FastTrack Immediate Care

Registration Form

Today's Date:					
PATIENT INFORMATION					
Patient's Last Name: First: Middle:			☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital Status (circle one) Single/Mar/Div/Sep/Wid
SSN:	DOB:		Age:		Sex: ☐ M ☐ F
Mailing Address:		Home #: ( )			Cell #: ( )
City:		State:	Zip Code:		
Occupation:	Employer:		Work #: ( )		
Employement Status: ☐ Full Time ☐ Part Time ☐ Retired					
PLEASE CHECK HERE IF NO HEALTH INSURANCE: ___________					
INSURANCE INFORMATION					
(Please give your co-pay, insurance card, and driver's license to the receptionist)					
Person Responsible For Bill:		DOB:	SSN:		
Mailing Address (If Different):		Home #: ( )	Cell #: ( )		
Name of PRIMARY Insurance:					
Policy Holder's Name, DOB, SSN:					**Co-Pay:** $
Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other					
Name of **SECONDARY** Insurance (if applies):					
Policy Holder's Name, DOB, SSN:					
Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other					

I authorize treatment and agree to pay all fees and charges for the person names above. I agree to pay all charges shown by statements, promptly upon their presentation. I authorize payment directly to FastTrack Immediate Care from my insurance company. I hereby authorize the release of any medical information necessary in order to process a claim for payment in my behalf.

______________________________ ______________________________

Patient/Guardian Signature Date

FASTTRACK IMMEDIATE CARE

DATE OF SERVICE ______________ NAME ____ DOB ______________

CELL # ____________________________ HOME # ________________________ WORK # ____________________

LIST CURRENT PHARMACY ________________________________ LOCATION ____________________________

TODAY'S PROBLEM ____

WORK RELATED: YES/NO SMOKER: YES/NO ALCOHOL: YES/NO PRIMARY MD: ________________

CICRLE CURRENT SYMPTOMS: cough shortness of breath chest pain palpitations sore throat earache sinus pressure/pain weight loss nausea vomiting headache dizziness weakness back/neck pain joint pain leg swelling indigestion bleeding fever burning on urination difficulty going to the bathroom diarrhea abdominal pain dental pain blurry vision double vision insomnia anxiety/depression

FEMALES LMP: ________________________ ANY RECENT FOREIGN TRAVEL: YES/NO

PAST MEDICAL HISTORY: **IF YOU HAVE BEEN HERE BEFORE JUST UPDATE NEW INFORAMTION BELOW**

MEDICATIONS: ____

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ALLERGIES: ____

CIRCLE ALL YOU HAVE BEEN DIAGNOSED WITH: HIGH BLOOD PRESSURE HEART DISEASE HEART ATTACK CONGESTIVE HEART FAILURE ATRIAL FIBRILLATION PACEMAKER DEFIBRILLATOR STROKE KIDNEY FAILURE DIABETES ARTHRITIS JOINT PROBLEMS CHRONIC NECK/BACK PAIN GOUT HIGH CHOLESTEROL ASTHMA BRONCHITIS EMPHYSEMA COPD DEPRESSION ANXIETY INSOMNIA BIPOLAR SLEEP APNEA GI BLEEDING STOMACH ULCERS THYROID DISEASE OTHER: ______________________ CANCER: ____________________

LIST ALL SURGERIES: ____

CIRCLE FAMILY HISTORY: diabetes hypertension heart disease kidney disease arthritis blood clots gout thyroid problems stomach problems high cholesterol stroke mental problems drug abuse alcoholism bleeding disorder neurological problems COPD breast cancer lung cancer prostate cancer colon cancer

other cancer: ____

OCCUPATION: ____

DO NOT SCAN

TO BE COMPLETED BY CLINICAL STAFF:

Today's Date: ______/______/______ **Name:** ____________________________

BP / HT/WT PULSE RESP TEMP/ROUT SAO2

REPEAT VITALS/TIME:

____

____

NURSING NOTES & MEDICATIONS:

Med/Dose ______ Route ______ Site ______ Administered By ______ Time ______

Med/Dose ______ Route ______ Site ______ Administered By ______ Time ______

Med/Dose ______ Route ______ Site ______ Administered By ______ Time ______

Med/Dose ______ Route ______ Site ______ Administered By ______ Time ______

Med/Dose ______ Route ______ Site ______ Administered By ______ Time ______

IV SITE ____________________

NORMAL SALINE IVF STARTED: ______ STOPPED: ______ TOTAL VOLUME: ______

CARDIAC MONITOR: YES/NO

CONTINUOUS OXYGENT AT ______ LPM

CONTINUOUS PULSE OXIMETRY: YES/NO

CONTINUOUS BP MONIORING: YES/NO

DRESSING APPLIED AT TYPE/SITE: ____________________

SUTURES REMOVED SITE/APPEARANCE: ____________________

SEND PT TO ER BY EMS AT/TIME: ____________________

ADDITIONAL NOTES: ____________________

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____

____

SCAN

CONSENT FOR USE/DISCLOSURE OF HEALTH INFORMATION

FAST TRACT IMMEDIATE CARE

Patient's Name:____

Patient's DOB: _______________________ Patient's SSN: _______________________

Notice to Patient:

By signing this form, you grant us consent to use and disclose your protected health information for the purposes of treatment, various activities associated with payment, and health care operations. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities, and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed, and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have the right to receive a copy by contacting our Privacy Officer.

You have the right to revoke your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this **Consent Form** after you have signed it.

(To be completed by patient or patient's representative)

I, _______________________________, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health information to carry out treatment, payment activities, and health care operations.

____ ____________________

Patient or Patient's Representative Signature Date

____ ____________________

Printed Name of Patient or Patient's Representative Relationship to Patient

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: BRANDY BASSETT
Practice Address: PO BOX 16100, Dublin, GA 31040
Phone: 478-296-2800 Fax: 478-296-2801 Email: billing@fasttrackic.com

HIPPA Consent for Use/Disclosure of Health Information

This form does not constitute legal advice and covers only federal, not state, laws.

ALL PATIENTS MUST READ AND SIGN

ALTHOUGH WE ARE KNOWN AS AN "URGENT CARE", WE ARE CREDENTIALED WITH INSURANCE COMPANIES AS FAMILY PRACTICE AND/OR SPECIALIST. THEREFORE, IF YOUR INSURANCE HAS URGENT CARE BENEFITS, THEY WILL NOT APPLY TO OUR FACILITY.

ALSO, SOME INSURANCE COMPANIES TREAT US AS A SPECIALIST AND REQUIRE YOU PAY THE SPECIALIST COPAY. PLEASE KNOW THAT IF THIS OCCURS, YOU ARE RESPONSIBLE FOR THE ADDITIONAL COPAY AMOUNT.

IF YOU HAVE SEND-OUT LABS, OR XRAYS DONE, YOU WILL RECEIVE A SEPARATE BILL FROM LABCORP AND/OR SOUTH GEORGIA RADIOLOGY ASSOCIATES.

Patient's Name:

____

Guarantor's Name:

____

Signature of Person Responsible for Bill:

____