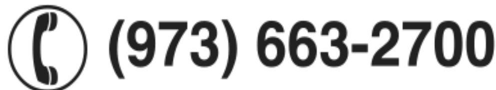
SKYLANDS
URGENT CARE

# SKYLANDS URGENT CARE




## PATIENT INFORMATION

Last name: First name: Middle Initial:

Would you like to register for the Portal ? Yes ☐ No ☐

Address:

Date of Birth: / /

City: State: Zip code:

Cell phone: ( )

Email:

Home phone: ( )

Preferred Pharmacy :

Marital status: (circle) S / M / W / D

Reason for Visit:

Prior medical history:

Current medications:

Allergies:

Primary care Doctor: Phone number:

Have you ever smoked? ☐ Yes ☐ No Currently smoke? ☐ Yes ☐ No Use recreational drugs? ☐ Yes ☐ No

## EMERGENCY CONTACT

Emergency contact name: Emergency contact phone #: ( )

## INSURANCE INFORMATION

Policy holders name (if different): Policy holders birthdate: / /

Your relationship with the policy holder:

*If proper insurance information is not provided on the date of service, our office is not responsible for filing back charges. Please be advised that it is your responsibility to be aware of the benefits that your medical plan provides. I verify that the above information is correct to the best of my ability. X_______________________Date: / /

**FINANCIAL RESPONSIBILITY:** I acknowledge full financial responsibility to any services received and understand that all charges incurred in this office is due at time of service, I also understand that the charges not covered by insurance remain my responsibility and assign endurance benefits to this office ____(initial)

**CONSENT FOR TREATMENT:** I consent to the care and treatment by the attending Provider, their associates and assistant acknowledge that no guarantees have been made as to the effect of such treatment.

**Patient/Guardian Signature:_______________________________ Date: __________**

****PLEASE SEE NEXT PAGE AND SIGN HIPAA FORM****

HIPAA Notice of Privacy Practices Statement

Notice of Information Practice and Privacy Statement

# SKYLANDS URGENT CARE

174 Edison Road, First Floor

Lake Hopatcong, NJ 07849

Phone: (973) 663-2700

Fax: (973) 663-2702

How we collect information about you: Skylands Urgent Care of Lake Hopatcong and its employees collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

What we do not do with your information: information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails) is held in strictest confidence. We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about clients who receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

Under no circumstances can we discuss any medical information such as, but not limited to (treatment, prescriptions, medical advice, medical records, lab results, etc.) via email/contact forms from the website. Any information pertaining to medical information must be requested in person or by phone.

Patient's Responsibility:

I authorize the physicians and medical personnel to provide necessary medical treatment. I verify the accuracy of afore-mentioned information, and I authorize the release of information as provided. I agree that I am fully responsible to pay all fees charged by the doctor, regardless of how much my insurance pays. If the doctor accepts assignment, the deductible and co-payments are my responsibility.

## Please Sign Below:

X______________________________________________ Date: __________________