UNIVERSITY of MARYLAND URGENT CARE

Check-In Form

Patient

Date: ____/____/____ Email: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of birth: ____/____/____ Phone: (____) ____ – ____

Primary Care Provider: _____ Gender: ❑ Male ❑ Female

Primary Care Provider Phone: (____) ____ – _____ Preferred Pharmacy: _____

How did you hear about us? _____

Referred by another provider? ❑ Y ❑ N If yes, Provider name: _____

Reason for visit today: _____

Is this visit workers' comp related? ❑ Y ❑ N If yes, date of injury: _____

If yes, employer name: _____

Responsible Party (for children under 18)

Name: _____

Date of birth: ____/____/____ Patient relationship to responsible party: _____

Same address **and** phone as patient? ❑ Y ❑ N

(If no, please provide): _____

Primary Insured (insurance policy holder)

Name: _____

Date of birth: ____/____/____ Gender: ❑ Male ❑ Female

Patient relationship to responsible party: _____

Same address **and** phone as patient? ❑ Y ❑ N

(If no, please provide): _____

_____ _____ ____/____/____

Signature of patient or legally authorized representative | Relationship to patient/witness or translator | Date (MM/DD/YYYY)

revised 3/21 CIFP

Your Experience is Our #1 Priority

Our goal today is to provide you with exceptional care.
Please review each of the items below and place your initials accepting your consent.
Let us know if you have any questions or need further clarification.

Patient Feedback	
❑ Accept ❑ Decline Initials	Your opinions and follow-up care matter. With your consent, we would like to send you automated text messages to obtain feedback on your experience as well as follow-up with you three days following your visit to check how you feel. By selecting Accept you agree to allow us to send automated text messages to the patient phone number(s) you provided. Message/data rates will apply. By agreeing to accept these text messages, you acknowledge SMS text messaging is not a secure form of communication and there is some risk that a text containing personal health information (PHI) may be disclosed to, or intercepted by, unauthorized third parties. We will NOT text you sensitive information such as your actual lab results, we will simply notify you via text that we have additional information to share and request that you call us at your convenience. You may opt out at any time by replying "STOP" to the text. Please note, our providers cannot engage in two-way text messaging. By selecting Decline you will not receive automated text messages regarding your experience or follow up care but are comfortable being contacted by telephone at the contact number(s) you provided.

Private Insurance	
❑ Accept ❑ Decline Initials	**Copay** - All patient co-pays must be paid at the time of service. **Card on File** - Our policy is to reserve a credit card on file so that any co-insurance or unmet deductible amounts can be easily managed after we receive the Explanation of Benefits (EOB) from your insurance company. *PLEASE NOTE: We receive the EOB from your insurance company at the same time that you do. The EOB should be considered your alert that you may owe an additional amount. You have roughly 7 days to contact us with questions or another form of payment before the card on file is charged. *We do not bill Personal Injury Protection insurance for visits related to a motor vehicle or personal injury. Please ask about our prompt pay rates for patients not using insurance.

Records Sent to PCP	
❑ Accept ❑ Decline Initials	When you provide your Primary Care Provider's (PCP) information, we will automatically share a copy of today's visit notes with your PCP following this visit.

Services Rendered	
❑ Accept ❑ Decline Initials	Once you have been evaluated by a provider there will be a charge for the visit. *A provider may determine that we do not have the appropriate equipment or specialization to provide the medically necessary care you require. In those cases, you will be billed for the evaluation, clinical guidance, and/or coordination of your transfer. Your wellbeing is always our highest priority.

Antibiotic Stewardship	
❑ Accept ❑ Decline Initials	Our providers are trained to provide the most medically appropriate and responsible care possible. Sometimes medication/antibiotics are not the best course of treatment based on your current symptoms or lab results. We take pride in ensuring we are not unnecessarily prescribing antibiotics that could negatively affect our patients' health.

Commercial Payor Patient Financial Responsibility Acknowledgement	
❑ Accept ❑ Decline Initials	UM Urgent Care offers certain clinical testing services to its patients, including SARS-CoV-2 RNA and Qualitative NAAT testing, to its patients ("COVID-19 Testing"). UM Urgent Care will use third party laboratories to perform the clinical laboratory services for the COVID-19 Testing. Depending on your individual health plan and coverage, your COVID-19 Testing may not be covered, and/or you may be subject to certain deductibles, copayments, coinsurance, prior authorization, or other medical management requirements. COVID-19 Testing for workplace safety, public health surveillance, asymptomatic testing, or any efforts not primarily associated with individualized diagnosis or treatment include some, but not all, of the reasons your COVID-19 Testing may not be covered by your individual health plan. By signing this form, you indicate your agreement that you will be billed and individually responsible for up to One Hundred Dollars ($100.00) for your COVID-19 testing if it is not covered, in whole or in part, by your health insurance plan, subject to UM Urgent Care's billing and collections procedures. You are solely responsible for checking with your individual health plan regarding whether your COVID-19 testing is covered by your individual health plan. You acknowledge that certain sites in Maryland may provide testing free of charge and that UM Urgent Care will provide you with a list of these sites if you would prefer to have your COVID-19 testing performed at an alternative free testing site. UM Urgent Care makes no representations regarding the charges at the free testing sites and you should verify your responsibility for payment at the alternate sites.

UNIVERSITY of MARYLAND URGENT CARE

Consent to Treat Form

CONSENT TO TREAT
By signing this form, I give permission to UM Urgent Care, and its associated physicians, assistants, agents, and other health care providers and suppliers to perform the medical and health care services ("Services") that my physicians and other non-physician providers and assistants may deem necessary.

I understand that: (i) such Services may include physical examinations, diagnostic and laboratory testing, and other diagnostic and treatment procedures; (ii) that as part of the Services, photographs, videos, and other images may be made/recorded for treatment and payment purposes; and that I have or will be given an opportunity to ask questions about the Services provided by UM Urgent Care.

NOTICE OF PRIVACY PRACTICES AND RELEASE OF MEDICAL INFORMATION
I acknowledge and understand that (i) I have received a copy of the UM Urgent Care "Notice of Privacy Practices" on or before the date on this form; (ii) the Notice of Privacy Practices provides information about how UM Urgent Care and its health care providers and workforce may use and/or disclose protected health information about me; (iii) I can get access to this information (iv) I may contact the Privacy Officer at 443-462-5425 or via email at Privacy@umm.edu if I have questions regarding this Notice of Privacy Practices; (iv) UM Urgent Care may release information obtained as a result of the Services to my other health care providers, my health care insurer or other payer, or as otherwise provided in the UM Urgent Care Notice of Privacy Practices; and (v) UM Urgent Care cannot be responsible for use or re-disclosure of information by third parties.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS
(non-occupational health visits only)
I understand that, based on my current health care insurance coverage (if any) and UM Urgent Care contract with my applicable insurance company or other third party payer (if any), I will be personally responsible for either:

1. The full payment for any Services provided to me by UM Urgent Care; or

2. My applicable co-payment and/or deductible plus the cost of any other Services not covered by my then current insurance.

I acknowledge and understand that (i) such payments will be due at the time that UM Urgent Care provides the applicable Services; (ii) such payments will be due each time that I receive Services from UM Urgent Care; (iii) depending on the current time and date, an after-hours fee may be applied to my visit which may or may not be covered by my insurance; (iv) I agree to pay all charges for Services not covered by my health insurer or other payer (including Medicare or Medicaid) and agree to make payment as requested by UM Urgent Care; (v) if I do not have insurance coverage or UM Urgent Care does not have a direct contract with my applicable insurer or payer, I will be required to pay in full for my Services at the time that such Services are provided or as otherwise requested by UM Urgent Care. In order to more efficiently manage the payment process, I assign to UM Urgent Care my rights to any applicable health care benefits payable to me under my insurance or other third-party payer program (including Medicare and Medicaid), and I authorize direct payments, up to the total amount of my charges, to be made by such payers directly to UM Urgent Care.

I acknowledge and understand that by signing this form and providing my email address and mobile number; that (i) I authorize UM Urgent Care to use my email address for practice and health-related messaging purposes and for certain limited marketing purposes; (ii) such marketing and messaging uses shall be limited to communications between and among UM Urgent Care and myself; (iii) UM Urgent Care values patient privacy and does not sell email addresses or use them for purposes other than those outlined herein or in the UM Urgent Care Notice of Privacy Practices; (iv) except as otherwise stated in the UM Urgent Care Notice of Privacy Practices, I can revoke this authorization and opt-out of such marketing and messaging uses at any time after receiving my initial email from UM Urgent Care; (v) I am consenting to allow UM Urgent Care or its contracted agencies to use the phone number I provided to communicate with me in the case of any outstanding balances on my account(s) or for the purposes of my healthcare coordination; and (vi) UM Urgent Care has not conditioned my treatment on the provision of these authorizations. The information provided is correct to the best of my knowledge. I will not hold UM Urgent Care, its health providers, or its employees responsible for any errors or omissions that I may have made in completing this form. For Occupational Health visits only: UM Urgent Care may contact my employer to verify the purpose of my visit, if necessary.

Printed patient name: _____

My signature indicates I have reviewed the Consent to Treatment and Financial Responsibility (or reviewed it with another party). I have reviewed the Notice of Privacy Practices. I agree to accept all the terms and conditions and agree with the statements on this form.

I understand the described authorizations and consents will be valid and remain in effect as long as I attend or receive services from UM Urgent Care, unless I revoke any such authorizations/consent.

Signature of patient or legally authorized representative	Relationship to patient/witness or translator	Date (MM/DD/YYYY)
		/ /