U.N.I. URGENT CARE CENTER

Last Name:_____ First Name:_____ Middle Initial:___

Birthdate:_____ Gender: Male:_____ Female:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ SSN:_____-_____-_____

Email:_____ Marital Status:_____

Employer:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Employer Phone Number:_____

Reason for today's visit:_____ Pharmacy of Choice:_____

Have you been here before?_____

How did you hear about us?_____

Primary Physicians name:_____ Referring Physician:_____

Insurance Company:_____

Insured Name:_____ Relationship:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Birthdate:_____ SSN:_____-_____-_____ Gender:_____

Employer Name:_____

Address:_____ City:_____ State:_____ Zip Code:_____

(Please complete if patient is under the age of 18)

Guarantor Name:_____ Relationship:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Birthdate:_____ SSN:_____-_____-_____ Gender:_____

SIGNATURE:_____(seal)

DATE:_____

Notice of Privacy

Protecting the confidentiality of the information you and your healthcare providers share with us is important to U.N.I Urgent Care Center. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and Disclosures of Health Information

We use health information about you for treatment, payment and administrative purposes. We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to several requirements, we may give out health information without your authorization for public health purposes, for auditing purposes and for emergencies. We provide information when required by law, such as for law enforcement in specific circumstances.

For any reason and all other circumstances, we will ask for your written authorization before using or disclosing identifiable health information about you.

If you choose to sign an authorization to disclose information, you can later revoke the authorization to stop any further uses of discloser.

We may change our policies at any time. Before we make significant change, however, we will post a notice of change in the waiting area of each medical dispensary. You can also request a copy of our policy at any time. For more information about our privacy practices, contact the medical director at the number below.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the medical director at the number below.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. The name and address of the person you can contact for further information concerning our privacy practice is:

U.N.I Medical Care, INC

Acknowledgement of Statement

I have received/read a copy of U.N.I Urgent Care Center's notice of Privacy Practices

Date:_____

Print Name:_____

Signature:_____

Medical Information Release Form

(HIPPA Release Form)

Patient Name:_____ Date of Birth:_____/_____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, medical records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Messages

If I am unable to be reached by phone, a detailed message may be left on:

[ ] my home phone [ ] my work phone [ ] my cell phone [ ] do not leave any messages

Signature:_____

Date:_____/_____/_____

Patient's Authorization

I authorize U.N.I. Urgent Care Center to apply for benefits on my behalf for services rendered. I request payment from my insurance company to be made directly to U.N.I. Urgent Care Center. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me or the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

_____(seal) **_____**

Signature of Subscriber or Beneficiary **Date**