6260 El Camino Real, Suite 101
Carlsbad, CA 92009
760.448.6650

PATIENT INTAKE FORM – Coastal Family Urgent Care

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ SS (For military insurances): _____

Sex: [ ] Male [ ] Female

Gender Identity:

[ ] Male
[ ] Male to female/Transgender Female/Trans Woman
[ ] Choose not to disclose
[ ] Other: _____
[ ] Female
[ ] Female to male/Transgender male/Transman
[ ] Genderqueer, neither exclusively male nor female

Preferred language (if other than English): _____

Phone Number: _____ [ ] Mobile [ ] Home [ ] Work

Email: _____

Preferred Method of Communication: [ ] Mail [ ] Phone [ ] Email

Mailing Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Preferred pharmacy: _____ City: _____ Zip Code: _____

RESPONSIBLE PARTY (Must be parent or legal guardian for patients under the age of 18 years old) [ ] Self

Name: _____ Relationship: _____

Billing Address: _____ Apt: _____ [ ] **Same as above**

City:_____ State: _____ Zip Code: _____

Date of Birth: _____ SS (For military insurances): _____

Phone Number: _____ [ ] Mobile [ ] Home [ ] Work Email: _____

EMERGENCY CONTACT (Enter additional parent or legal guardian for patients under the age of 18 years old if applicable)

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____ [ ] Mobile [ ] Home [ ] Work

INSURANCE INFORMATION [ ] Self Pay

Primary Health Insurance Provider: _____

Healthcare Plan: _____ Member ID: _____

Secondary Health Insurance Provider: _____

Healthcare Plan: _____ Member ID: _____

Reason for visit: _____

How did you hear about us? [ ] Google [ ] Insurance Website [ ] Handout [ ] Friend or Family Member
[ ] Yelp [ ] Provider Referral [ ] Fundraiser [ ] Other: _____

Please review carefully. Your initials indicate your acknowledgement and permission for the following:

_____ Authorization to leave voicemails on the phone number provided, which may contain personal medical information. This information may include, but is not limited to, demographic information (patient name, date of birth, address, etc.), billing information, and medical information (appointment dates, diagnosis, medications, test results, etc.).

_____ Authorization to send emails to the email address provided, which may contain personal medical information, if we are not able to do so through our patient portal. This information may include, but is not limited to, demographic

information (patient name, date of birth, address, etc.), billing information, and medical information (appointment dates, diagnosis, medications, test results, etc.). Communications via email over the internet may not be secure. Although it is unlikely, there is a possibility information included in an email can be intercepted and read by other parties besides the person to whom it is addressed.

_____ Authorization to send text messages to the phone number provided for purposes such as appointment reminders, billing statements and patient satisfaction questionnaires. Messaging rates may apply.

_____ Authorization to request and use the patient's prescription medication history from a third party for treatment purposes.

_____ Authorization for Coastal Family Urgent Care to release medical records to the patient's insurance carrier for billing purposes.

_____ Understand Coastal Family Urgent Care will not assume responsibility for any personal property brought into the facility.

_____ If any healthcare worker is exposed to the patient's blood or other bodily fluid, Coastal Family Urgent Care can test the patient's blood for diseases including, but not limited to, hepatitis, HIV, and syphilis.

The following outlines our **Insurance Billing Policy**:

- It is the intent of Coastal Family Urgent Care to provide quality health care in a cost-effective manner. It is our obligation to provide services, supplies or medications which are deemed medically necessary under generally accepted professional standards for your medical condition(s). Any other services or services which are not customarily covered by healthcare insurance plans will be discussed prior.
- Your insurance policy is a contract between you and your insurance company, and we encourage patients to understand the details of their healthcare plan. While we attempt to provide the most accurate information possible, eligibility and benefits differ with each patient's healthcare plan, and it is ultimately your responsibility to check with the insurance carrier to determine network status, coverage, and financial responsibility. You are responsible for any of the services or charges not covered.
- Accurate insurance information with a valid photo ID is required at the time of service. If we are not able to verify/confirm eligibility, you will be charged our cash pay rate and the amount will be collected at the time of service. You will be responsible for obtaining reimbursement from your insurance company.
- Some services may be billed separately to provide ancillary services (i.e., imaging, lab specimen processing) and all attempts will be made to utilize participating facilities. Any amounts not paid by the patient's insurance company are your individual responsibility.
- A piece of durable medical equipment (DME) may be provided and fitted (i.e., walker boot, crutches, etc.) to be used for a period of time to aid in your recovery. While we will bill your insurance company for these products, it will be your responsibility if they are not covered. Due to regulations, these products may not be returned.
- Any estimated co-payment amount determined by your insurance company's contract must be paid at the time of service. These amounts may not be waived pursuant to our contractual obligation.
- If your insurance company has not processed your visit within sixty (60) days after proper submission of your claim, the balance may be transferred to your responsibility for payment.
- Delinquent accounts are subject to collection at any time including at the time of service.

_____ You understand and agree to our **Insurance Billing Policy** (***Required for submission to insurance company***)

Prior to completing this next section, please review our TERMS OF USE, NOTICE OF PRIVACY PRACTICES and PATIENT RIGHTS AND RESPONSIBILITIES. These forms can also be found on our website at www.coastalfamilyuc.com/forms. A copy may also be provided upon request.

After review, please initial the following:

_____ I have reviewed, acknowledge, and accept the terms in the NOTICE OF PRIVACY PRACTICES.

_____ I have reviewed, acknowledge, and accept the terms in the PATIENT RIGHTS AND RESPONSIBILITIES.

_____ I have reviewed, acknowledge, and accept the terms in the TERMS OF USE.

By signing below, you as the patient or authorized representative, consent for Coastal Family Urgent Care to provide health care services for the patient named above, and acknowledge, understand, and accept the terms stated.

_____	_____	_____
Patient/Authorized Representative Name	Patient/ Authorized Representative Signature	Date