SKYLANDS URGENT CARE
(973) 663-2700

MVA INTAKE

To help us provide the best care possible, please thoroughly complete and sign the following form. This information is confidential and will be kept as a part of your permanent record.

Patient Info

Patient Name________________________ ____________________________ **Today's Date** ______/_________/______

Address ____ **APT No**______________________

City:_________________________________**State:**_____ **Zip Code** ______________ **Phone No**_________________

Date of Birth:____/____/_____ **Social Security No** _________________ **Email** ______________________________

Auto Insurance Info

Name of Insurance Co _______________________

Policy No ___________________________________

Phone No ___________________________________

Adjuster's Name ____________________________

Claim No ____________________________________

Precertification Phone No ___________________

Address for Claims __________________________

City:_______________**State:**____ **Zip Code**_______

Accident Details

Date of Accident _______ ____________________

Time of Accident _______________ **AM**____ **PM**_____

Did you report the accident to your auto insurance?

Yes ☐ **No** ☐**If yes, when?** ___/___/___

Did you file a PIP/NO-FAULT application with your auto insurance carrier? **Yes** ☐ **No** ☐ **Motorcycle PIP** ___

Claims will be paid by:

☐ **Auto insurance**

☐ **Primary health insurance**

Accident Description

Did accident occur in New Jersey Yes ☐ **No** ☐ **Out of state? Yes** ☐ **No** ☐

Please give a full description of how the accident occurred.

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Medical Insurance Info

Name of Insurance Co _______________________

Policy No ___________________________________

Phone No ___________________________________

Policy Holder Name________________________

Date of Birth:____/____/____ **Sex** ☐ **M** ☐**F**

Relationship to Patient

☐ **Self** ☐ **Parent** ☐ **Guardian** ☐ **Spouse**

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PATIENT NAME ____ **DATE** ____/______/_______

Consent for Treatment

I Consent to the care and treatment by the attending physician, his/her associates or assistants and acknowledge that no guarantees have been made as to the effect of such treatment.

Patients Initial: _____________ **Date:** ______/_______/_______

Consent for Treating a Minor:

The information I have given this office pertaining to __________________________ is true and complete to the best of my knowledge. I authorize the doctors and staff of Skylands Urgent Care to administer such care and treatment as they seem necessary to my child/ward in my legal custody. The doctors have implied that no guarantees have been made as to the effect of such treatment.

Parent/Guardian Initial: _____________ **Date:** ______/_______/_______

For Women Only

The attending physician and his/her associates of Skylands Urgent Care have advised me that x-rays can be hazardous to an unborn child. Currently and to the best of my knowledge, I am not pregnant. I consent to have an x-ray taken.

Patients Initial: _____________ **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).*

Patient/Guardian Signature: ____ **Date:** _______________________

PATIENT HISTORY INFORMATION RELEASE

Is there a person that you authorize to receive/discuss your PHI? ☐ **Yes** ☐ **No**

If yes, please indicate name and relationship: **Name**____

Relationship____________________ **Date of Birth** ___________________**Phone No**_______________________

__________________________________	______________________________	_________________________
PRINT NAME	**SIGNATURE**	**DATE**

HIPAA Notice of Privacy Practices Statement

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 aforementioned 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:

Patient/Guardian Signature: ____ **Date:** __________________________