

Patient Name: _____ Date of Birth: _____ Date: _____

Patient COVID-19 Questions

YES NO

Have you been tested previously for COVID-19? If yes, Date: _____ Result: _____

YES NO

- 1.) Have you had close contact with a **laboratory-confirmed** coronavirus case?
a. If YES, how many days ago was your exposure _____
- 2.) Do you work in a healthcare facility, are you a first-responder or at high risk for exposure?
List profession: _____
- 3.) Do you have underlying condition(s)?
List condition(s): _____
- 4.) Are you 65 years or older?
- 5.) Do you have cough, shortness of breath, or measured fevers of 100.4 or higher?
- 6.) Do you have two of the following symptoms: sore throat, fatigue, headache, body aches, vomiting, nausea, diarrhea, loss of taste or smell, shaking chills, subjective fevers?

IMPORTANT ITEMS TO NOTE:

- While there are multiple testing options available for patients, **not all tests are recommended for every patient**. If a test is needed, the provider will discuss the most appropriate test for your situation.
- **Rapid testing is often not the recommended test for all exposures/situations - especially recent exposures within 4-5 days of testing, and has a 10-20% false-negative rate. Antibody tests or the more sensitive send-out (PCR test), may be indicated for many cases.**
- Due to limited supplies, we may occasionally run out of rapid tests, testing supplies and personal protective equipment required for testing.
- Current CDC cleaning and staffing guidelines are unfortunately creating longer wait times. **We apologize in advance for any inconvenience** as we prepare to safely care for our patients and guest.
- Please remember to be kind to our frontline staff - we are working hard to help each and every patient.

Last Name: _____ First Name: _____

Date of Birth: _____ Date of Visit: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Reason for your visit today: _____

Is this an injury resulting from a work or motor vehicle accident? YES NO

Primary Care Physician (PCP) Name: _____

Please note we routinely send correspondence to PCP for continuity of care.

PCP Office Location: _____ PCP Office Phone: _____

Preferred Pharmacy: _____

Location (Cross streets): _____ Pharmacy Phone: _____

- The above information is correct and accurate
- I have updated or changed the above demographic information

I am having severe chest pain and shortness of breath, and I think I may be having a heart attack. Yes No
 I am having numbness/weakness in my arms, legs or face, and I think I may be having a stroke. Yes No
 I have recently lost consciousness or I am having extreme weakness, and I think I may pass out. Yes No
 I am pregnant and I am having vaginal bleeding. Yes No

If you answered yes to any of the above questions or if you have a life-threatening medical concern, please notify our staff immediately.

Review of Systems: Please mark all recent symptoms associated with today's visit.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Runny Nose | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Loss of Consciousness |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Nausea | <input type="checkbox"/> Weakness or Paralysis |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Tingling or Numbness |
| <input type="checkbox"/> Weight Loss (unintentional) | <input type="checkbox"/> Loss of Voice | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Weight Gain (unintentional) | <input type="checkbox"/> Post Nasal Drip | <input type="checkbox"/> Constipation | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Throat Swelling | <input type="checkbox"/> Dark Tarry Stools | <input type="checkbox"/> Easy Bleeding |
| <input type="checkbox"/> Loss of Vision | <input type="checkbox"/> Dental Pain | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Leg Cramps |
| <input type="checkbox"/> Blurring of Vision | <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Pain with Urination | <input type="checkbox"/> Heat or Cold Intolerances |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Swollen Neck Glands | <input type="checkbox"/> Frequent Urinations | <input type="checkbox"/> Increased Thirst |
| <input type="checkbox"/> Eye Irritation or Redness | <input type="checkbox"/> Chest Pain (Cardiac) | <input type="checkbox"/> Strong Urge to Urinate | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Itchy Eyes | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Itchy Skin |
| <input type="checkbox"/> Drainage from Eyes | <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Dry Skin |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Cough | <input type="checkbox"/> Urine Output Changes | <input type="checkbox"/> Lumps or Swelling |
| <input type="checkbox"/> Decreased Hearing | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Changes in Hair or Nails |
| <input type="checkbox"/> Ringing of Ears | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Depressed Mood |
| <input type="checkbox"/> Ear Discharge | <input type="checkbox"/> Coughing up Blood | <input type="checkbox"/> Muscle Aches | <input type="checkbox"/> Sleep Disturbances |
| <input type="checkbox"/> Sinus Pain or Pressure | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Other / Not Listed |
| <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Painful Swallowing | <input type="checkbox"/> Back Pain | |

Patient Signature or Signature of Authorized Representative of Patient

Date

Last Name: _____ First Name: _____
 Date of Birth: _____ Date of Visit: _____
 Preferred Email: _____ (To receive future notifications, please opt in on your initial email)

Patient Responsibilities

Thank you for choosing TGH Urgent Care powered by Fast Track. We are committed to providing you with quality and affordable healthcare. To address some common questions, we have developed this Patient Responsibility Form. Feel free to ask any questions.

1. **Self-Pay** – Uninsured or out of network insurance patients must pay for service at the time of the visit. Any services rendered but not billed at the date of service are the patient’s responsibility and will be billed. We may discount Self Pay charges, but untimely payments will result in loss of any discount. Self-Pay charges cannot be subsequently submitted to the insurance company by TGH Urgent Care. Patients can request cost of services before any service is performed. Ultimately, the Patient will decide whether service will be performed or not.
2. **Insurance** – We participate in many insurance plans, [see our website for a list](#). If you have a plan we do not participate with or you do not have a current insurance card, payment is due at point of service (Self-Pay). Please contact your insurance company with any questions that you may have regarding your coverage and urgent care benefits.
 - a. All patients must complete our [Patient Demographic Form](#) for each visit to ensure current and accurate information on file. We must obtain a copy of your valid government issued ID and current insurance for proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.
 - b. We make every effort to verify and collect accurate patient responsibility with your insurance carrier. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect these from patients can be considered fraud.

3. **Non-covered Services**—Please be aware that some and perhaps all of the services you receive may not be covered or not considered reasonable or necessary by your insurer. The following services typically are not covered:

| | |
|-------------------------------|--|
| School/Sports Physicals | Routine Vaccinations |
| Employment and DOT Physicals | Form Completion (Medical Leave/Disability) |
| Travel and Wellness Physicals | Prescribed Medications |
| PPD (Tuberculin Skin Test) | Medical Equipment (Crutches, Braces, etc.) |

You are responsible to pay for these services at the time of the visit. It is important to note, these services may be covered by your insurance at another office, such as your primary care physician’s office. Knowing your insurance benefits is your responsibility.

For your convenience, we carry commonly prescribed medications onsite. If you are prescribed a medication we stock, you will have the opportunity to purchase it at check-out. We do not bill insurances for these medications. Payment is due at check-out and any charges unpaid at check-out will be billed.

4. **Claims Submission** – Your insurance is a contract between you and your insurance company which we are not party to the contract. The undersigned understands that TGH Urgent Care will file the patients claim(s) as a courtesy and authorizes TGH Urgent Care to release any and all information necessary to perfect said insurance claim and/or to collect any balance due to TGH Urgent Care. It is understood that the patient is responsible for perfecting and follow up on any claims, including obtaining necessary authorizations and referrals required for payment. Please be aware, that the balance of your claim is your responsibility whether or not your insurance company pays your claim.
 - a. After 10 days, should medical claim information for auto accidents, workers compensation or employer requested services not be obtained, patient will be responsible for payments.
5. **Accounts on File** – We require all commercially insured patients to establish an Account on File where our processing system will store a payment method (debt/credit card or bank account information) using an encryption and tokenization process to electronically debit your account according to the [Card on File Agreement](#). We will send a pre-notification 7 days prior to debit for those with an email on file. **Debits will be the lessor of the outstanding balance or capped at \$250 for a single charge.**
6. **Billing Questions** – For questions about your bill, please call our billing office, Monday through Friday between 8 AM – 5 PM at 813-616-6670.
7. **Non-payment** – If your account is +90 days past due, you will receive a letter stating that you have 20 days to pay your account is full. Partial payments will not be accepted unless otherwise negotiated. **Past due accounts may be turned over to a collection agency and the undersigned agrees to pay all costs of collection including a service charge of 30% all sums due and reasonable attorney’s fees. Paper check and electronic debits that fail to clear are subject to a service charge of \$25.**
8. **Privacy Practices** – You have the right to receive a copy of our office [Notice of Privacy Practices](#) to signing this consent.
9. **Pathogen Exposure Policy** – In the event any healthcare provider is exposed to my blood and/or body fluids, I shall be deemed to have consented to laboratory testing for HIV, Hepatitis B, and Hepatitis C with release of results to the person exposed.
10. **Fraud** – “Any person who, knowingly and with intent to injury, defraud, or deceive and employer or employee, insurance company, or self-insured program, files a statement of claim containing and false or misleading information commits insurance fraud, punishable as provided in s. 817.234” under Florida statutes.

Thank you for reviewing our policy.

I hereby acknowledge I have read and understand this policy and agree to abide by its guidelines.

Patient Signature (or Authorized Patient Representative)

Date