Welcome to Advanced Urgent Care of Pasadena!

No Street Parking after 3pm. Parked at PETCO? it may get towed

Please fill out this form completely ***PLEASE PRINT CLEARLY***

Name			Date of Birth		
Social Security #			Occupation		
Address	Apt/Unit:		Gender		
City		State		ZIP	
Mobile Phone		Home Phone			

Do we have permission to leave a message on your answering machine? □ Yes □ No
(We sometimes call to give lab results or other communication)

Email		Work Phone	

Preferred Pharmacy Information	Name: Address: Phone Number:

Emergency Contacts

Name		Phone		Relationship	
Name		Phone		Relationship	

How did you learn about our practice?

□ Google ad □ Internet search □ Google Maps □ Apple Maps

□ Yelp □ Facebook □ Insurance □ Drive by □ Friend/Family

□ Other: □ Referred by:

Primary reason for today's visit	Example: Problem Location Duration Is this a work-related issue? □ Yes □ No Is this a car accident-related issue? □ Yes □ No

Advanced Urgent Care of Pasadena

Medical Questionnaire

Name: _____ Date of Birth: _____

Medical History: Today's Date: _____

- ☐ **Heart Disease or Cardiovascular disease**
  - ☐ Atrial fibrillation
  - ☐ Coronary Artery Disease
  - ☐ High Blood Pressure
  - ☐ High Cholesterol
  - ☐ Murmur
- ☐ **Respiratory or Lung disease**
  - ☐ Asthma
  - ☐ COPD
- ☐ **Liver disease**
- ☐ **Cancer type** _____
- ☐ **Musculo-skeletal disease**
  - ☐ Arthritis
  - ☐ Back Pain
  - ☐ Joint Disease
  - ☐ Tendonitis
- ☐ Prostate Disease: _____
- ☐ Kidney Disease: _____

- ☐ **Neurological or psychiatric**
  - ☐ Anxiety
  - ☐ Depression
  - ☐ Headaches
  - ☐ Migraine
  - ☐ Seizures
- ☐ **Endocrine**
  - ☐ Low Thyroid (hypothyroid)
  - ☐ High Thyroid (hyperthyroid)
  - ☐ Diabetes Type I Type II
- ☐ **Infections**
  - ☐ HIV
  - ☐ Others:
- ☐ Other medical history: _____

Surgical History: _____

Family History: _____

Medications you are currently taking: _____

Allergies to medications: _____

Cigarette Smoking: __None ___#Packs per day/weeks Alcohol Use: __none __occasionally __1-4 drinks/week __ 5-10/wk

Recreational Drug Use: __No or What Type: __11-15 drinks/week __more then 16 per week

Review of Systems: *(circle please)*

General:	otherwise well	Fatigued Fever/Chills Lightheaded Weakness Weight changes
Skin:	no changes	Rash Lumps Sores Itching hair/nail changes
Head/Neck:	doing well	Sore Throat Vision changes Hearing changes Nasal issues Swollen glands
Respiratory:	breathing well	Wheezing Cough Rapid breathing Pain with deep breath Short of Breath
Heart:	no chest pain	Palpitations Racing heart Chest Pain
Abdomen:	doing well	Nausea Vomiting Diarrhea Constipation Abdominal Pain Black Stools
Bladder:	normal urination	Burning w/urination Urgency Frequency changes Urine color changes
Muscular:	doing well	Muscular aches weakness focal or diffuse
Joints:	doing well	Joint pains History of joint swelling Morning Stiffness
Neuro:	no headaches	Headaches Confusion Forgetful Neck Stiffness Slurred Speech
Psychiatric:	self-content	Sadness Nervous Poor concentration Obsessive thoughts Hearing voices

Other: _____

797 S. Arroyo Parkway ▪ Pasadena, CA 91105 ▪ Tel: 626-304-0404 ▪ Fax: 626-304-0405

MEDICAL SERVICES AGREEMENT

Patient's Name: _____

1. **MEDICAL CONSENT**: I consent to any medical treatments or procedures which may be performed on an outpatient basis (including emergency treatment or services), which may include but are not limited to medications, injections, photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the physicians, staff, or other health care providers of Advanced Urgent Care Pasadena, A Medical Corporation (herein referred to as "AUCP") assisting my care. Your medical provider may be an independent contractor and not an employee of AUCP.

2. **FINANCIAL AGREEMENT: I understand that all charges are due at the time of service.** I agree to pay AUCP for all charges for healthcare services and professional services provided to me by physicians and other healthcare professionals. Acceptable forms of payment include Cash, Visa, MasterCard, Discover and Debit card. If I am a non-insured patient, I agree to pay for my visit in full at the time of service. If AUCP is a participating provider with my insurance company I understand that my co-pay, coinsurance, deductible and/or any outstanding balances are due at the time of service. I understand that my insurance policy is a contract between myself and my insurance company; AUCP is not involved. In order for AUCP to file claims and accept payments from my insurance company, I understand that I must present current insurance information at each visit and that AUCP will need to verify my health insurance coverage. In the event that AUCP is not able to verify my insurance eligibility and benefits before my visit, I agree to pay for my visit in full at the time of service. A refund will be issued if my insurance pays for the visit. I also understand that I am financially responsible for any services not covered by my insurance company. When my spouse or a financial guarantor signs this agreement, the spouse or the financial guarantor shall be jointly and individual liable with me. Should my account(s) be referred to an attorney or a collection agency for the collection, the undersigned shall pay the actual attorney's fees (including costs) and collections expenses incurred in addition to the other amounts due. Unpaid accounts referred to outside agencies for collection shall bear interest at the current rate per year from the date of referral.

3. **INSURANCE AUTHORIZATION AND RELEASE:** I request that payment of authorized benefits, including Medicare, and any other government sponsored program, private insurance, and any other health plans be made to AUCP for any services furnished by that provider. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize AUCP to disclose portions of or all of my records, including my medical records to any person or corporation which is or may be liable for all or any portion of AUCP's charges, including but not limited to insurance companies, health care service plans, governmental agencies, or worker's compensation carriers. I authorize AUCP to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give AUCP any information required to fulfill this function. This will remain in effect until revoked in writing.

4. **RELEASE OF MEDICAL INFORMATION:** I hereby authorize AUCP to release any information in my chart to any practitioner, doctor, hospital, or medical institution to which I may be referred to assist in my care. Additionally, I authorize AUCP to provide a copy of my medical records to my primary care physician (PCP) to allow for continuity of care.

5. **NOTICE OF PRIVACY PRACTICES:** By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" of AUCP. Our "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting AUCP at (626) 304-0404.

6. **IN-HOUSE PHARMACY:** I understand that, for my convenience, AUCP can dispense some prescription medications necessary to treat my medical condition(s). I understand that my insurance will not be billed for medications dispensed and that my pharmacy benefits DO NOT apply to this service. **Any medication(s) dispensed in the office are my responsibility and are an additional charge to my office visit charge.** I also understand that if I prefer to use an outside pharmacy, a prescription can be provided to me at no additional charge.

7. **PERSONAL VALUABLES:** AUCP shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs, or other articles of unusual value and shall not be liable for loss or damage to any personal property.

AUCP and the patient or the patient's representative, hereby enters into this agreement. The undersigned certifies that he/she has read and agree to the foregoing, received a copy thereof, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____	_____	or	_____	_____
Signature of Patient	DATE		Signature of Patient's Representative	DATE
_____	_____		_____	
Medical Practice's Representative	DATE		Name & Relationship of Representative to Patient	