SAWNEE MOUNTAIN URGENT CARE
AND
MALCOLM P. DULOCK, M.D. FAMILY PRACTICE

Please Print the Following Information: Date: _____

Name of Patient: _____
First Middle Last

Gender: ____ Male _____ Female Date of Birth: _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____ Email Address: _____

Phone: _____ Alternate Phone: _____

Race: _____ White _____ Black or African American _____ American Indian or Alaska Native
_____ Asian _____ Unknown _____ Declined

Ethnicity: _____ Non-Hispanic or Latino _____ Hispanic or Latino _____ Other _____ Declined

Preferred Language: _____

Please List your Primary Care Physician: _____

Please list your preferred Pharmacy name/ Phone number:

_____

Please List your **CURRENT** medications and dosages:

_____ _____

_____ _____

_____ _____

_____ _____

Please list any allergies (with reaction) you may have:

_____

_____

Reason for you being seen today:

_____

_____

Smoker (Please circle one): Currently Former Never

	Disorder with eyes, ears, nose, throat		Stroke, epilepsy
	Nervousness, Mental Problems		Thyroid, diabetes
	Kidney stone, blood in urine		Cancer, tumor
	Dizziness, fainting, headache		Menstrual dysfunction
	Asthma, shortness of breath		Back/joint aches, arthritis
	Chest Pain/ palpitations/ heart murmurs		High blood pressure/ heart problems
	Hepatitis, pancreatitis, gall bladder		Stomach or abdominal ulcers
	Prostate or venereal disease		Hemorrhoids, blood in stool, bowel irregular

Explain:

_____

_____

_____ _____

Patient Signature Date

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New Patient Packet
PATIENT RECORD OF DISCLOSURE

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

_____ Home Telephone _____
___ OK to leave message with detailed info.
___ Leave message with call back number only

_____ Written Communication
___ OK to mail to home address
___ OK to mail to my office address
___ OK to fax to this number
_____

Other_____
____ OK to speak to spouse
____ OK to speak to _____

Email Address _____
Social Security Number_____

The Privacy Rule (TPO generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entitles must keep records of PHI disclosures. Information provided below, if completed properly, will constitute as adequate records.

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NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

By signing below I acknowledge having read the Patient Record of Disclosure, Patient Financial Policy and Informed Consent to Routine Procedures/Treatments. I have also read a copy of our HIPPA Policy/Privacy Notice.

ACKNOWLEDGE OF FINANCIAL POLICY: I have fully read the Patient's Financial Policy and understand my financial responsibilities under this policy.
AUTHORIZATION FOR TREATMENT: I consent to examination, treatment, and any procedures including emergency treatment deemed necessary and ordered by our physician and I am personally responsible for any charges.
AUTHORIZATION FOR INSURANCE: I authorize release of any information concerning myself or child to my insurance company regarding treatment for services rendered.
AUTHORIZATION FOR INSURANCE BENEFITS: I authorize my insurance company to send payment directly to **Sawnee Mountain Urgent Care and Dr. Malcolm P. Dulock, M.D., LLC** for services covered by my insurance plan.
AUTHORIZATION OF RECEIPT OF PRIVACY NOTICE: I hereby acknowledge that Sawnee Mountain Urgent Care amd Dr. Malcolm P. Dulock, M.D., LLC has provided me a copy of their Privacy Notice.
AUTHORIZATION TO CONTACT ME: I authorize Sawnee Mountain Urgent Care and Dr. Malcolm P. Dulock, M.D., LLC to contact me by either phone, electronic mail, or mail to provide a reminder appointment, gather demographic or insurance information, or to inform me of services or events offered at the facility.

READ ALL THE INFORMATION IN THIS PACKET BEFORE SIGNING BELOW
DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS

SIGNED _____ DATE _____

PRINT _____ WITNESS _____

SAWNEE MOUNTAIN URGENT CARE

AND

MALCOLM P. DULOCK, M.D. FAMILY PRACTICE

INFORMED CONSENT TO ROUTINE PROCEDURES/ TREATMENTS

I understand that Physicians rendering services at Sawnee Mountain Urgent Care and Malcolm P. Dulock, M.D., LLC are either owners, employees, or independent professionals engaged in the private practice of medicine.

1. I acknowledge and understand that, during the course of my or my child's care and treatment it is likely that various types of routine diagnostic and treatment it is likely that various types of routine diagnostic and treatment procedures may be utilized, which are considered necessary techniques for the ordinary care and treatment of my condition(s).
2. While these types of Procedures are routinely performed in hospitals and doctors' offices without incident, there are certain risks associated with each of these Procedures.
3. The physician or his/her associates or assistants are responsible for providing me with information about the Procedures and for answering all of my questions. It is not possible to enumerate each and every risk for every Procedure utilized in modern health care. However, physicians who practice medicine at their associated risks and possible alternatives. If I have further questions or concerns regarding these Procedures, I agree to ask my/my child's physician to provide additional information.
4. I further acknowledge and understand that my or my child's physician may ask me to provide a separate informed consent document to provide additional information.
   The procedure referenced herein may include, but are not limited to the following:
   - **(a)** Needle Sticks, such as shots, injections or intravenous injections (IV's). The risks associated with these types of Procedures include, but are not limited to, nerve damage, causing tingling or burning, infection, swelling, bruising, infiltration (fluid leakage into surrounding tissue), and skin sloughing, bleeding, clotting, allergic reactions to paralysis. Alternatives to Needle Sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.
   - **(b)** Physical test and treatments, such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, rehabilitation procedures, etc. which may be utilized in conjunction with diagnosis and treatment. The risks associated with these types of Procedures include, but are not limited to reactions to the material(s) used, infection, bleeding, discomfort, muscular-skeletal or internal injuries, nerve damage, paralysis, bruising, worsening of the condition and/or re-injury. Apart from using modified procedures and/ or refusal of treatment, no practical alternatives exist.
   - **(c)** Medications/ drug therapy, which may be utilized in the care and treatment of patients. The risks associated with these types of Procedures include, but are not limited to food drug- herbal interactions, allergic reactions, adverse reactions, drug dependency and both long- term and short- term side effects, which vary from

medication to medication. Apart from varying the medication prescribed and/or refusal of treatment, no practical alternatives exist.

(d) Repair of lacerations/ cuts to tissues of the body. The risks associated with this type of Procedure include, but are not limited to, fluid discharging through the suture line which would require additional treatment, scarring as part of the normal healing process, the wound may heal and stretch as time goes on causing some disfigurement, wound may heal with a thick scar which may be discolored and painful, edges of the wound may not be in perfect alignment and may overlap. Apart from refusal of treatment, no practical alternatives exist.

5. **I consent to and authorize the persons participating in and responsible for my or my child's care to utilize the Procedures, such as those set forth above, as they may dream reasonably necessary or desirable in the exercise of their professional judgement, including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained. This consent shall also extend to the treatment of all conditions which may arise during the course of such Procedures including those conditions which may be unknown or unforeseen at the time this consent is obtained.**
6. **By signing, I acknowledge and understand that I have been informed in general terms of the following:**
   - **(a) The nature and purpose of the Procedure(s).**
   - **(b) The material risks of the Procedure(s). and:**
   - **(c) The practical alternatives to such Procedure(s).**

   If I have further questions or concerns regarding these procedures, I agree to ask my or my child's physician to provide additional information.
7. **I understand that the practice of medicine is not an exact science and that no guarantees or assurances have made to me concerning the outcome and/or result of any Procedure(s).**
8. **I understand that the physician, medical personnel and other assistants participating in the patient's care will rely upon the patient's documented medical history, as well as other information obtained from the patient, the family or others information obtained from the patient, the family or others having knowledge regarding the patient, in determining whether to perform the Procedure(s) or the course of treatment for my/ the patient's condition and in recommending the Procedure.**

PATIENT FINANCIAL POLICY

OUR POLICY requires payment of money of money due at the time of services!

If you are a member of an HMO, POS or PPO plan, who has chosen us as a provider of care, it is your responsibility to:

- Provide us with the information required in filing a claim; the insurance card, patient ID number, employer, date of birth, address and social security number. The above information is requested on the Patient Registration Form, which is completed during the initial or subsequent visit.
- Pay your deductible, co-payment, or total balance at time of service, if applicable. Failure to do so can and will result in $25.00 surcharge added to your account.

- If you do not have insurance information, it is your responsibility to:
  - Submit a claim to the insurance carrier provided.
  - Provide the insurance carrier with the necessary information, to determine the medical and/or surgical care received.
- If your insurance carrier has not chosen **SAWNEE MOUNTAIN URGENT CARE/ MALCOLM P. DULOCK, M.D.** as one of the participating providers, we will:
  - Require payment at the time of service.
  - Assist the patient submitting the proper documentation so that they may file the claim; detailed statement summary, proper ICD-10 and CPT codes.
  - We gladly accept cash and Credit Cards: Master Card, Visa and Discover (We NO LONGER except AMERICAN EXPRESS).
  - We will also accept personal checks with proper identification.
    (a) Please note: a $25.00 overdraft charge will be added to all returned checks.
- **MISSED APPOINTMENTS-** you may be charged a no- show fee of $50.00 for each physical appointment missed.

- When your bill remains unpaid a collection agency may be chosen to manage delinquent accounts. If your account is placed with a collections agency, the patient will be accessed a 30% surcharge. The patient is solely responsible for all costs of collections.

- Sawnee Mountain Urgent Care and Malcolm P. Dulock, M.D. Family Practice wants to be your chosen provider. If we are not participating with a specific insurance company, we will, from time to time, contact insurance companies and ask for an agreement to provide service.

Patient Signature: _____ Date: _____