HIPAA / Financial Policy

THIBODAUX REGIONAL URGENT CARE

2031 Audubon Ave
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Ph. 985-803-8383
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www.CoastalUC.com

Authorization for Use or Disclosure of Protected Health Information

I authorize my physician and/or administrative and clinical staff of Thibodaux Regional Urgent Care, to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name, relationship and a personal identification method of persons you wish to allow access – for example:

Name:	**Relationship:**	**Personal Identification:**
John Doe	**Father**	**Date of Birth, Address or last 4 of SS #**

Restriction Request: _____

This authorization to use and disclose this protected health information is being submitted by my request and shall be in force and effect until revoked in writing by me.

I understand that information used or disclosed pursuant to this authorization may be disclosed by Thibodaux Regional Urgent Care and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information to obtain payment from my health insurance company.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

_____ Date _____ _____

Signature of Patient or Personal Representative | Print Name of Patient or Personal Representative

Date of Birth of Personal Representative _____ Last 4 of SS# _____

If not signed by the patient, please indicate relationship and describe authority to act:

Name of Patient: _____ parent or guardian of minor patient
guardian or conservator of an incompetent patient

Coastal URGENT CARE

Staff Only
Room: _____
Triage Time: _____
MR #: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Medication Allergies: _____

Medications Taking: _____

Is this visit a result of a work related accident? Yes / No **Have you been a patient here before? Yes / No**

Past Medical History (please check all that apply)

□ Acid Reflux	□ Diabetes	□ Migraines
□ Anemia	□ Down Syndrome	□ Seizures
□ ADHD	□ Heart Attack	□ Skin Disorder
□ Anxiety/Depression	□ High Cholesterol	□ Stroke
□ Asthma	□ High Blood Pressure	□ Thyroid Disease (hypo/hyper)
□ Cancer	□ Kidney Disease	List Other:
□ COPD	□ Liver Disease	List Other:
□ **NO PAST MEDICAL HISTORY**		

Immediate Family History

□ CVA (Stroke)
□ Diabetes
□ Cancer
□ Heart Disease
□ Hypertension
□ No family history

Past Surgeries

□ Appendectomy	□ Gall Bladder removal	□ Hysterectomy
□ Cardiac Stent	□ Tubes in ears	□ Thyroidectomy
□ Heart Bypass	□ Tubal ligation	□ Tonsillectomy/Adenoidectom
□ C-Section	□ Hernia repair	List Other:
□ **NO PAST SURGERIES**		

Social History

□ **Pediatric only Circle**: Smoking/ Nonsmoking Family	
□ Nonsmoker	□ Do not drink alcohol
□ Former Smoker Years smoked: _____	□ Occasional Drinker
□ **Current smoker**: Occasional/Daily Years smoked: _____	□ Daily Drinker

Current Symptoms (please check all that apply)

Constitutional	Pulmonary	Pain/Injury
□ Fever (Max _____)	□ Shortness of breath	□ Back pain
□ Chills	□ Cough	□ Headache
□ Body Aches	Cardiovascular	□ Location_____
HEENT	□ **Chest pain, NOTIFY STAFF!**	GU
□ Eye Problems	□ Passed out	□ Burning with urination
□ Ear Problems	□ Skin Problems (Rash)	□ Frequent Urination
□ Sore Throat	□ Laceration	□ Other _____
□ Sinus Congestion	□ Abscess (Boil)	□ Other _____
When did symptoms start?(Use a number) _____minutes ago _____hours ago _____days ago _____weeks ago		

Vital Signs (Staff only)

BP-_____ Pulse-_____ RR- _____ Pulse Ox -_____

Temperature: _____ Oral/ Ax / Rectal

Immunizations up to date: YES or NO

Tetanus up to date: YES or NO

Last Menstrual Period: _____

Ht: _____ inches WT: _____ LBS Pharmacy: Walgreens: _____

_____ KG CVS: _____

Other: