



Ascent Urgent Care & Walk-In Clinic

Health History

PLEASE ANSWER ALL QUESTIONS, *PUT NONE IF NOT APPLICABLE*:

Reason for Today's Visit: _____

Chronic Medical Problems	Previous Surgeries	Medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DRUG ALLERGIES: _____ Quantity _____

Smoker YES NO (ex: 1 pack/day) _____ If former smoker, what year did you quit? _____

Family Health Problems (check if yes)

Diabetes _____ High BP _____
 Stroke/Heart Attack _____ Cancer _____
 High Cholesterol _____ Others? _____

Females Only:

Are you pregnant? YES NO N/A
 When was your last menstrual cycle: _____

Dear Patient,

The staff of Ascent Urgent Care & Walk-In Clinic provides professional health services. Due to many changes in insurance policy, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. It is your responsibility to know your individual coverage. A charge of \$35.00 will be applied to any account that is sent to collections. A \$25.00 fee will be incurred for any returned checks. Please remember your insurance policy is between you and your company and not with the Physician. For Work-related injuries, if your employer or the Workman's insurance does not pay, you the patient will be responsible for any charges incurred. By signing below, you hereby authorize your insurance benefits to be paid directly to Ascent Urgent Care & the on-staff physicians, realizing that you are responsible to pay non-covered services, and you hereby authorize the release of pertinent medical information to the insurance carriers. Receipt of HIPAA (Health Insurance Portability and Accountability Act) Privacy Notice

Ascent Urgent Care is committed to maintaining the integrity of your protected health information and complies with all applicable state and federal regulations. In support of our policy of complying with all applicable regulations, Ascent Urgent Care provides patients with the HIPAA Notice of Privacy Rights. I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Ascent Urgent Care may use and disclose my protected health information with my permission. I understand that Ascent Urgent Care reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me. While not required in order to receive treatment at Ascent Urgent Care, we are obliged under federal regulations to ask that you sign an acknowledgement of the HIPAA Privacy Notice being made available to you. (Refusal to sign does NOT prevent the patient from being treated)

Whom else do you give permission to send your medical records to: (ex: spouse, parents, friends, etc).

(Please write full name)

Signature of Patient or Parent/Guardian _____ **Date:** _____

Front Desk Signature: _____ **Date:** _____