iCARE

Historial Medico De Paciente

Alergias:

Medicamentos Actuales:

Habitos Personales: Bebes
Alcohol? SI
Fumas Tobaco? Si No
Usas Cigarrillos Electronico Si No

Historial Medico Personal (circular todo lo que aplique)

la Cardiopatia
Preston Alta
Colesterol Alto
COPD
Asthma
Trastorno de la Tiroides
Apoplejia
Tendencia a sangrar
Convulsion
ctatica

Diabetes (1 or 2)
enfermedad estomacal
trastornos intestinales
enfermedadhepatica
Enfermedad renal
enfermedad prostata
Desorden Vesical

Anemia/Tansorno de sangre
Coagulo de Sangre
Otra:

Cancer (pasado orpresente)
Apnea de sueno
Tuberculosis
Anstedad
Depresion
Migranas Cronicas

Historia Cirugia: (circular to que applique) Amigdalectomia
Histerectomia
Ortopedico
Apendectomia

Mastectomia
Extirpactondevesiculabiliar
Miringotomia(tubodeloido)
Ctirugia espinal

Estetico

Otra _____

Receipt of HIPAA Privacy Notice

iCare Urgent Car is committed to maintaining the integrity of your protected health information and complies with all applicable state and federal regulations. The federal privacy regulation of the health insurance portability and accountability act (HIPAA) had taken effect April 14, 2003. In support of our policy, complying with all applicable regulations iCare Urgent Care Centers provides patients with a HIPAA notice of privacy rights. While not required in order to receive treatment at iCare Urgent Care Centers, we are obligated under federal regulation to ask that you sign an acknowledgement of the HIPAA privacy notice and that a copy of the notice be made available to you.

_____ _____

Patient of Guardian Signature Date

Patient Consent for Treatment

I voluntarily consent to all healthcare treatment and diagnostic procedures provided by iCare Urgent Care Centers and its associated physicians, practitioners, clinicians, and other personnel. I am aware that the practice of medicine and other healthcare professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the result of the treatments or examinations at iCare Urgent Care Centers.

1. I consent to the use and disclosure of my/the patients protected health information for the purposes of obtaining payments for services rendered to me/the patient consistent with the notice of privacy practices.
2. I authorize payment of medical benefits to iCare Urgent Care Center physicians and their designee for services rendered.
3. I give my permission to obtain all my medication/prescription history when using an electronic system to process prescriptions of all my medical treatment.
4. I expressly consent and agree that, to discuss or service you account(s) or to collect amounts you may ow, iCare Centers LLC, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith, may contact you by telephone at any number associated with the accounts.
5. I expressly consent and agree that we may contact you by email provided to us or a voice message on the given telephone associated with the accounts, regardless of whether you incur charges as a result.

_____ _____

Patient or Guardian Signature Date