NEW PATIENT APPOINTMENT

First Name	MI	Last

Address	Apt/Unit #	City:	State	Zip code

DOB	SSN	Gender ϒ Male ϒ Female	Preferred Language

Phone (H)	(C)	PREFERRED METHOD OF CONTACT: ϒ Phone (Voice) ϒ Text ϒ Email

Email Address:

Employer	Employer Phone	Occupation

☐ **Worker's Comp Case**

RACE		ETHNICITY	MARITAL STATUS
☐ White ☐ American Indian ☐ Asian ☐ Native Hawaiian ☐ Hispanic	☐ Black or African American ☐ Other ☐ Alaskan Native ☐ Other Pacific Islander ☐ Declined	ϒ Hispanic/Latino ϒ Not Hispanic/Latino ϒ Declined	ϒ Single ϒ Married ϒ Widowed ϒ Divorced ϒ Declined

HOW DID YOU HEAR ABOUT US?

ϒ Drive By ϒ Facebook ϒ Google ϒ US Website ϒ Insurance Referral ϒ Physician/Provider Referral ϒ Friend or Family ϒ Yelp ϒ Instagram ϒ Other

Primary Care Provider

Emergency Contact Name	Phone	Relationship to Patient

INSURANCE INFORMATION

Primary Insurance:	Relationship to Insured □ Primary (Self) □ Dependent	*PROVIDE NAME & DOB OF PRIMARY HOLDER* Name: _____ DOB: _____
Secondary Insurance:	Relationship to Insured □ Primary (Self) □ Dependent	*PROVIDE NAME & DOB OF PRIMARY HOLDER* Name: _____ DOB: _____

FINANCIAL RESPONSIBILITY

If patient is a minor financial responsibility must be completed entirely

Responsible Party Name □ Self	Relationship to Patient	SSN	DOB

Primary Phone	Address

PREFERRED PHARMACY

Pharmacy Name	Pharmacy Cross Streets or Address if known

REASON FOR YOUR VISIT TODAY (WRITE BELOW):

WHAT SYMPTOMS ARE YOU FEELING TODAY? (PLEASE MARK BELOW) □ NONE APPLY

GENERAL
□ Fever □ Chills
□ Body aches □ Night sweats
□ Fatigue

EYES
□ Double vision □ Photopsia (flashes)
□ Worsening vision □ Pain with movement in the eye(s)
□ Floaters in the eye □ Vision loss
□ Blurry vision

EARS
□ Ear Pain □ Ringing in the ears
□ Ear Drainage □ Hearing Loss
□ Dizziness

NOSE
□ Nasal obstruction □ Altered sense of smell/taste
□ Nosebleeds □ Nasal discharge
□ Sneezing
□ Sinus pain

THROAT
□ Hoarseness □ Painful swallowing
□ Throat pain □ Trouble swallowing

ALLERGY
□ Itchy nose □ Itchy eyes

RESPIRATORY
□ Shortness of breath □ Coughing up phlegm
□ Dry Cough □ Wheezing

CARDIAC
□ Chest pain □ Defibrillator
□ Irregular heartbeats □ Pacemaker
□ Currently on blood thinners

GI
□ Heartburn □ Diarrhea
□ Nausea □ Constipation
□ Vomiting □ Blood in stool

GU
□ Difficulty urinating □ Blood in urine
□ Frequency/ Urgency □ Lower back pain
□ Painful urination

HEMATOLOGIC
□ Bleeds easily □ Bruising

NEUROLOGIC
□ Headaches □ Seizure
□ Migraines □ Numbness/Tingling

MUSCULOSKELETAL
□ Knee pain □ Hand/Wrist pain
□ Shoulder pain □ Ankle/Foot pain
□ Hip pain □ Back pain

SKIN
□ Itching □ Skin discoloration
□ Peeling of skin □ Open wound
□ Rash

PSYCH
□ Anxiety □ Depression

ALERTS
□ Pregnant (weeks: ____) □ Breast feeding
□ **First day of last menstrual period:** _____ □ # pregnancies ___ High risk pregnancy? Y/N
□ Post-menopausal

OTHER
□ Other: _____

Immunizations up to date? □ **Yes** □ **No**

Allergies
Provide type of reaction (e.g. rash) □ **NONE**

1) _____
2) _____
3) _____

Current Medication(s)
Provide dose/ frequency □ **NONE**

1) _____
2) _____
3) _____

PAST MEDICAL HISTORY □ NONE APPLY

□ Cancer Type & Location: _____

□ Skin disorder: _____

CARDIOLOGY
□ Arrhythmia
□ Atrial Fibrillation
□ CHF
□ High Cholesterol
□ High Blood Pressure
□ Heart Disease
□ MI/Heart Attack
□ Valve disease

ENDO
□ Diabetes Type 1
□ Diabetes Type 2
□ Hypothyroid □ Hyperthyroid
□ Obesity

GI
□ Barret's Esophagus
□ Cholecystitis/gallstone
□ Cirrhosis
□ Irritable Bowel Syndrome
□ Crohn's/Ulcerative Colitis
□ Hepatitis C
□ Reflux/GERD

GENITO-URINARY
□ BPH (Enlarged Prostate)
□ Kidney Disease/Failure
□ Kidney stones
□ Recurrent UTI
□ HPV (Papilloma virus/warts)
□ Other STD: _____

GYN
□ Irregular periods
□ Ovarian Cysts
□ # of pregnancies _____
□ # of live births _____
□ Date of last menstrual period _____
□ Immuno: HIV

LYMPH/HEME
□ Clotting Disorder
□ Sickle Cell
□ Anemia

ORTHO
□ Arthritis
□ Degenerative Joint Disease
□ Osteoporosis
□ Spinal Stenosis

NEURO
□ Alzheimer's
□ Autism
□ CVA/Stroke
□ Dementia
□ Developmental delay
□ Parkinson's
□ Seizure
□ Concussion
□ Headaches

OPHTHO
□ Blindness
□ Macular degeneration
□ Cataracts
□ Glaucoma
□ Detached Retina

PSYCH
□ Anxiety
□ Bipolar
□ Depression
□ Schizophrenia
□ PTSD
□ Alcohol/Substance Abuse

PULM
□ Asthma
□ COPD
□ Emphysema
□ Sleep Apnea/Snoring
□ Pulmonary Embolism

RHEUM
□ Auto-immune disorder
□ Lupus
□ Rheumatoid Arthritis
□ Scleroderma
□ Sjogren's

VASCULAR
□ Peripheral Artery Disease
□ Carotid Artery Stenosis
□ Abdominal Aortic Aneurysm

OTHER
□ Seasonal Allergies
□ Prior Pain Management
Pain contract Yes/No
□ Other: _____
□ Other: _____

PAST SURGERIES □ NONE APPLY

□ Appendectomy
□ Kidney Stone Removal
□ Bariatric surg. _____
□ Gallbladder removal
□ Colon Resection
□ Colostomy (colon bag)
□ Hernia Repair
□ Splenectomy
□ Lumpectomy (BILATERAL/L/R)
□ Mastectomy (BILATERAL/L/R)
□ Heart Valve replacement
□ Heart: CABG
□ Cardiac Stent
□ Heart: Pacemaker/AICD
□ Joint replacement: _____
□ Neck/Back surgery: _____
□ Tumor Removal
□ Hysterectomy
□ Bilateral Tubal Ligation
□ Cesarean Section
□ Vasectomy
□ Prostate surgery
□ Cataracts
□ Glaucoma
□ Ear tubes
□ Tonsillectomy
□ Lung Removal
□ Basal Cell Carcinoma
□ Melanoma
□ MOHS
□ Squamous Cell CA
□ Kidney Transplant
□ Kidney Removal
□ Carotid endarterectomy
□ Vascular procedure: _____
□ Other: _____
□ Other: _____

SOCIAL HISTORY □ NONE APPLY

Smoking Status:

□ Current every day/some day smoker (circle): cigarettes e-cigarettes vape cigar pipe
□ Former smoker — What date did you quit smoking? _____
□ Never smoked — Number of packs a day? _____
□ Chewing tobacco — Total years smoking? _____

Drug use? (type) _____
Alcohol (circle) YES/NO
_____# drinks in a week
Medical Marijuana (circle) YES/NO

FAMILY HISTORY □ NONE APPLY

Do you have any FIRST DEGREE relatives with the following:

□ Diabetes, who? _____
□ High Blood Pressure, who? _____
□ Bleeding disorder, who? _____
□ Cancer, who/what kind? _____

CONSENT TO TREATMENT AND BILLING

By signing below, I (or my authorized representative on my behalf) authorize Urgent Specialists L.L.C. and their staff to conduct diagnostic examinations, tests and procedures to assess, diagnose, and treat my illness(es) and/or injury(ies). I authorize Urgent Specialists to provide medications, treatment, or therapy necessary to effectively assess and maintain my health. I understand that it is the responsibility of my individual treating healthcare provider(s) to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment. It is my responsibility to pay for services rendered. I understand that Urgent Specialists will collect payment from my insurance company(ies) on my behalf, but I am ultimately responsible for payment if my insurance does not cover my fees obtained at Urgent Specialists L.L.C. I understand my care may have additional charges billed by outside facilities (i.e. labs, x-rays, and splints) that may not be covered by my insurance carrier and therefore will be my responsibility. If collection proceedings are required, I agree to pay reasonable collection fees.

STATEMENT OF LIMITATION REGARDING ADVANCE DIRECTIVE

Our team is dedicated to delivering the highest quality care in a safe environment that places the patient at the center of our care. The majority of treatments performed at Urgent Specialists are considered to be minimal risk. It is policy of Urgent Specialists that if an adverse event occurs during your treatment, the medical team will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatment or withdraw of treatment measures already begun will be ordered in accordance with you wishes, advance directive, or health care power of attorney.

If you do have an Advanced Directive or Living Will and wish to provide us with a copy of the document, we will place a copy in your medical record. In the event of transfer to a hospital is required a copy will be forwarded to the hospital.
If you do not have an Advanced Directive/Living Will and wish to create one you may refer to one of the following:

www.willsofamerica.com
www.legalzoom.com
www.health.state.tn.us./Boards/AdvanceDirectives
www.azsos.gov/services/advance-directives

If you would like a copy of the State of Arizona official Advance Directives form, please ask when you arrive at the center and a copy will be provided to you.

HIPAA NOTICE OF PRIVACY PRACTICES

Signature below is only acknowledgement that you have received the Notice of our Privacy Practices.

NOTICE OF PATIENT RIGHTS

Signature below is only acknowledgement that you have received the Notice of Patient Rights.

NOTICE OF LIMITATION REGARDING ADVANCE DIRECTIVE

Signature below is acknowledgement that you understand the limitation regarding advance directive.

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION

I hereby authorize the staff of Urgent Specialists to disclose medical information (results of tests, care plan, medications, diagnosis, appointment times/dates, etc.), to the parties listed below.

Individual(s) authorized to receive information:

Name: _____ Name: _____
Relationship: _____ Relationship: _____
Phone:_____ Phone: _____

I understand,

- This authorization will remain in effect from the date signed below until the patient revokes it.
- I may revoke this authorization in writing, delivered by patient to Urgent Specialists.
- This authorization is giving Urgent Specialists the right to discuss my medical information with the one or more individuals listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the HIPAA.
- I may refuse to sign this authorization and you will not condition treatment or payment on my providing authorization.

Patient Signature (or Legal Guardian) _____

Name (Printed) _____ **Date:** _____

NOTICE TO PATIENTS

As a prospective patient of **Urgent Specialists**, we are pleased to inform you of the following:

DISCLOSURE OF PHYSICIAN PARTNERSHIP

1. Your provider may consult with a specialist telephonically or via telehealth on your case, or the specialist may evaluate you in the clinic. Similar to an emergency department (ED), this in-network provider may bill your insurance as well. You understand your insurance carrier may require an additional co-pay, deductible and/or co-insurance to have the involvement of a specialist or higher-level services at Urgent Specialists. This would be similar to what is experienced at an ED, however much more cost effective in our setting.
2. You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than Urgent Specialists. Alternative options include the closest emergency department or following up with another outside specialist.
3. You will not be treated differently by your provider if you choose to use a different facility. If desired, your provider can provide information about alternative providers.

If you have any questions regarding the information contained in this Notice to Patients, please feel free to ask your physician or a representative of Urgent Specialists. We welcome you as a patient and value our relationship with you.

Acknowledgment of Disclosure

By signing this Acknowledgment of Disclosure, you acknowledge that you have read and understand the foregoing Notice to Patients regarding billing, co-pay responsibility and patient safety measures.

_____ _____

Signature of Patient Signature of Parent or Guardian (if applicable)

_____ _____

Print Name of Patient Print Name of Parent or Guardian

Date: _____

Assignment of Benefits/Right to Payment and Patient Responsibility Form

I, the undersigned, irrevocably assign to the provider/entity Urgent Specialists ("Provider"), all of my rights and benefits and any other interests that I have in any medical insurance plan, health benefit plan, indemnity plan, trust fund or other source of payment for healthcare services (each a "Plan") in connection with medical services provided by Provider, its employees and agents. I understand that this document is a direct assignment of my rights and benefits under my Plan.

I instruct my insurance company to pay Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to Provider, I instruct my insurance company to make out the check to me and mail it directly to Urgent Specialist 2120 W Ina Road Tucson, AZ 85741 for the professional or medical expense benefits payable to me under my Plan as payment towards the total charges for the services rendered. In addition, I agree and understand that any funds I receive by my insurance company due for services rendered by Provider will be immediately signed over and sent directly to Provider.

Patient Responsibility: I acknowledge and agree that I am responsible for all charges for services provided to me which are not covered by my Plan or for which I am responsible for payment under my Plan. To the extent no coverage exists under my Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by my Plan.

A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ Date:_____
Signature of Patient/Person Legally Responsible

_____
Print Name of Patient/Person Legally Responsible/ Date of Birth/ Phone Number

_____
Relationship to Patient
(If signed by Person Legally Responsible)

PATIENT STICKER

VITALS

Temp: _____ Pulse: _____
POx: _____% RR: _____
BP:_____/_____
HT:_____inches WT: _____ kgs

VISION ACUITY

OU(B):20/___
OD(R): 20/___ OS(L): 20/___

EYE PRESSURES

OD(R):_____ OS(L):_____

Chief Complaint:

_____

OFFICE VISITS	
Office Visit	$ 159
Employer Physical	$ 60
Sports/School Physical	$ 35
Nurse Visit	$ 60
	$
Form Fee	$ 40
IMMUNIZATIONS	
Flu Shot	$ 40
TB Screening	$ 40
TDAP	$ 85
OFFICE PROCEDURES	
Abscess I&D	$ 100
Breathing Treatment (Duo or Alb.)	$40
Ear Packing	$10
Ear Wick	$25
Ear Wax Removal (microscope)	$ 100
EKG	$ 45
Epley Maneuver	$80
Excision of cyst/growth <10min	$ 90
Excision of cyst/growth >10min	$175
Fluorescein Eye Stain (SL)	$ 20
IV Fluids 1st hr	$ 80
IV Fluids each additional hr.	$60
Joint Injection or Drain	$85
Laceration simple *(Suture/Staple/Glue)	$ 150
Laceration Complex >15min*	$200
Nasal Cautery w/sliver nitrate	$60
Nasal Rhino Rocket Placement	$125
Skin Tag/Wart < 10min	$ 75
Skin Tag/Wart >10min	$100
Steri-Strips	$35
Suture/Staple Removal	$ 40

Toenail/Fingernail Removal	$125
Trigger Point	$75
Urinary Cath Insertion	$75
X-Ray per exam	$75
Vaginal Exam	$75
Wound/Burn Care	$75
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
IN HOUSE LABS	
Venipuncture	$ 20
R L Needle _____ AC Hand	
INR	$ 25
Blood Glucose Finger Stick	$ 20
CBC	$ 30
CMP	$ 30
COVID Rapid	$ 139
COVID PCR or Dual COVID/Flu	$169
Influenza A&B	$60
Strep A	$ 35
Urinalysis	$ 20
Urine Pregnancy	$ 20

MEDICATIONS	
Oral QTY _____	$ 10
IM Injection QTY_____	$ 25
IV QTY_____	$ 30
B12	J3420
Ceftriaxone/Rocephin	J0696
Clindamycin	S0077
Clonidine	J0735
Diphenhydramine	J1200
Demerol	J2175
Dex inject	J1100
Dex oral	J8540
Kenalog	J3301
Ketorolac	J1885
Methylprednisolone	J2920
Meperidine	J2175
Morphine	J2270
Prednisone oral	J7506
Promethazine	J2550
Zofran inject	J2405
Zofran oral	S0119

REFERRALS			
Simon Med		Radiology Ltd	
MRI	US	CT	Other
Other:			
Referral to Specialist			
Name:			
Urgency			
Routine		STAT	

I acknowledge that self-pay charges have been discussed with me prior to treatment and that I am responsible for any charges in addition to the $159 office visit for procedures performed/medications provided.

Patient Signature: _____