valley immediate care

Site:_____ Name: _____

Scanned to REG STAFF at completion of visit.

Today's Date_____

Patient's SSN:_____-_____-_____
Patient First Name (Legal):_____ Middle Initial:_____ Last:_____
Prior or Maiden Name:_____
Mailing Address:_____ City:_____ State:_____ Zip:_____
Physical Address:_____ City:_____ State:_____ Zip:_____
Local Address (For patients from out of town):_____ City: _____

Home #:_____-_____-_____ Cell #:_____-_____-_____

(Cell phones may be used by VIC to send you texts regarding referrals,reminders and occasional surveys for continuity of care)

Email address:_____ (Gives VIC consent to send emails to this address)

DOB:_____/_____/_____ Age:_____ ☐ English Speaking Preferred Language:_____

☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partner
Primary Care Physician:_____ (Gives VIC consent to send chart notes to PCP)
Driver's License #:_____ State Issued:_____
Emergency Contact:_____ Phone:_____-_____-_____ Relationship:_____
Local Emergency Contact_____ Phone:_____-_____-_____ Relationship:_____

How would you like us to contact you for follow up calls and/or lab results? ☐ Phone (OK to leave a message) ☐ Mail
Employer:_____ Occupation:_____ Work #:_____-_____-_____

Is this a work related injury? ☐ Yes ☐ No

If patient and guarantor are the same please check here ☐ Relationship to patient:_____
First Name:_____ Middle Initial:_____ Last:___ _____
Guarantor Social Security #:_____-_____-_____ Guarantor's DOB:_____/_____/_____
Address (if different from patient):_____ City:_____ State:_____ Zip:_____
Phone #:_____-_____-_____Employed by:_____ Work Phone:_____-_____-_____

I understand that if my insurance is state funded (OHP, Medicaid, etc.), that Valley Immediate Care cannot bill them and I am responsible for payment of my visit. (Allcare and Jackson Care Connect medical coverage is accepted by VIC)

Primary Insurance Company: _____ Employer Name:_____
ID #:_____ Group number/Group name:_____
Subscriber name: _____ Subscriber DOB: _____/_____/_____ Subscriber SSN: _____-_____-_____
Secondary Insurance Company: _____ Employer Name:_____
ID #:_____ Group number/Group name:_____
Subscriber name: _____ Subscriber DOB: _____/_____/_____ Subscriber SSN: _____-_____-_____

Fees for office visit are determined by the complexity of the medical problem, the time spent with the patient, and when indicated, the use of lab, medications, x-ray or specialty procedures and supplies. The responsibility for payment for services rendered ultimately rests with the responsible party indicated above. Valley Immediate Care accepts cash, checks, and most major credit cards. All balances are due at the time of service. If payment arrangements are needed these must be established prior to receiving services. Valley Immediate Care will bill selected insurance carriers for covered services. You must provide all necessary information prior to your treatment. If elected to have your insurance company billed, you will be required to pay for any co-pays or deductibles at the time of service. Valley Immediate Care will make every attempt to verify your insurance eligibility prior to your visit. However, if service coverage cannot be verified you will be responsible for all charges incurred at the time of service. If you desire to file your insurance claim, Valley Immediate Care will provide you with Summary Forms necessary to do so at checkout today. It is your responsibility to make payments on any balances owed. If you are having problems paying your bill, please contact our billing office and make arrangements regarding timely

payments. Unpaid service charges may be referred to a collection agency for legal action, which may adversely affect your credit rating and availability of services.

Some of the samples drawn or collected today may be forwarded to RRMC Lab for further testing. We would like to notify you of a separate charge from RRMC for this service.

I understand that Valley Immediate Care will use and disclose health information about me in the course of providing medical care to me. I understand that my health information may include information both created and received by the clinic, may be in the form of written or electronic records or spoken word, and may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatment, procedures, prescriptions and similar health-related information. I understand that the clinic is permitted to use and disclose my health information in order to:

- ✔ Make decisions about and plan for my care or treatment;
- ✔ Refer to/or consult and coordinate with other health care providers in the course of my treatment;
- ✔ Determine my eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies and others who may be responsible to pay for some or all of my health care;
- ✔ Perform various office, administrative and business functions that support the clinic's ability to provide me with appropriate care, including provision of medical supplies and equipment and arrange for payment.
- ✔ Perform and process patient surveys via text or email in the effort to increase customer service and satisfaction.

I understand that the Notice of Privacy Practice describes how I can exercise my right to ask that some or all of my health information not be used or disclosed. A copy of the clinic's Notice of Privacy Practice is available to you.

In order to share any of your medical information with another person, you must write their name and relationship below. Without this authorization, Valley Immediate Care will not release any of your medical information. *You may revoke this release at any time.*
Name & Relationship (spouse, parent, etc.)

_____

_____

I give Valley Immediate Care permission to send my medical records to my Primary Care Provider.
By signing you understand and agree to all of the above stated.

Patient/Guarantor Signature X_____ Date_____

Patient/Guarantor Printed Name X_____

North Medford Medical Clinic
1600 Delta Waters Rd, Ste. 107
Medford, OR 97504
Tel: 541-858-2515

South Medford Medical Clinic
235 Barnett Rd, Ste. 106
Medford, OR 97501-7903
Tel: 541-773-4029

Ashland Medical Clinic
1401 Siskiyou Blvd, Ste. 1
Ashland, OR 97520
Tel: 541-488-6848

Grants Pass Medical Clinic
162 NE Beacon Dr, Ste. 103
Grants Pass, OR 97526
Tel: 541-479-1090

Revised 5/12/19…jsteiger

Time In:_____
(Office Use Only)

valley immediate care

PATIENT CONSENT FOR TREATMENT

Today's Date:_____

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

Cell Phone:_____ **(Please verify for emergency purposes.)**

I hereby authorize all treatment that may be considered necessary or advisable by the provider and certify that no guarantee or assurance has been made as to the results which may be obtained.

By signing you understand and agree to all of the above stated and give your consent for treatment.

Patient/Guarantor Signature X_____ **Date**_____

We're here when you need *us!*

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Dermatology Clinic Consent

I give my permission for the providers of VIC Derm Clinic to evaluate and treat me as deemed necessary in their professional judgement, which may or may not include surgery.

The most commonly encountered procedures in a dermatologic office setting are skin biopsies, cryotherapy, skin lesion removal, curettage, excision and debridement and administration of local anesthesia. Each procedure has a small risk of scarring that may or may not be noticeable (common), mild pain (common), infection (uncommon), bleeding (rare), or allergic reaction (rare). Separation of incision, abnormal scarring, atrophy (thinning or depression of the skin), or discoloration of the skin are also possible complications. Complications could also result in the need to repeat the procedure, additional medical or surgical procedures, hospitalization, or very rarely, permanent disability or death.

I understand that:

_ During these procedures, the skin may be cleansed with Hibiclens, betadine-iodine or alcohol and local anesthetic may be injected into the skin. An area of skin may be removed and sent for testing. If an incision is done, it may be sewn (sutured) up and ointment and a bandage will be applied.

_ My tissue sample will be sent to an outside lab for processing and that a Dermato-pathologist not associated with Valley Immediate Care will be consulting regarding my tissue diagnosis. While insurance information will be forwarded to these other offices and organizations, I am responsible for any bill that my insurance does not pay.

_ I understand I am responsible to notify my Valley Immediate Care provider of any special requests on sending pathology or specimens to specific labs at each appointment.

_ I understand that if today's procedure is not deemed medically necessary by my insurance policy contract, my insurance may not cover the treatment. Valley Immediate Care will make every effort to identify what an insurance company may deem non-necessary treatments and counsel on such prior to any procedure or treatment.

_ The practice of medicine and surgery is not an exact science, primarily due to a patients individual response to treatment and healing, and therefore results and outcomes can not be guaranteed by any provider or personnel of Valley Immediate Care.

_ Photographs may be taken before and/or after any procedure to help with documentation, follow up treatment or educational purposes.

I certify that I have read, or have had read to me, the contents of this form. I understand the risks and alternatives involved in this procedure. I have had the opportunity to ask any question that I have at this time and all my questions have been answered. I agree to the terms of this agreement and release the provider, technician and facility from any liability.

Patient's Name (please print): _____

Patient Signature of Consent:_____ Date:_____

Cell Phone:_____ (Please verify for emergency purposes.)

VIC Provider/Tech Signature (at time of review): _____

****

Today's procedure may be deemed as cosmetic or not medically necessary. I acknowledge this and wish to receive treatment.

Patient Signature of Consent:_____ Date:_____

UC SF Dermatopathology Service

Biopsies removed today will be sent to UC SF Dermatopathology Services for evaluation. This means that you may be receiving a bill from UC SF.

If you have questions about your bill or statement please call UC SF (415) 353-7546.

I understand that my tissue specimen(s) will be sent to and outside lab for processing, and I understand that a Dermato-pathologist not associated with Valley Immediate Care is consulted regarding my tissue diagnosis. While my insurance information will be forwarded to these other offices, I understand that if my insurance does not pay for these lab fees, I am responsible for the bill.

Name - Please print _____ Date _____

Signature _____