TGH URGENT CARE powered by FAST TRACK

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.

☐ None
☐ Fever
☐ Fatigue
☐ Weight Loss (unintentional)
☐ Weight Gain (unintentional
☐ Headaches
☐ Loss of Vision
☐ Blurring of Vision
☐ Eye Pain
☐ Eye Irritation or Redness
☐ Itchy Eyes
☐ Drainage from Eyes
☐ Earache
☐ Decreased Hearing
☐ Ringing of Ears
☐ Ear Discharge
☐ Sinus Pain or Pressure
☐ Nasal Congestion

☐ Runny Nose
☐ Nose Bleeds
☐ Sore Throat
☐ Loss of Voice
☐ Post Nasal Drip
☐ Throat Swelling
☐ Dental Pain
☐ Neck Stiffness
☐ Swollen Neck Glands
☐ Chest Pain (Cardiac)
☐ Palpitations
☐ Leg Swelling
☐ Cough
☐ Shortness of Breath
☐ Wheezing
☐ Coughing up Blood
☐ Loss of Appetite
☐ Painful Swallowing

☐ Abdominal Pain
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Dark Tarry Stools
☐ Blood in Stool
☐ Pain with Urination
☐ Frequent Urinations
☐ Strong Urge to Urinate
☐ Difficulty Urinating
☐ Blood in Urine
☐ Urine Output Changes
☐ Joint Pain
☐ Joint Swelling
☐ Muscle Aches
☐ Neck Pain
☐ Back Pain

☐ Loss of Consciousness
☐ Weakness or Paralysis
☐ Tingling or Numbness
☐ Dizziness
☐ Easy Bruising
☐ Easy Bleeding
☐ Leg Cramps
☐ Heat or Cold Intolerances
☐ Increased Thirst
☐ Rash
☐ Itchy Skin
☐ Dry Skin
☐ Lumps or Swelling
☐ Changes in Hair or Nails
☐ Depressed Mood
☐ Sleep Disturbances
☐ Other / Not Listed

_____
_____
_____

_____ _____
Patient Signature or Signature of Authorized Representative of Patient Date

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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**