care □ Probation/Parole

I understand:

● I may revoke this authorization at any time by providing written request to the address of Railyard Urgent Care listed above. My revocation will not apply to information already retained/used/or disclosed in response to this authorization. Unless sooner revoked, this authorization expires one year (12 months) from date of signature

● If medical records include drug screening information I understand this category of medical information is protected by Federal Confidentiality rules (42CFR Part 2). Federal rules prohibit anyone receiving this information from making further
release unless further release is expressly permitted by written authorization of the person to whom it pertains.

Patient Signature: _____Date: _____

Patient Representative (Print Name): _____Relationship to Patient: _____

***Please request additional release as needed.**