New Patient
URGENT CARE

Date: _____ Time: _____

This packet MUST be COMPLETELY filled out in order to be seen.

REASON FOR VISIT:

What are you here for Today? (Reason for Visit) _____
Date and time of Injury: _____

Have you previously been seen for this injury? ☐ No ☐ Yes (If yes, where?) _____
Explain the nature of illness and/or injury and what BODY PART was affected: _____
_____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Social Security last 4: _____
Street Address: _____ Birth Date:_____ Age:_____
City, State, Zip:_____ Primary Phone: _____
Sex: ☐ Male ☐ Female ☐ X (non-binary)
Drivers License #: _____
Emergency Contact Name: _____ Phone: _____

INSURANCE/PHARMACY INFORMATION

Name of Insurance:_____ Subscriber # or Claim #:_____
Subscriber's Date of Birth (if not patient):_____

☐ *I understand that if I do not supply my insurance information, I am responsible for all charges or fees for services, including outside laboratory/radiology services. By checking this box, I acknowledge this responsibility. I understand that I may ask for an approximate cost breakdown for services that may be rendered.*

Preferred Pharmacy: _____

ASSIGNMENT OF BENEFITS – FINANCIAL AGREEMENT:

I hereby authorize WorkFit Medical and its staff and providers to examine and treat my condition as the providers deem appropriate and I give authority for those procedures to be performed. I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my behalf. Should collection of past due amount(s) become necessary, I will be responsible for all charges, fees, and attorney fees. I (we) hereby authorize the provider to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

GINA Notice: Do Not Provide Genetic Information, Including Family Medical History

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or any embryo lawfully held by an individual or family member receiving assistive reproductive services.

Signature of Patient/Guardian: _____ Date: _____

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

1881 Western Avenue Suite 130
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-0769 Fax

Consent for
Examination, Treatment, Testing &
Release of Information

I consent to the use or disclosure of my confidential health information by WorkFit Medical, LLC for the purpose of diagnosis or treatment, obtaining payment for services rendered, and conducting operations of WorkFit Medical, LLC. My signature below is evidence of my consent for evaluation, diagnosis, or treatment by WorkFit Medical, LLC.

I understand that I have the right to request a restriction as to how my confidential health information is used or disclosed while providing treatment, payment, or health care operations of the practice. WorkFit Medical, LLC is not required to agree to the restrictions that I may request. However, if WorkFit Medical, LLC agrees to a restriction I request the restriction is binding on WorkFit Medical, LLC and the providers contracted or employed by WorkFit Medical, LLC. I have the right to revoke this consent in writing, at any time, except to the extent WorkFit Medical, LLC has taken action in reliance on this consent.

My confidential health information includes my demographic information provided by me as well as information provided by or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This confidential health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

The Notice of Privacy Practices for WorkFit Medical, LLC is provided on the wall in the waiting area. I understand I have a right to review WorkFit Medical, LLC's Notice of Privacy Practice prior to signing the document. The WorkFit Medical, LLC's Notice of Privacy Practice has been provided or offered to me.

The Notice of Privacy Practice describes the types of use and disclosures of my confidential health information that will occur pursuant to treatment, payment, or in the performance of healthcare operations of WorkFit Medical, LLC. This Notice of Privacy Practice also describes my rights and the duties of WorkFit Medical, LLC with respect to my confidential health information. WorkFit Medical, LLC reserves the right to amend the Notice of Privacy Practice at any time. I may obtain a revised copy of Notice of Privacy Practice upon request.

I agree to undergo clinical examination, diagnostic tests, medical treatment, and drug and/or alcohol testing consistent with the accepted standards of care and practice. The information obtained will be used to carry out treatment plans, to determine my fitness for work, or for billing purposes. I understand that the services routinely provided by WorkFit Medical, LLC are not meant to replace medical care provided by my personal healthcare provider. I am granting permission to WorkFit Medical, LLC to release the results of the examination/treatment and drug and/or alcohol results to the company specified above.

Patient Signature: _____ Date: _____

CONSENT TO TREAT A MINOR: YOU MUST HAVE DOCUMENTATION OF GUARDIANSHIP OR CUSTODY PAPERWORK WHEN BRINGING IN A MINOR

I (we) being the parents, guardian, or custodian of the minor being:
Last Name: _____ First Name: _____ M.I.: _____, Age: _____ do hereby request, and direct WorkFit Medical, LLC, its providers, and staff to perform examinations, diagnostic X-Rays, laboratory tests, and any treatment that in their judgement is deemed advisable or is required while said minor child is under care of this office's providers and staff until legal age. All charges for service and care given to said minor child will be charged directly to me (us) and I(we) will be personally responsible for payment of them. I (we) hereby authorize the provider to release all information necessary to secure payment of benefits. I authorize the use of this signature of this signature on all insurance submissions.

Parent, Guardian, or Custodian Signature: _____ Date: _____

Relationship to Patient: _____ Witness: _____ Date: _____

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Rochester WalkInCare Medical Treatment

Patient Consent Form

Albany WalkInCare Medical Treatment

Patient's Name: _____ Date of Birth: _____

CONSENT FOR TREATMENT:

Acting on my own behalf or on behalf of my child, I hereby authorize Rochester/Albany Walk In Care Medical Treatment to use and/or disclose my health information which specifically identifies me or which can be used to identify me to carry out my treatment. Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

PATIENT FINANCIAL INFORMATION/GUARANTEE OF ACCOUNT:

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and/or percentage, which the insurance is not responsible for on the day of your visit. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor, we will place your account with a collection agency, which will leave you liable for any additional charges incurred.

I hereby authorize and direct Rochester/Albany Walk In Care Medical Treatment, having treated me or my child, to release to governmental agencies mandated by law, insurance carriers, or other entities financially liable for the medical care of myself or my child/ward, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

It is the policy of Rochester/Albany Walk In Care Medical Treatment to release copies of your medical records to your primary care physician after each visit. We will release your medical records for today's visit based upon the information you provide on your patient intake forms at the time of your visit. Today's Authorization serves as an Authorization for Release of Health Information Pursuant to HIPAA and it supersedes all prior Authorizations on record with Rochester/Albany Walk In Care Medical Treatment.

PLEASE CHECK ONE OF THE BOXES BELOW:

☐ I authorize Rochester/Albany Walk In Care Medical Treatment to release my medical records for this encounter to my PCP.

☐ I **DO NOT** authorize Rochester/Albany Walk In Care Medical Treatment to release my medical records for this encounter to my PCP.

AND **PLEASE CHECK OPTIONAL SERVICES ONLY IF REQUESTED:**

☐ I **AUTHORIZE, at my expense,** Rochester/Albany Walk In Care Medical Treatment to perform Hepatitis C testing.

☐ I **AUTHORIZE, at my expense,** Rochester/Albany Walk In Care Medical Treatment to perform HIV testing.

If you would like Rochester/Albany Walk In Care Medical Treatment to release your medical records for this visit to a third party, or if you would like to authorize Rochester/Albany Walk In Care Medical Treatment to release information related to ALCOHOL/DRUG ABUSE, MENTAL HEALTH TREATMENT, or CONFIDENTAL HIV RELATED INFORMATION to ANY third party, at your request you will be provided with a separate Authorization for Release of Health Information Pursuant to HIPAA form which must be completed and returned to Rochester/Albany Walk In Care Medical Treatment before any protected health information will be released to any third party.

I hereby acknowledge the right to consent or refuse any proposed procedure(s) or treatment(s). This consent has been fully explained to me and I am satisfied that I understand its content and significance.

Patient/Guardian Signature: _____ Date: _____

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Patient's Name: _____ Date: _____

Yes	No	List medication allergies you have:
		Allergies (Specify):

Yes	No	List Medications You Take: (use back for more space)
		1.
		2.
		3.

Yes	No	Do **you** have any of the following?
		Cancer (Specify Type):
		Asthma
		Heart Disease (CAD)
		Stroke (CVA)
		Depression/Anxiety
		Diabetes
		Diverticulitis
		Hyperlipidemia
		Hypertension
		Hypothyroidism
		Peptic Ulcer
		Other

Yes	No	Have you had Surgeries or Operations?
		Surgeries (Specify):

Yes	No	Does your **family** have any of the following?				
		Blood Diseases		Father		Mother
		Cancer or Leukemia		Father		Mother
		Diabetes		Father		Mother
		Heart Disease		Father		Mother
		High Blood Pressure		Father		Mother
		Strokes		Father		Mother
		Mental Illnesses		Father		Mother

Yes	No	Do you use alcohol, drugs, or smoke?	
		Tobacco Use: How Much per Week?	
		Alcohol Use: How Much per Week?	
		Drug Use: Describe use & drug:	

Yes	No	Are you employed?	
		How long Employed?	
		Position?	

Yes	No	Menstrual History (Woman):	
		Are you pregnant?	
		Last Menstrual Date:	
		Last Pap Smear Date:	

		Left or Right Handed?		Left		Right
		Last Tetanus Shot Date?				

Are you Experiencing any of the following conditions/symptoms **TODAY**?

Yes	No	CONSTITUTIONAL
		Change in Appetite
		Chills
		Fatigue
		Fever
		Sweats
		Weight Loss
Yes	No	EYES AND VISION
		Blurred or Double Vision
		Contact Lenses
		Eye Discharge
		Eye Pain
Yes	No	EARS, NOSE, THROAT, TEETH
		Dizziness
		Ear Pain
		Nasal Congestion
		Nose Discharge
		Sneezing
		Sore Throat
Yes	No	CARDIOVASCULAR/HEART
		Chest Pain or Pressure
		Fainting
		Irregular Heart Beat
Yes	No	RESPIRATORY/LUNGS
		Congestion
		Cough
		Shortness of Breath
		Wheezing
Yes	No	GASTROINTESTINAL SYSTEM
		Abdominal Pain
		Diarrhea
		Nausea
		Urinary/Bowel Changes
		Vomiting

Yes	No	GENITOURINARY
		Discharge
		Frequent Urination
		Nighttime Urination
		Painful Urination
Yes	No	MUSCULOSKELETAL
		Joint Pain
		Muscle Pain
		Swelling
Yes	No	SKIN
		Easy Bruising
		Rash/Itching
		Redness
		Skin Sores
Yes	No	NEUROLOGICAL
		Headache
		Light Headedness
		Numbness
		Poor Balance
		Tingling
		Weakness
Yes	No	PSYCHIATRIC
		Anxiety/Nerves
		Depression
Yes	No	ENDOCRINE SYSTEM
		Diabetes
		Hyper or Hypothyroid
		Heat or Cold Intolerance
Yes	No	HEMATOLOGIC/BLOOD DISORDERS
		Frequent Infections
		Swollen Glands
Yes	No	IMMUNE SYSTEM
		Hay Fever or Allergies
		Food Allergies

Patient's Signature: _____ Date: _____

Chief Complaint:	Height	Weight	Temp	BP	Pulse	Resp	PO %	Room

ROCHESTER RHIO

Regional Health Information Organization

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

PROVIDER: _____

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans attached to this form to obtain access to my medical records through the health information exchange organization called Rochester RHIO. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Rochester RHIO is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Rochester RHIO's website at www.RochesterRHIO.org.

My information may be accessed in the event of an emergency, unless I complete this form and check box #2, which states that I deny consent even in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **I GIVE CONSENT** for above-named Provider Organization, or Health Plan or reference to a list of specific Provider Organizations and/or Plans to access ALL of my electronic health information through Rochester RHIO to provide health care services (including emergency care).

☐ **I DENY CONSENT** for above-named Provider Organization, or Health Plan or reference to a list of specific Provider Organizations and/or Plans to access my electronic health information through Rochester RHIO for any purpose, ***even*** *in a medical emergency (except for minor patients)*.

If I want to deny consent for all Provider Organizations and Health Plans participating in Rochester RHIO to access my electronic health information through Rochester RHIO, I may do so by visiting Rochester RHIO's website at www.RochesterRHIO.org or calling Rochester RHIO at 1-877-865-RHIO(7446).

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)