CLEARCHOICEMD®
URGENT CARE

Date:_____ CCMD Staff Member:_____

Last Name:_____ First Name_____ M.I.:___

Date of Birth:_____ SS#:_____ Sex: Male / Female

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email:_____

Emergency Contact:_____ Phone:_____ Relationship:_____

Guarantor (person responsible for bill, if applicable):_____DOB:_____

Guarantor Address (if different from patient):_____ Relationship:_____

Insurance Policy Holder (if different from patient): _____

Insurance Policy Holder Date of Birth: _____

Primary Care Provider Name:_____

Pharmacy and Location:_____

Reason for Visit:_____

How did you hear about us?:_____ (Please be specific)

Please answer the following questions:

1. **Do you want your records sent to your primary care provider? Yes or No**
2. **I have read and understand the Consent for Treatment, Controlled Medication, Assignment of Benefits, Confidentiality, Complaint Procedure, Release of Information, Bill of Rights and Privacy Policies.**

   Yes or No

   Would you like a copy of these policies? Yes or No

3. **Follow-up communication: We may contact you after your visit in order to request feedback on your experience.**

   May we contact you via text message Yes or No

SEE OTHER SIDE

Co-Payments/Assignment of Benefits/Confidentiality/Release of Information/Privacy Practices

Co-Payment

Please note that Co-Payments will be collected at the beginning of each visit and can be paid in any manner you choose. Please see your health insurance card or contact your insurer to understand the co-pay amount and any possible additional financial responsibilities as these may differ by plan.

Assignment of Benefits

I request that payment of authorized insurance benefits, including Medicare and/or Medicaid, be made on my behalf to the ClearChoiceMD, PLLC for any equipment or services provided to me by that organization

Statement of Confidentiality and Release of Information

I authorize the release of necessary medical information to ClearChoiceMD, PLLC for the purposes of processing these or any related insurance claims. I also give ClearChoiceMD, PLLC the authority to make available any requested documents contained in my file to myself and/or the other health care providers involved in the treatment of my condition.

Agreement and Notice of Privacy Practices

I understand that I am financially responsible for payment of this account regardless of insurance or third-party involvement. If the account is sent to an attorney or collection agency, I will be responsible for any agency or collection fee and/or court cost. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.

By signing the consent form, I also acknowledge that I have been offered a copy of the organizations Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Consent for Treatment

I, hereby, authorize ClearChoiceMD Urgent Care, its medical providers, employees, or agents to provide medical evaluation and treatment as deemed necessary by the treating medical provider. This includes any medical examinations, x-rays/diagnostic procedures, or laboratory tests ordered by the treating medical provider to be carried out by designated staff.

Any comments, questions or inquiries should be directed to:

ClearChoiceMD, PLLC
74 Pleasant St, Suite 204
New London, NH 03257

Patient/Guardian Signature: _____ Date: _____

Patient/Guardian Printed Name: _____

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URGENT CARE

2021-2022 Influenza Vaccine Form

Name (Last, First, MI): _____ **DOB**: _____

1. Do you feel sick today with a fever or respiratory illness?
   - **YES** **NO**
2. Do you have an allergy to eggs, medications or foods?
   - **YES** **NO**

   If **YES**, what type of allergy (please circle)? **EGGS** **MEDS** **FOODS**
3. Have you ever had an allergic reaction to the Influenza Vaccine?
   - **YES** **NO**
4. Have you received a live vaccine within the last 30 days?
   - **YES** **NO**
5. Have you ever been diagnosed with Guillain-Barre Syndrome?
   - **YES** **NO**
6. Have you ever had seizures, or active neurological disease?
   - **YES** **NO**
7. Do you have a weakened immune system or disorder ex: AIDS, HIV?
   - **YES** **NO**
8. Do you take cortisone, prednisone or other steroids?
   - **YES** **NO**
9. Do you have close contact with anyone who has a severely weakened immune system?
   - **YES** **NO**
10. *FEMALE PATIENTS:* Are you pregnant or think you may be pregnant?
    - **YES** **NO**

I have received and read a copy of the CDC vaccine information sheet concerning the Influenza vaccine. I fully understand the information, benefits and risks of the influenza vaccine, and my questions have been answered.

I request that ClearChoiceMD administer the vaccination to the authorizing signature below.

I understand that I have been advised to wait 15 minutes after the vaccination before leaving the clinic area, so that I can be observed for possible adverse reaction.

Patient Signature or Guardian:_____ **Date:** 9/15/2021

Clinic Location:	Rutland	**Date Given:**	
Injection Site:	L / R Deltoid		
Vaccine Manufacturer:	Seqirus	**NDC:**	70461-321-03
Expiration:	06/30/2022	**Lot Number:**	308455
Signature / Title of Vaccine Administrator:			