Patient Information

First Name | Middle | Last Name | Date of Birth

Address

City | State | Zip

Sex: M ☐ F ☐

Social Security Number

Cell Phone | Home Phone

Email

Employer or Parent Occupation | Work Phone

Emergency Contact | Relationship

Emergency Contact Address

Emergency Contact Phone | Emergency Contact Email

RESPONSIBLE PARTY/GUARANTOR

First Name | Last Name | M

Social Security Number | Date of Birth

Relationship to Patient

Address

City

State | Zip

Email

Phone

RACE (OPTIONAL)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

ETHNICITY (OPTIONAL)

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Preferred Language

PREFERRED PHARMACY

Preferred Pharmacy and Location

INSURANCE

☐ Self Pay/No Insurance

Patient's relationship to insured:

☐ Self ☐ Spouse ☐ Dependent

Please present your insurance card to the receptionist.

PRIMARY REASON FOR TODAY'S VISIT

IS THIS VISIT RELATED TO:

☐ **WORK INJURY/ACCIDENT?** ☐ **MOTOR VEHICLE ACCIDENT?** ☐ **PREGNANCY?**

Primary Care Physician | Address/City | Phone / Fax

VERIFICATION OF INFORMATION

I verify that the above information provided is true and correct to the best of my knowledge. I hereby authorize PORTOLA MEDICAL SERVICES, PC dba Clineva Urgent Care ("Clineva") to accept assignment of insurance benefits and I understand that I am responsible for coinsurance, copayments, and/or deductibles at the time of service. I understand that if my insurance is a non-contracted plan (out of network); Clineva will courtesy file the claim for services rendered. If the claim is denied and/or out-of-network, it is my responsibility to pay the balance on my account. If I have no insurance coverage, I understand that the fees are due at the time of service. As part of my treatment it may be necessary to prescribe Durable Medical Equipment (DME). Clineva will make every effort to authorize this service (if needed) with my insurance company. If my insurance company denies this item, or I do not have DME benefits, I will be responsible for any balances. Durable Medical Equipment is nonrefundable and may not be returned.

CONSENT FOR TREATMENT

I hereby consent to medical evaluation, testing, and/or treatment provided to me by staff of Clineva which may also include medical and minor surgical treatment or procedures, emergency treatment, and laboratory procedures. I understand that Clineva may use or disclose Protected Health Information (PHI) necessary to carry out treatment, payment, or healthcare operations. I authorize release of any information concerning me or my child's healthcare, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize the facility to e-prescribe my prescriptions. For treatment purposes, Clineva may request and utilize my medication history from other health care providers or third party pharmacy benefit payers. I acknowledge that if the provider has ordered additional laboratory testing that the collected specimens will be sent to a local laboratory for testing. Clineva will forward your payer information to the laboratory but you will be responsible for the charges incurred for these services and will receive a separate bill from the laboratory. I understand that there may be a portion of the cost of Durable Medical Equipment that is not covered by my insurance and I will be responsible for the balance. Please notify staff of any barrier to effective communication or educational instruction that would prevent the understanding of information about the patient's health status, treatment, or the informed decision making process, such as foreign language, hearing or speech impairment, difficulty with reading or writing, or inability to comprehend verbal instruction.

CARD ON FILE AGREEMENT

I AGREE TO ALLOW CLINEVA TO CHARGE MY CREDIT CARD FOR ANY AMOUNT NOT COVERED BY INSURANCE (UP TO $150), FOR ALL SERVICES RELATED TO THE APPOINTMENT IDENTIFIED WITH THIS AGREEMENT. I ACKNOWLEDGE THAT A) MY CREDIT CARD WILL BE CHARGED UPON REVIEW OF THE FINAL EXPLANATION OF BENEFITS FROM EACH APPLICABLE INSURANCE COMPANY FOR SERVICES PROVIDED WHILE THIS AGREEMENT IS IN EFFECT, B) CLINEVA WILL ISSUE A BILL TO ME FOR ANY BALANCE REMAINING AFTER INSURANCE THAT IS GREATER THAN $150.00, C) MY CREDIT CARD WILL BE STORED BY ELAVON, INC., A SECURE CREDIT CARD PROCESSOR AFFILIATED WITH U.S. BANK THAT PARTNERS WITH CLINEVA TO COLLECT PAYMENTS, D) I WILL RECEIVE RECEIPTS DETAILING THE AMOUNT CHARGED, AND E) I MAY CANCEL THIS AGREEMENT AT ANY TIME BY CONTACTING CLINEVA; ANY UNPAID AMOUNTS RELATING TO THIS APPOINTMENT THAT ARE NOT COVERED BY INSURANCE WILL THEN BE BILLED TO ME DIRECTLY.

I hereby acknowledge to have read and understood all paragraphs ("Verification of Information", "Consent for Treatment" and "Card on File Agreement") and hereby consent to all terms and conditions:

Authorized Signature of Patient / Guardian / Accompanying Adult Print Name Date

By signing above, I hereby attest that I am the patient or am otherwise the patient's personal representative legally authorized to make healthcare decisions on his/her behalf.

AUTHORIZATION FOR DISCLOSURE AND RELEASE TO YOUR PRIMARY CARE PROVIDER

I hereby authorize PORTOLA MEDICAL SERVICES, PC dba Clineva Urgent Care ("Clineva") to automatically disclose and release the medical records from my visit with Clineva to my designated primary care provider.

I understand that I may get a copy of this form after I sign it. I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time; provided, however, that if I revoke this authorization, I understand that it will not have any effect on actions that Clineva and the above-described recipient(s) already took. If I do not revoke this authorization, it will expire six (6) years from my last visit with Clineva. This authorization may be revoked at any time by notifying Clineva's Privacy Office in writing at info@clineva.com.

HIPAA PRIVACY AND RELEASE OF INFORMATION AUTHORIZATION

I understand that the information described, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I understand that by signing this authorization form, I authorize the disclosure and use of my protected health information as described above, and that this information may ultimately be re-disclosed if the recipient(s) described on this form are not required by law to protect the privacy of the information. I understand that signing this authorization is voluntary. My healthcare treatment and benefits (including payment rights and eligibility, as applicable) will not be affected if I do not sign this form. I understand that I may refuse to authorize the automatic release of any personal or health information as described herein and that my refusal to sign and thereby consent to this release will prevent the automatic disclosure of such information for such purposes until Clineva receives a request for a release by me or my primary care physician or other provider, but will not affect the health care services I presently receive, or will receive, from Clineva.

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A Notice of Privacy Practices (NPP) is provided to all patients. This NPP identifies: 1) How medical information may be used or disclosed; 2) Your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our use and disclosures of that information; 3) Your rights to complain if you believe your privacy rights have been violated; and 4) Our responsibilities for maintaining your privacy as your medical representative. I have been offered and have read a copy of the facility's Notice of Privacy Practices, Patient Rights and Responsibilities, and the Patient Payment Policy.

I certify that I have read Clineva's Notice of Privacy Practices and the above Authorization and fully understand its terms.

Authorized Signature of Patient / Guardian / Accompanying Adult Print Name Date

By signing above, I hereby attest that I am the patient or am otherwise the patient's personal representative legally authorized to make healthcare decisions on his/her behalf.