EMERGENCYONE

40 Hurley Ave. Ste. 4	4250 Albany Post Rd Ste. 1	306 Windsor Highway
Kingston, NY 12401	Hyde Park, NY 12538	New Windsor, NY 12553
845-338-5600	845-229-2602	845-787-1400
845-338-3058 Fax	845-229-2830 Fax	845-787-1393 Fax

Section 1 PATIENT INFORMATION

Primary reason for today's visit? _____

E-mail Address (for health news letter and payment receipt)

_____

Pharmacy & Address: _____

Last Name, First, Middle_____

Street_____

City, State, Zip_____

Home Phone #_____

Cell Phone#_____

SEX: M ___F___ Birth Date_____ Age_____

__Single __Married __Widowed __Separated __Divorced
Race: ___ White ___Black/African American __ Asian
Ethnicity: ___ Hispanic Origin ____Non Hispanic Origin
Language: ___ English ___Other_____

Occupation/Employer_____

SS#_____

How did you hear about us? _____

Section 3

It is our policy that we share your visit notes today with your primary care physician. Please provide us with their information. If you do not want us to share your medical documentation, please decline by checking the box.

Primary Care Physician:_____

Address_____

_____

☐ **DECLINE**

INSURANCE INFORMATION

Section 2
Primary Insurance

Insurance Co._____

ID#_____

Group#_____

Policy Holder's Name_____

Date of Birth_____

Relationship to Patient_____

Secondary Insurance

Insurance Co._____

ID#_____

Group#_____

Policy Holder's Name_____

Date of Birth_____

Relationship to Patient_____

Please see reverse side.

Section 4

Emergency One has my permission to leave a message with a family member or on my home answering machine to confirm an appointment or leave test results. Yes__ No__ Alternate#_____

I acknowledge that I have been provided with a copy of Emergency One's HIPAA Privacy Notice.

I am consenting to the evaluation and treatment of the condition for which I sought treatment at Emergency One today.

I have had the opportunity to ask questions about this consent and they have been answered to my satisfaction

Signature:_____Date:_____Witness:_____

Section 5: FOR EMPLOYER PAID SERVICES ONLY

I understand that if I am here for an employer paid physical examination, other employer required medical screening, or a drug/BAT screen for an employer or potential employer, I give my permission for such required records and/or results to be released to that employer or potential employer

Signature:_____Date:_____Witness:_____

Patient Rights

I consent to customary care which consists of, but is not limited to: nursing services, administration of medications and intravenous therapy, noninvasive diagnostic procedures, and routine laboratory work (including random drug screening) as ordered by the physician when necessary as a patient at Emergency One Urgent Care and Diagnostic Center.)

I am aware:
I have the right to be treated with courtesy, respect and dignity.

A. I have a right to receive from the physician or other health care professional any and all information about invasive, non-routine procedures that are proposed to me.
B. I have the right to consent or refuse to consent to any proposed treatment while a patient at Emergency One.
C. I have the right to privacy as described in HIPAA.
D. I have the right to an interpreter.
E. I have the right to submit a complaint or grievance for follow up by Emergency One.
F. I have the right to receive accurate and easily understood information about my healthcare professional and healthcare facility.
G. I have the right to refuse the release of personal health information (except when permitted by law or in regard to work status).
H. I have the right of access to, and request for, amendment of my medical records.
I. I acknowledge that no guarantees of cure have been made to me as a result of examination or treatment while here at Emergency One.
J. I further consent to the necessary transfer of medical information about me to the appropriate parties for the purposes of insurance payment submission, workers' compensation including fitness to return to work, or transfer to another facility or physician for continuation of my care, if necessary.

Patient Responsibilities

As a patient of Emergency One, I have the following responsibilities to assist in my medical care:

A. I have the responsibility of full disclosure of medical information to assist in establishing a diagnosis and an appropriate plan of care.
B. I have the responsibility to support an environment where the safety and property of Emergency One's personnel and other patients are respected.
C. I have the responsibility to inquire if any portion of my care-giving or follow-up are not entirely comprehended.
D. I have the responsibility to notify the staff or medical provider if there are any limitations (cultural, religious or other) that may limit my care or pose barriers to providing care.
E. In the event that a service is not covered by my insurance company, I will be responsible for payment to Emergency One.
F. I authorize insurance payment of medical benefits for the services rendered