PRIMARY
WALK-IN
Medical
Center

Primary Walk-In Medical Center
684 Warren Avenue
East Providence, RI 02914
T: (401) 434-0022
F: (401) 434-6111
Hours of Operation: Monday -Friday 9am-7pm, Saturday-Sunday 9am-2pm

Medical Questionnaire

Please take a few minutes to answer the following questions so we may better assist your healthcare needs

Name: _____ **D.O.B:** _____ **Today's Date:** _____

Best Contact Phone #: _____

Reason for today's visit:

_____

_____

_____

Do you or have you smoked? □ No □ Yes When?_____**Pks/Day:** _____ **Yrs Smoke:**_____

Any allergies to food or medicine? □ No □ Yes _____

Please check off any of the following conditions you have or had in the past:

□ Heart attack
□ Heart palpitations
□ Angina
□ Chest pain with exertion
□ Heart murmur
□ Abnormal heart rate
□ Pacemaker
□ Any other heart problems
□ Metal Implants/Plates/Screws
□ Diabetes
□ Low blood sugar
□ Shortness of breath
□ Asthma or allergies
□ Other lung problems
□ Heartburn, stomach or intestinal upset
□ High Cholesterol
□ History of ulcers
□ Cancer
□ Chance of pregnancy
□ High blood pressure
□ Night sweats or fever
□ History of neck or back pain
□ Bowel/bladder problem
□ Thyroid problem
□ Osteoporosis
□ Headaches
□ Frequent sprains/strains
□ Joint pain or swelling
□ History of fractures
□ History of trauma
□ Loss of appetite
□ History seizure/epilepsy
□ Other:_____

Please check off any of the following conditions your Family have or had in the past:

□ Heart palpitations
□ Angina
□ Chest pain with exertion
□ Cancer
□ Metal Implants/Plates/Screws
□ Night sweats or fever
□ Asthma or allergies
□ Other lung problems
□ Heartburn, stomach or intestinal upset
□ High Cholesterol
□ High blood pressure
□ Seizure/epilepsy
□ Thyroid problems
□ Osteoporosis
□ Heart murmur
□ Frequent sprains/strains
□ Diabetes
□ Heart attack

Is there anyone who may obtain your Medical Information without your written consent? □ Yes □ No

_____ _____ _____
Name **Relationship** **Phone #**

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CREDIT/ DEBIT/ HSA CARD BALANCE DUE AUTHORIZATION; NO CALL NO SHOW SERVICE FEE AUTHORIZATION FORM

At Primary Walk-In Medical Center, we require keeping your Credit/Debit/HSA card on file as a convenient method of payment for the portion of services that your insurance company doesn't cover, but for which you are liable. Insurance is a contract between you and your insurance company. In most cases, we are not a party of this contract. It is your insurance company that makes the final determination of your eligibility and benefits. You will be notified, by way of hard copy mail to the address you provide the front desk, what portion of the balance your insurance company covers and what you are obligated to pay. All balances due will be settled through the Credit/Debit/HSA card on file. Rest assured, this will not compromise your ability to dispute a charge or question your insurance company's determination of payment. If in the event that an outstanding balance is settled, and your insurance company reimburses this balance to our facility, a credit will then be held here at Primary Walk-In Medical Center, that can be utilized for future visits. This credit will be held here until it is either utilized for office visits, or until a written request is submitted for refunding of these fees/credit.
If you are unable to provide a Credit/Debit/HSA card on file OR if you are a patient who has an insurance plan to where your deductible has not yet been met, ***you will be charged the estimated contractual rate of $120.00 at each office visit (this fee is predetermined by your insurance), until you have fully met your deductible***.
INITIAL _____

ANY AND ALL SCHEDULED APPOINTMENTS: Failure to cancel/reschedule a scheduled appointment of any kind, within 24 hours of visit, will result in a ***NO CALL NO SHOW SERVICE FEE*** of **$50.00 (*fifty dollars*)**. These service charges are deemed outstanding and are due immediately. These fees will be immediately settled through the Credit/Debit/HSA card on file. Service to our patients is of paramount concern. In order to be able to properly and efficiently schedule appointments, for all of our patients, it is important that our patients maintain appointments. We understand that circumstances occur, in which you must cancel/reschedule an appointment. We kindly ask that you notify us within 24 hours of a previously booked visit, that you must cancel or reschedule. Missed appointments without such 24 hour notice, impact other patients with their scheduling. **INITIAL** _____

Please note, your Credit/Debit/HSA card information is kept confidential and secure within our medical charts, once scanned in. The paper copy of this information is immediately shredded. Payments through your Credit/Debit/HSA card ***are initiated only after*** the claim has been filed and processed by your insurance company, ***and after*** the insurance portion of the claim has been paid and posted to your account. We thank you in advance for your cooperation. I, the undersigned, authorize and request **Primary Walk-In Medical Center** to charge my Credit/Debit/HSA card, indicated below, for balances due from "no call no show service fees" and/or services rendered that my insurance company identifies as my financial responsibility.

Card Number: _____ **Exp. Date:**_____ **CVV:**____

Name on Card (Please Print): _____

Signature: _____ **Date:**_____

*****PLEASE HAVE THIS CARD READY IN HAND WHEN RETURNING TO FRONT DESK.*****

This policy is MANDATORY and there will be no exceptions made.
If you have any questions, do not hesitate to ask.

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Medical Questionnaire

Please list all medications that you are currently taking, including over the counter medications.

_____

_____

_____

_____

Do you have any current or past medical conditions that we should be aware of?

_____

_____

_____

_____

Please list any surgeries you have had and their dates:

_____

_____

_____

_____

Primary Care Physician's Name: _____

Address: _____ Phone: _____

Emergency Contact: _____

Relation: _____ Phone: _____

CONSENT, ACKNOWLEDGEMENT, AUTHORIZATION AND ASSIGNMENT TO SERVICE INTERVENTION FORM

ACKNOWLEDGEMENT OF OFFER TO READ AND QUESTION HIPPA NOTICE OF PRIVACY PRACTISES: This is to certify that I have been provided a copy of Primary Walk-In Medical Center (PWIMC) NOTICE OF PRIVACY PRACTICES as has been mandated by the Health Care Information Privacy and Portability Act (HIPPA). I have been given the opportunity to ask questions which have been answered to my satisfaction.

CONSENT TO TREATMENT AND RECEIPT OF SERCVICES: I voluntarily consent to the provision of services at PWIMC for evaluation and treatment or testing relative to my diagnosis/medical condition as directed by my referring physician. I understand that the provider may request other practitioners, to participate in my care. I understand that based upon the finding from my initial assessment, the Physician or their designee will explain to me their recommendations and, as applicable, establish a plan of care in cooperation with myself and my referring physician which may be modified during my treatment sessions as determined by my reports, physical presentation and clinical findings. I understand that, with few exceptions, providers are employees of the center. I understand that specific testing may require separate consent.

AUTHORIZATION FOR RELEASE OF INFORMATION TO PAYORS: I authorize PWIMC and any provider administering care to me, including, but not limited to physical therapist, occupational therapists and functional capacity assessment specialist to release medical and or other information necessary for the 1) completion of insurance claims or receipt of benefits, 2) review the quality and appropriateness of my care by representatives of external agencies designated by law to conduct such review. I understand that PWIMC will forward copies of all or part of my medical record to my Referring Physician and/or any physician or facility participating in my care of continuation of care. If my care is related to an accident at work, I understand that my employer's Workers' Compensation Carrier will also have access to information contained in my record. I specifically authorize release of the following information which may be included in my medical record if it applied to me: AIDS, HIV, presence of a sexually transmitted disease, mental illness and/or drug or alcohol addiction or abuse.

DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY INSURANCE POLICIES: I authorize my insurers to pay benefits, which would otherwise be payable to me under my insurance policies, directly to PWIMC and/or to the provider administering the professional services to me.

MEDICARE AUTHORIZATION: I certify that the information given by me in applying for payment of Medicare benefits under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration ad the Center for Medicare and Medicaid Services (CMS) (formerly known as the Healthcare Financing Administration (HCFA) or its intermediaries or carriers any information needed for this and related Medicare claim. I request the payment of authorized benefits to be made on my behalf to PWIMC.

WORKER'S COMPENSATION: In the event that I have identified that my injury was a result of a work related incident, I hereby authorize PWIMC to contact my employer to establish or verify the workers compensations carrier that will process claims relative to my care for this injury and to identify the physical job demands required for my employment and any other information that is relative to my ability to return to work. I understand that not all potential workers compensation claims filed are accepted for liability. As such, I agree, upon registration, to provide to PWIMC my personal health insurance that I hereby authorize PWIMC to bill should workers compensation deny or not provide acceptance of a valid claim within 60 days of my initial visit.

MOTOR VEHICLE and PERSONAL INJURY: In the event that I allege that my injury was sustained as a result of another party's negligence, I will provide PWIMC my personal health insurance information which I hereby authorize to be billed as the primary carrier to avoid potential timely filing denials with my carrier should the liability claim be denied. I agree to also provide at registration, the third party insurance carrier information. I authorize PWIMC to be the third party insurance carrier for all services received in the event of a denial from my health insurance carrier or as a secondary carrier for my deductible, co-payment upon payment from my health insurance carrier. I agree to provide the name of the attorney pursuing my claim for damages. I also agree to sign a contractual lien for payment (Lien). If I or my attorney refuse to sign the Lien, I understand that any unpaid balance shall then be due PWIMC post insurance submission and response will become immediately due and payable.

FINANCIAL RESPONSIBILITY: Most insurances policies provide coverage for the services provided by PWIMC, however, this office makes no representations that yours does. Insurance policies differ greatly in terms of provider requirements, deductibles, co-insurance, co-payments and visit allowances. Because of these variations, this consent reminds the patient of the guardian is personally responsible for any deductible, co-payment, co-insurance or any unpaid balances due to non-payment by the insurance carrier. PWIMC will make all efforts to obtain and meet the necessary requirements for reimbursement from the third parties provided to PWIMC as having responsibility to compensate for services rendered. It is the sole responsibility of the patient or guardian to understand and adhere to all aspects of their third party healthcare insurance contract. It is further understood that patients or guardian not having third party reimbursement contracts (IPRCs) are themselves responsible for compensating PWIMC for services rendered. I agree to notify PWIMC immediately of any change in information relative to my claim; change in insurance carrier or plan, my billing address, or attorney representing my case. Should bills/invoices be sent to the address on file and returned as undeliverable return to sender as a result of incorrect information, upon receipt of the returned mail, without further notice, the account will be forwarded to the collection attorney and all costs and fees of collection will be applied as identified below for delinquent accounts. I agree that should I make payment on my account with a personal check and that check is returned unpaid by the bank, I will be charged a fee of $35.00 of which I will promptly pay

MEDICAL RECORDS: I will notify all parties that require a copy of my medical record that all request must be submitted to PWIMC's main office at 684 Warren Ave East Providence, RI 02914 for processing. A fee for the retrieval and processing of the record may be applicable.

SIGNATURE: I have read the information above or have had it read to me, I understand the information and have had my questions answered to my satisfaction. My signature below verifies that I have consented to the above.

A Photocopy of the Consent, Acknowledgment, Authorization and Assignment shall be considered effective and valid as the original.

Signature of Patient	Date	Signature of Witness	Date
Signature of Guardian/Representative	Relationship	Reason for Giving Consent	Date