QUALITY CARE ASSOCIATES

416 Front Street Marietta, Ohio 45750

Today's Date _____

Last Name _____ First Name _____ Middle Name _____ Nickname _____

DOB _____ SSN _____ Gender (circle one) Male or Female

Mailing address _____ Apartment Number _____

City _____ State _____ Zip Code _____

Home phone _____ Cell Phone _____ Work Phone _____

May we text you? Y or N Status (circle one) Single Married Divorced Widowed

Email Address (This allows us to send lab work and communications through our portal) _____

Patient Employer _____

Partner or Spouse _____ Phone Number _____

Emergency Contact _____ Phone Number _____

Preferred Pharmacy _____ Primary Care Physician _____

Who may we thank for referring you? _____

Responsible Party Information (if different from patient)

Last Name _____ First Name _____ MI ____

DOB ___/___/_____ SSN _____ Age ____ Gender (circle one) Male or Female

Home Address _____ Apartment Number _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Relationship to Patient (circle one) Parent Spouse Legal Guardian

Insurance Information (please present card and a picture ID to receptionist

Primary Insurance Company _____ Insurance Phone Number _____

Insured Last Name _____ Insured First Name _____

ID# _____ Group# _____

Insured DOB ___/___/_____ Relationship to Patient (circle one) Parent Spouse Legal Guardian

Secondary Insurance Company _____ Insurance Phone Number _____

Insured Last Name _____ Insured First Name _____

ID# _____ Group# _____

Insured DOB ___/___/_____ Relationship to Patient _____

QUALITY CARE ASSOCIATES

416 Front Street
Marietta, OH 45750
Office (740) 236-4131 Fax (740) 371-7778

HIPAA CONSENT FORM

I understand that as part of my healthcare, Quality Care Associates Urgent Care and Wellness Center, LLC, originates and maintains records describing my healthcare, medical history, symptoms, diagnoses, examinations, test results, and treatments, medications, and future care planning. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communicating among other healthcare professionals that contribute to my care.
- As a source of information in applying for healthcare and various insurance coverage.
- As a source of information for payment of medical bills.
- A source by which third party payers and or billing parties can verify treatment.
- A tool for routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.
- As requested by bonafide legal authorities.

I have been provided with a copy and understand the HIPAA Privacy notice as it relates to this office. I understand that I have the right to review this document before signing it. I understand the practice reserves the right to change the notice in accordance with the law. I may request a copy at any time.

I understand I have the right, in specific incidences, to restrict release of my information.
Healthcare operations, legal, and payment issues are not required to be restricted.
I understand I may revoke or change my authorization at any time with written notice.

Information may be released to the following:

Name_____ Name_____

Relationship_____ Relationship_____

Phone Number_____ Phone Number_____

Signed_____

Date_____

Office Registration Clerk_____

Date_____

ASSIGNMENT OF BENEFITS

FINANCIAL RESPONSIBILITY

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Quality Care Associates and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify Quality Care Associates of any changes in my health care coverage. In some cases exact insurance benefits can not be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Quality Care Associates and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

ASSIGNMENT OF BENEFITS

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Quality Care Associates for all covered medical services and supplies provided to me during all courses of treatment and care provided by Quality Care Associates and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Quality Care Associates, and will constitute a continuing authorization, maintained on file with Quality Care Associates, which will authorize and allow for direct payment to Quality Care Associates of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Quality Care Associates.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by Quality Care Associates. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by Quality Care Associates.

Patient/Insured (Printed Name) _____ Date of Birth _____ Social Security Number _____

Patient/Insured (Signature) _____

Date of Signature _____

NO SHOW/MISSED APPOINTMENT POLICY

We, at QCA Urgent Care and Wellness, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: (740) 236-4131

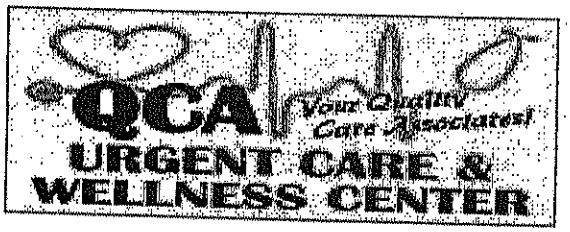
To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see the clinician's at QCA Urgent Care and Wellness and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.
2. If less than a 24-hour cancellation is given this will be documented as a "No-Show" appointment.
3. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.
4. After the first "No-Show/Missed" appointment, you will receive a phone call or letter warning that you have broken our "No-Show" policy. QCA Urgent Care and Wellness will assist you to reschedule this appointment if needed.
5. If you have 2 "No-Show/Missed" appointments within a one-year time period, you will receive a warning letter from our office and will be assessed a $35.00 no show fee.
6. If you have 3 "No-Show/Missed" appointments within a one-year time, you will receive a second $35 no show fee assessment. Dismissal from the practice will be considered.
   "You will be notified by letter if the dismissal was approved.

I have read and understand QCA Urgent Care and Wellness' No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify QCA Urgent Care and Wellness appropriately if I have difficulty keeping my scheduled appointments.

Patient Name	Date of Birth	Date
Patient Signature or Parent/Guardian if minor		Relationship to Patient
Staff Signature	Date	



Primary Care	Urgent Care
Richard Clark, MD	Jeff Patey, MD
Michele Brown, NP	Gina Prunty, NP
Renea Ball, NP	

MEDICATION REFILL POLICY

- It is your responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to three business days so please be courteous and do not wait to call. If you use a mail order pharmacy, please contact us fourteen (14) days before your medication is due to run out.
- Medication refills will only be addressed during regular office hours (Monday-Saturday 8am-8pm). The Urgent Care staff will not return any phone calls regarding refills. Please notify your provider on the next business day if you find yourself out of medication after hours. No prescriptions will be refilled on Sundays or Holidays.
- Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers.
- Some medications require prior authorization. Depending on your insurance this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.
- It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations will result in a denial of refills. All prescriptions require a follow up appointment every 3 to 6 months.
- If you have any questions regarding medications please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed please contact us immediately.
- New symptoms or events require a clinic appointment. Your provider will not diagnose or treat over the phone.

Patient's Signature _____ Date _____

Guardian's Signature (if under 18) _____ Date _____