Adult Re-Visit

DATE:

What is your insurance?

Primary:

Secondary:

Who is the subscriber? :

What is the DOB of the subscriber? :

CONSENT TO TREATMENT

I hereby consent to medical evaluation, testing and/or treatment provided to me by the Wyoming Urgent Care staff. I understand that such medical care may include history taking, diagnostic testing and administration of medication and/or treatment. I understand I may discontinue treatment or any part thereof.

DISCLOSURE OF MY PROTECTED HEALTH INFORMATION:
I understand that Wyoming Urgent Care may use or disclose my Protected Health Information to carry out treatment, payment, or healthcare. Any information concerning mine (or my child's) health care, advice and treatment provided for the purpose of obtaining insurance benefits.

ASSIGNMENT OF BENEFITS: I also hereby authorize payment of insurance benefits, otherwise payable to me be made directly to Wyoming Urgent Care. I understand I am responsible for any balance not paid by my insurance.

Signature of patient or responsible party _____ Date_____

Print Name: _____ Relationship_____

Wyoming Urgent Care

Because illnesses don't happen by appointment.

HIPAA form to be sign by patient

Confidentiality of your information

RIGHT TO RECEIVE NOTICE OF CHANGE TO WYOMING URGENT CARE PRIVACY STATEMENT

You have the right to receive any changes to our privacy statement that affect you on or after the effective date of change. If you have any questions about this notice contact any of the contact persons listed below.
I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I understand that if I have questions or comments regarding my privacy rights that I may contact any of the persons listed above. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified, changed in any way.

Please list the names of any persons to whom you wish us to disclose your PHI and state how the individual is related to the patient: **If no one just sign the form**

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Signature: _____Date: _____

TODAY'S DATE: _____ **Vaccination status Yes ( ) no ( )**

Revisit I

Wyoming Urgent Care

Because illnesses don't happen by appointment.

PATIENT'S NAME: _____DOB: _____ Height _____ Weight _____

Please update the following information:

ADDRESS: _____Town _____State_____ Zip code _____

PHONE: _____CELL PHONE: _____

Is your insurance the same? [ ] yes [ ] no

Are you S M W D

Reason for the visit_____

PRESENT ILLNESS:

- How long have you had this problem: _____?
- Severity of your pain (Circle one): 1 2 3 4 5 6 7 8 9 10

Are you pregnant? YES NO Is this a work related injury? YES NO

Allergies: _____

Current Medications:_____

VITAL SIGNS

Height: _____ Weight: _____ Blood Pressure: _____/ _____

Temperature: _____ Pulse: _____ Respiration: _____ P O2(1): _____

Subjective	Conjunctivitis [ ] Sore Throat [ ] Asthma [ ] Laryngitis [ ] Nasal Congestion [ ] Earache [ ] Rhinorrhea [ ] Green Yellow Since_____ Cough [ ] Since_____
Objective	Ears: Cerumen [ ] Redness [ ] Fluid presence [ ] Pain [ ] Throat: Tonsils present [ ] Inflammation [ ] Exudation [ ] Abscess [ ] Sinus: Tenderness [ ] Lymph Node: Enlargement [ ] Tenderness [ ]
Assessment	Diagnosis: Treatment:

Your Preferred Pharmacy_____

Wyoming Urgent Care

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DISCHARGE PLAN

PLEASE GIVE TO YOUR PCP

Name:_____

DOB_____

You have been diagnosed with: _____

You were prescribed the following medication(s):

_____

_____

_____

_____

_____

_____

Follow the above instructions carefully. Take your medications as prescribed. Most importantly follow up with you PCP. If you have any questions or concerns call or visit your PCP. If unable to reach your PCP or your condition gets worse, please return to Wyoming Urgent Care or your local Emergency Department for further evaluation. Do not hesitate to call us with any questions or concerns at the office or after hours at (585)322-6422.

I have received this information. The doctor has addressed any questions or concerns I have with my plan of treatment.

Signature of Patient or Responsible Party_____ Date_____