



	PI F	PATIENT RE	EGISTRATIO				
PATIENT NAME (LAST FIRST			DRESS	-WIKIES			
CITY, STATE		ZIP	HOME PHONE		CELL PHONE		
EMAIL ADDRESS			L		D YOU LIKE TO BE WEB ENABLED		
PATIENT DATE OF BIRTH F	PATIENT SSN	SEX ☐ Male ☐ Other_	☐ Female	MARITAL STA	_		
PATIENT RACE	ENT ETHNICITY			PREFERRED LANGUAGE			
INSURED/RESPONSIE	BLE PARTY INFORMATION	ON REI	ATION TO PA	ATIENT: 🗖 spo	use 🛘 parent 🗘 guardian		
NAME (FIRST LAST MIDDL			f different from		450 <u>— paroni — 5</u>		
HOME PHONE V	WORK PHONE	SSN		BIRTH DATE	EMPLOYER		
PRIMARY INSURANCE NAME	ADDR	INSURANCE RESS (STREET - (INFORMATION CITY - STATE -		PHONE		
ID NUMBER	INSURED/SPONSER NA	AME	INSURED/SPO	ONSER SSN	INSURED/SPONSER DATE OF BIRTH		
SECONDARY INSURANCE NAM	1E ADDR	ESS (STREET - 0	S (STREET - CITY - STATE - ZIP)		PHONE		
ID NUMBER	INSURED/SPONSER NA	AME	INSURED/SPO	ONSER SSN	INSURED/SPONSER DATE OF BIRTH		
PRIMARY DOCTOR/FAMILY DO	OCTOR		REFFERIN	G DOCTOR			
IN CASE OF EMERGENCY CONT	ACT		RELATIONSHIP		PHONE NUMBER		
PREFERRED PHARMACY		ADDRESS	ADDRESS		PHONE NUMBER		
STANDA	ARD AUTHORIZATION O	DE USE AND DIS	CLOSURE OF P	ROTECTED HEALT	HINFORMATION		
					protected health information.		
Persons who can use this	information: Pulse U	rgent Care Ce	nter, DOCS M	edical Group In	c., their associates and staff.		
Persons we are authorized	d to disclose informa	tion to:					
Name of person or persons allowed access to			ords	elationship to patient			
This authorization will rer	main in affact until		or one ve	er from signatur	re date, unless otherwise revoked		
or terminated by the patie	ent or the patient's pa	arent, guardia	n or represen	itative.			
the office manager or reco	ords department to te				Care Center. You can also contact		
Potential for re-disclosure	_						
	ed by the above may	be disclosed a	again by the p	erson or organi	under this authorization any ization to which it is sent. The		
SIGNATURE OF PATIENT OR LE	EGAL REPRESENTATIVE			DAT	E		
IF SIGNED BY LEGAL REPRESE	NTATIVE, RELATIONSHIF	P TO PATIENT	SIGNATURE	OF WITNESS (Opt	ional):		





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
- 3. PARTNERSHIP HEALTHCARE
- 2. KAISER (ANY PLAN)
- 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. <u>WE ARE NOT CONTRACTED WITH THEM AND WILL NOT RECEIVE PAYMENT.</u>

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. <u>SIGNATURE AND DATE ARE REQUIRED FOR SERVICES TO BE RENDERED.</u>

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

DAT

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.

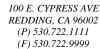
In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as full charge, and patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductible are based on the Medicare carrier.

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





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.

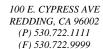
PLEASE DO NOT take, share or post pictures, recordings or videos of Pulse Urgent Care Center Doctors, PAs, RNs, Medical Assistants, Receptionists or other patients/visitors without their explicit permission to do so. This includes but is not limited to group treatment settings, joyous occasions, etc.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





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.

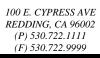
I acknowledge the treatment at Pulse Urgent Care Center/DOCS Medical Group, INC is intended to address specific episodic illnesses or injury and is not intended to substitute for comprehensive care in lieu of a primary care physician or other specialized physician. In order to provide the best chance 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	FREAT MINOR					
I,, parent of	or legal guardian of,					
horn on do hereby consent to any m	edical care and the administration of anesthesia as determined by a					
	sales and the daministration of anostriosia 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 m	other 🗆 Lives with grandparent 🗆 Foster Care 🗆 Other					





PATIENT MEDICAL HISTORY PATIENT NAME (LAST FIRST MIDDLE INITIAL)									
REASON FOR TODAYS VISIT:									
Medications: List any medications: List any medications PLEASE PRINT LEGIBLY – NO COMEDICATION	ations you are cu CURSIVE PLEASE * DOSAGE	rrently taking (plea *PLEASE CONTINU FREQUENCY	E ON BAC	de over the KIFMORES	SPACE IS REQUI	IRED**	d vitamin		FREQUENCY
Medical History: Have you	ı <u>ever</u> had any o	f the following?	•						
 NONE of the problems listed □ allergies □ anemia □ arthritis conditions □ asthma 	□ bleeding pr □ cancer □ cardiac arre □ chest pain □ depression	☐ di ☐ he ☐ hi	☐ 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 knowr	n Allergies			
☐ Adhesive Tape☐ Iodine/Shellfish/Contrast Dye	Adhesive Tape		in hine	_	Codeine Penicillin				airy products Ilfa Drugs
OTHER:									
Surgical and Hospitalizat TYPE OF SURGERY	ion History: Pl DATE	ease list any <u>hosp</u> DOCTOR	<u>oitalizatio</u> 	ions, surgeries, fractures, o TYPE OF SURGERY		or <u>major illnesses</u> DATE		s you have had. DOCTOR	
FAMILY HISTORY – Please Diabetic	indicate if any of FATHE			ve had any o DFATHER	f the following I		g an X in SIBLI		ropriate box. CHILDREN
Diabetic Hypertension (high blood pressure) Heart Disease									
Diabetic Hypertension (high blood pressure) Heart Disease Stroke									
Diabetic Hypertension (high blood pressure) Heart Disease Stroke Mental Illness									
Diabetic Hypertension (high blood pressure) Heart Disease Stroke									
Diabetic Hypertension (high blood pressure) Heart Disease Stroke Mental Illness Cancer Unknown Liver Failure									
Diabetic Hypertension (high blood pressure) Heart Disease Stroke Mental Illness Cancer Unknown Liver Failure Asthma									
Diabetic Hypertension (high blood pressure) Heart Disease Stroke Mental Illness Cancer Unknown Liver Failure	FATHE		GRAND	DFATHER	GRANDMO	THER	SIBLI		
Diabetic Hypertension (high blood pressure) Heart Disease Stroke Mental Illness Cancer Unknown Liver Failure Asthma SOCIAL HISTORY	bacco?	Smoke (pac	ks per da	ay) □ Ch	GRANDMOT	rested in	quitting	NGS	CHILDREN
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Diabetic Hypertension (high blood pressure) Heart Disease Stroke Mental Illness Cancer Unknown Liver Failure Asthma SOCIAL HISTORY □Yes □No - Do you use tol	bacco? [creational drugs?	Smoke (pac	drance ks per da at kind? _	ay) □ Ch	ew Inter	rested in	quitting overy since	NGS e	CHILDREN
Diabetic Hypertension (high blood pressure) Heart Disease Stroke Mental Illness Cancer Unknown Liver Failure Asthma SOCIAL HISTORY □Yes □No - Do you use recompared to the control of the contr	bacco? Ecreational drugs?	Smoke (pac If yes, wha Daily	ks per da	ay) □ Characteristics	ew Inter	rested in	quitting overy since	ecoholic	CHILDREN
Diabetic Hypertension (high blood pressure) Heart Disease Stroke Mental Illness Cancer Unknown Liver Failure Asthma SOCIAL HISTORY Yes No - Do you use to live you use record to live you use record yes No - Do you drink as Yes No - Do you have as	bacco? Ecreational drugs? alcohol? En smoke detector use caffeine?	Smoke (pac If yes, what I Daily	ks per da	ay)	ew Inter	rested in In reco	quitting overing Al	ecoholic	CHILDREN
Diabetic Hypertension (high blood pressure) Heart Disease Stroke Mental Illness Cancer Unknown Liver Failure Asthma SOCIAL HISTORY Yes No - Do you use to limit t	bacco? [Coreational drugs? alcohol? [Consider the content of the c	Smoke (pac	ks per da	ay)	ew Inter Infrequently How much/o	rested in lareco	quitting overing Alexandly act	ecoholic	CHILDREN
Diabetic Hypertension (high blood pressure) Heart Disease Stroke Mental Illness Cancer Unknown Liver Failure Asthma SOCIAL HISTORY Yes No - Do you use recomply to you drink as you wanted to you have a pressure of your have a pressure of	bacco? Ecreational drugs? alcohol? En smoke detector use caffeine? If the detector d	Smoke (pac If yes, what in your home? f yes, what kind? _ d smoke? f yes, how many a	ks per datate kind? _	ay)	ew Inter Infrequently How much/o	rested in lareco	quitting overing Alexandly ac	ecoholic	CHILDREN
Diabetic Hypertension (high blood pressure) Heart Disease Stroke Mental Illness Cancer Unknown Liver Failure Asthma SOCIAL HISTORY "Yes "No - Do you use to "Yes "No - Do you use red" "Yes "No - Do you drink a "Yes "No - Are you expos" "Yes "No - Are there pets"	bacco? Excreational drugs? alcohol? Example detector use caffeine? If the detector in your home? If the detector in your home?	Smoke (pac If yes, what in your home? f yes, what kind? _ d smoke? f yes, how many a cine? If yes, wher	ks per da at kind? _ ly	ocially kind? ere did you	ew	rested in Reco	quitting overy since overing Alexandly ac-	ecoholic	CHILDREN
Diabetic Hypertension (high blood pressure) Heart Disease Stroke Mental Illness Cancer Unknown Liver Failure Asthma SOCIAL HISTORY Yes No - Do you use recovered processed pro	bacco? Excreational drugs? alcohol? Example detector use caffeine? If the detector in your home? Int on your flu vaceled outside the detector the detector of	ISmoke (pac	ks per da at kind? _ ly Sind what and what and where	ocially	ew	rested in In reco Reco often? e you se	quitting overing Alexandria	ecoholic	CHILDREN