PULSE
Urgent Care Center

100 E. CYPRESS AVE
REDDING, CA 96002
(P) 530.722.1111
(F) 530.722.9999

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	CELL PHONE
EMAIL ADDRESS	WOULD YOU LIKE TO BE WEB ENABLED ☐Yes ☐No		
PATIENT DATE OF BIRTH	PATIENT SSN	SEX ❑ Male ❑ Female ❑ Other_____	MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
PATIENT RACE	PATIENT ETHNICITY	PATIENT PREFERRED LANGUAGE	

INSURED/RESPONSIBLE PARTY INFORMATION — RELATION TO PATIENT: ❑ spouse ❑ parent ❑ guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)	ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)		PHONE
ID NUMBER	INSURED/SPONSER NAME	INSURED/SPONSER SSN	INSURED/SPONSER DATE OF BIRTH
SECONDARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)		PHONE
ID NUMBER	INSURED/SPONSER NAME	INSURED/SPONSER SSN	INSURED/SPONSER DATE OF BIRTH

PRIMARY DOCTOR/FAMILY DOCTOR	REFFERING DOCTOR	
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER
PREFERRED PHARMACY	ADDRESS	PHONE NUMBER

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The information to be covered by this authorization includes: Printed, digital and verbal protected health information.

Persons who can use this information: Pulse Urgent Care Center, DOCS Medical Group Inc., their associates and staff.

Persons we are authorized to disclose information to:

Name of person or persons allowed access to records	Relationship to patient
_____	_____
_____	_____

This authorization will remain in effect until ___/___/_____ or one year from signature date, unless otherwise revoked or terminated by the patient or the patient's parent, guardian or representative.

You may revoke or terminate this authorization by submitting in writing to Pulse Urgent Care Center. You can also contact the office manager or records department to terminate this authorization.

Potential for re-disclosure

For the safety and protection of your protected health information please be aware that under this authorization any information that is obtained by the above may be disclosed again by the person or organization to which it is sent. The privacy of the release information may not be protected under the federal regulations.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):

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IMPORTANT SERVICE FEE INFORMATION

SERVICE ALERT

Self-pay patients (patients seen without insurance)
Are responsible for urine analysis, strep tests, injected medications, breathing treatments, etc. received as treatment during your visit. These fees are due after treatment is rendered and prior to leaving the facility. If you receive additional services and fees are not collected for any reason you will receive a bill.

X-Ray Services
If you receive x-ray services at the clinic during your visit you will receive two separate bills. You will be billed for the technical component (*the taking of the x-ray*) by Pulse Urgent Care staff, and you will be billed separately from Medical Doctor's Imaging (MDI) for the reading of the x-ray (*radiologist report and diagnosis*).

Laboratory Services
Labs drawn on the premises are billed by Orville Hospital and not Pulse Urgent Care Center. The lab provided as a convenience to our patients but is NOT part of Pulse Urgent Care Center and services are not billed through Pulse Urgent Care Center. We have no responsibility for fees that are established through Orville Hospital. If you have questions regarding lab fees please as your phlebotomist.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

IMPORTANT INSURANCE INFORMATION AND ACKNOWLEDGEMENT

PULSE URGENT CARE CENTER IS NOT CONTRACTED WITH ANY OF THE FOLLOWING INSURANCE PLANS

1. **MEDI-CAL**
2. **KAISER (*ANY PLAN*)**
3. **PARTNERSHIP HEALTHCARE**
4. **MEDI-CAID (*ANY STATE PROGRAM*)**

We do not accept any HMO plan of any kind including Medicare, Anthem Blue Cross, Blue Shield, Medi-Cal, Medicaid, etc. – Regardless if we are contracted with the individual health plan. IF YOU HAVE AN HMO PLAN AND STILL CHOOSE TO BE SEEN YOU ARE RESPONSIBLE FOR THE CHARGES INCURRED DURING YOUR VISIT. Charges and fees are due at the time services are rendered.

We do not bill Medi-Cal or Partnership Healthcare as a secondary insurance to any commercial insurance plan. WE ARE NOT CONTRACTED WITH THEM AND WILL NOT RECEIVE PAYMENT.

Signing below will be considered acknowledgement and agreement to the above policies. You are agreeing that you have been made aware of our insurance billing restrictions and will be held financially responsible if you choose to be seen/treated at Pulse Urgent Care Center. If you have any of these insurance plans and choose to be seen you will be charged as Self-Pay for services payable to Pulse Urgent Care Center and will receive our cash pay discount. Fees are due at the time of service. SIGNATURE AND DATE ARE REQUIRED FOR SERVICES TO BE RENDERED.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

Medical/Insurance Assignment of Benefits

All co-pays, co-insurance and deductibles are payable at the time of service. These fees will be collected at check-in if they are known in advance; otherwise they will be collected at the time of check-out.

I hereby authorize payment of medical benefits to Pulse Urgent Care Center, DOCS Medical Group, Inc. and affiliated MD's, NP's, PA's to release and request any medical records from and to other health care providers, medical institutions, or insurance companies on my behalf. I authorize the holder of medical information needed to determine these benefits payable to related services. I understand I am financially responsible for charges not covered by this assignment.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as full charge, and patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductible are based on the Medicare carrier.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the CMS 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.

I acknowledge that I have read this medical practice's Notice of Privacy Practices (posted in lobby). I further acknowledge that I will be offered a copy of any amended Notice of Privacy Practices as they occur.

There will be a $25.00 charge for any returned checks and all unpaid balances will be required to be paid with either cash, debit or credit card. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

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PATIENT/VISITOR CELL AND MOBILE DEVICE POLICY

At Pulse Urgent Care Center, DOCS Medical Group, Inc., our patients are at the center of everything we do. Among our many priorities, we value and respect the privacy of our patients, visitors and our staff. This is our policy regarding personal cell phones and mobile device usage while on the premises.

Patients and visitor can use their personal cell phones and mobile devices in the following areas:

- Outside of the building
- Common/Public areas, such as waiting rooms or foyer

Please be considerate of the patients around you. Remember conversations can be heard and you may not have the privacy you think, quiet voices, do not act disruptive or disrespectful manner. Patients engaging in disruptive and/or disrespectful conversations will be asked by staff to continue their conversation outside of the building. You are responsible for your own safety and security while using your cell phone and/or mobile device.

Our Priority is to deliver quality patient care. For us to do that, use of cell phones and mobile devices by patients, family and friends is prohibited in patient care areas:

- In patient rooms while treatment evaluations or activities are occurring with the medical assistants, nurses or providers.
- In the procedure rooms, no pictures or video recording are allowed at any time.
- **Medical assistants are not required to locate you outside if you are using your cell phone or mobile device. If you are outside having a conversation when your called back to be seen the medical assistant will call your name a maximum of three (3) times before they will move to the next patient.**

Our providers may take a picture of an injury/wound for documentation in the patient's chart only. This will be done with the permission of the patient or patient guardian if patient is a minor.

PLEASE DO NOT take, share or post pictures, recordings or videos of Pulse Urgent Care Center Doctors, PAs, RNs, Medical Assistants, Receptionists or other patients/visitors without their explicit permission to do so. This includes but is not limited to group treatment settings, joyous occasions, etc. Without permission to do so would violate the privacy rights of each person.

We have the right to ask you to stop using your cell phone or mobile devices and/or recording for violation of our policy.

If you refuse and you are not receiving emergency care/treatment, we may stop your visit and ask you to leave the clinic. If you are a visitor or family member, we may ask you to leave even if treatment of the patient continues.

PRIVACY IS EVERYONE'S RESPONSIBILITY AND RIGHT, WE APPRECIATE YOUR COOPERATION IN THIS MATTER.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE

IF SIGNED BY LEAGE REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (optional):

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MEDICAL TREATMENT CONSENT

PATIENT NAME	PATIENT DATE OF BIRTH

Consent for treatment: Knowing that I (or the patient indicated above) desires evaluation and/or treatment at Pulse Urgent Care Center/DOCS Medical Group INC., I voluntarily consent to such care. I consent to routine diagnostic procedures, including but not limited to x-rays, blood draw, laboratory tests, administration of medicine and medical or surgical treatment by physicians, physician assistants, nurses, technicians, medical assistants or other healthcare professional staff members of Pulse Urgent Care Center and/or DOCS Medical Group, INC and other health care providers who may be called upon to consult or assist in my care as deemed necessary by my treating physician.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of my examination or treatment at Pulse Urgent Care Center/DOCS Medical Group, INC.

I acknowledge the treatment at Pulse Urgent Care Center/DOCS Medical Group, INC is intended to address specific episodic illnesses or injury and is not intended to substitute for comprehensive care in lieu of a primary care physician or other specialized physician. In order to provide the best chance for successful treatment I accept responsibility to follow the advice of my treating physician including compliance with medications, discharge instructions and re-evaluation with follow up for referral physicians.

I agree to return to the clinic or seek care in an Emergency Department of a hospital if my condition substantially changes. I further agree to hold harmless the physicians and staff of Pulse Urgent Care Center/DOCS Medical Group, INC should I fail to comply with the above conditions.

Patients at Pulse Urgent Care Center/DOCS Medical Group, INC will be treated regardless of race, color, age, national origin, disability or religion. Notwithstanding the above criteria, Pulse Urgent Care Center/DOCS Medical Group, INC reserves the right to refuse service to any individual who may have an unpaid balance, exhibits rude or disruptive behavior or any other reason at the discretion of the physician on duty.

This consent shall remain in force until such time as it is specifically revoked.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE

IF SIGNED BY LEAGE REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (optional)

CONSENT TO TREAT MINOR

I, _____, parent or legal guardian of _____,

born on _____, do hereby consent to any medical care and the administration of anesthesia as determined by a

physician to be necessary for the welfare of my child.

This authorization is effective from _____ to _____ unless otherwise revoked in writing.

SIGNATURE OF PARENT OR LEGAL GAURDIAN	DATE

RELATIONSHIP TO PATIENT	SIGNATURE OR WITNESS (optional)

The following information will assist in the care and treatment, however it is optional and is not required

Father's Phone number	Mother's phone number
☐ Home ☐ Work ☐ Cell ☐ Primary contact	☐ Home ☐ Work ☐ Cell ☐ Primary contact

Primary address for child ☐ Lives with father ☐ Lives with mother ☐ Lives with grandparent ☐ Foster Care ☐ Other

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PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)

REASON FOR TODAYS VISIT:

Medications: List any medications you are currently taking (please include over the counter medications and vitamins):
PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE **PLEASE CONTINUE ON BACK IF MORE SPACE IS REQUIRED**

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

Medical History: Have you ever had any of the following?

- ❑ NONE of the problems listed
- ❑ allergies
- ❑ anemia
- ❑ arthritis conditions
- ❑ asthma
- ❑ bleeding problems
- ❑ cancer
- ❑ cardiac arrest
- ❑ chest pain
- ❑ depression
- ❑ diabetes
- ❑ drug/alcohol abuse
- ❑ heart disease
- ❑ high cholesterol
- ❑ hypertension
- ❑ infection problems
- ❑ migraines/headaches
- ❑ osteoporosis
- ❑ pulmonary embolism/blood clot in legs
- ❑ shortness of breath

Allergies

❑ NONE/No known Allergies

- ❑ Adhesive Tape
- ❑ Iodine/Shellfish/Contrast Dye
- ❑ Anesthesia
- ❑ Latex
- ❑ Aspirin
- ❑ Morphine
- ❑ Codeine
- ❑ Penicillin
- ❑ Dairy products
- ❑ Sulfa Drugs

OTHER:

Surgical and Hospitalization History: Please list any hospitalizations, surgeries, fractures, or major illnesses you have had.

TYPE OF SURGERY	DATE	DOCTOR	TYPE OF SURGERY	DATE	DOCTOR

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	FATHER	MOTHER	GRANDFATHER	GRANDMOTHER	SIBLINGS	CHILDREN
Diabetic	☐	☐	☐	☐	☐	☐
Hypertension (high blood pressure)	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Unknown	☐	☐	☐	☐	☐	☐
Liver Failure	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

☐**Yes** ☐**No -** Do you use tobacco? ☐ Smoke (___ packs per day) ☐ Chew ☐ Interested in quitting

☐**Yes** ☐**No -** Do you use recreational drugs? If yes, what kind? _____ ☐ In recovery since _____

☐**Yes** ☐**No -** Do you drink alcohol? ☐ Daily ☐ Weekly ☐ Socially ☐ Infrequently ☐ Recovering Alcoholic

☐**Yes** ☐**No -** Do you have a smoke detector in your home?

☐**Yes** ☐**No -** Do you drink/use caffeine? If yes, what kind? _____ How much/often? _____

☐**Yes** ☐**No -** Are you exposed to second hand smoke? ☐**Yes** ☐**No -** Are you sexually active?

☐**Yes** ☐**No -** Are there pets in your home? If yes, how many and what kind? _____

☐**Yes** ☐**No -** Are you current on your flu vaccine? If yes, when and where did you get it? _____

☐**Yes** ☐**No -** Have you traveled outside the US? If yes, when and where? _____

☐**Yes** ☐**No** - Do you exercise? ☐ Daily ☐ 5-6 times a week ☐ 3-4 times a week ☐ 1-2 times a week ☐ Rarely

Occupation: _____ ☐ Retired ☐ Disabled (reason _____)