FirstCare Urgentcare Center, P.C.

New Patient Registration Packet

9115 S Cicero Ave, Suite 200, Oak Lawn, IL 60453

708-265-2702

firstcareurgentcarecenter@gmail.com

Patient Demographics

Thank you for choosing FirstCare Urgentcare Center. Please complete the following forms in full. If you have questions, please ask a member of our front desk staff for assistance.

Patient Information

Last Name *

First Name *

Middle Initial

Date of Birth (MM/DD/YYYY) *

Sex *

Social Security Number

Preferred Language

Home Address *

Apt/Unit #

Home Address (cont.)

City *

State *

ZIP Code *

Mobile Phone *

Home Phone

Email Address

☐ OK to leave voicemail ☐ OK to text appointment reminders ☐ OK to email

Emergency Contact

Full Name *

Relationship to Patient *

Phone Number *

Preferred Pharmacy

Pharmacy Name

Pharmacy Phone

Pharmacy City

How Did You Hear About Us?

☐ Insurance provider ☐ Friend/family referral ☐ Online search ☐ Drove by / signage ☐ Other

Primary Insurance

Insurance Company *

Plan/Group Number

Member/Policy ID Number *

Claims Phone Number

Policy Holder (if not the patient)

Policy Holder Name

Date of Birth

Relationship to Patient

Secondary Insurance (if applicable)

Insurance Company

Plan/Group Number

Member/Policy ID Number

Claims Phone Number

Responsible Party (Guarantor)

Complete this section only if someone other than the patient is financially responsible for this visit (e.g., parent/guardian of a minor).

Guarantor Name

Relationship to Patient

Date of Birth

Guarantor Address

Phone Number

Assignment of Benefits & Financial Responsibility

I authorize payment of medical benefits to FirstCare Urgentcare Center, P.C. for services rendered. I understand that I am financially responsible for any charges not covered by my insurance, including co-payments, co-insurance, deductibles, and services deemed not medically necessary or not covered. I authorize FirstCare Urgentcare Center, P.C. to release medical information necessary to process insurance claims and to bill my insurance carrier(s) directly on my behalf.

Patient / Responsible Party Signature

Date

Reason for Today's Visit

Chief Complaint / Reason for Visit *

Allergies

☐ No known drug allergies (NKDA)

List all medication, food, or environmental allergies and reaction (e.g., Penicillin - rash)

Current Medications

List all current prescription medications, over-the-counter drugs, and supplements

Past Medical History — Please check all that apply

☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Asthma/COPD

☐ Cancer ☐ Thyroid Disorder ☐ Seizure Disorder ☐ Kidney Disease

☐ Bleeding Disorder ☐ Anxiety/Depression ☐ None of the Above

☐ Pregnant / Possibly Pregnant

Other medical conditions or past surgeries not listed above

Social History

☐ Tobacco use ☐ Alcohol use ☐ Recreational drug use ☐ None of the above

Consent to Treat

I hereby request and consent to examination and treatment for myself (or the patient named above, if I am signing as parent/guardian) by the physicians, nurse practitioners, physician assistants, and staff of FirstCare Urgentcare Center, P.C. I understand that urgent care treats episodic, non-life-threatening conditions and that in the event of a medical emergency, I should call 911 or proceed to the nearest emergency room. I understand that no guarantee has been made regarding the outcome of examination or treatment. I consent to the performance of routine diagnostic tests, laboratory work, and treatment as deemed medically necessary by the treating provider.

Patient / Guardian Signature

Date

HIPAA Notice of Privacy Practices — Acknowledgment

FirstCare Urgentcare Center, P.C. is required by the Health Insurance Portability and Accountability Act (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices describing how we may use and disclose your PHI, and your rights regarding that information. A copy of our Notice of Privacy Practices is available at the front desk and on our website. By signing below, I acknowledge that I have been given the opportunity to review this Notice.

☐ I acknowledge receipt of the Notice of Privacy Practices.

Authorization to Discuss Care With Others (optional)

Name(s) authorized to receive my health information

Patient / Guardian Signature

Date

Financial Policy

- Payment (co-pay, deductible, or self-pay fee) is due at the time services are rendered.
- We accept cash, major credit/debit cards, and HSA/FSA cards.
- It is your responsibility to notify us of any change in insurance coverage or personal information.
- If your insurance is not verified or you are uninsured, you will be treated as a self-pay patient and full payment is expected at the time of visit.
- Accounts unpaid after 60 days may be subject to collections. A returned-check fee applies to any declined payment.

I have read and understand the financial policy of FirstCare Urgentcare Center, P.C. and agree to be bound by its terms.

Patient / Responsible Party Signature

Date

Consent for Use of Ambient AI Scribe Technology

FirstCare Urgentcare Center, P.C. uses an ambient artificial intelligence (AI) scribe tool to assist our providers in documenting your visit. With your permission, the tool listens to and transcribes the conversation between you and your provider during your visit in order to help generate a draft of your clinical note in your medical record.

How it works

- The AI scribe is active only during your visit, with your provider present, and only after you consent.
- The audio is used to generate a draft clinical note; your provider reviews, edits, and approves every note before it becomes part of your permanent medical record.
- The recording/transcript is processed under the same HIPAA privacy and security protections that apply to the rest of your medical record and is not used for marketing or shared with unauthorized third parties.
- You may decline or withdraw consent at any time, before or during your visit, without any effect on the care you receive.

Patient Acknowledgment

I understand that FirstCare Urgentcare Center, P.C. uses an ambient AI scribe tool as described above to assist with clinical documentation, and that my provider reviews and is responsible for the accuracy of my final medical record. I understand this technology is optional and that declining will not affect the quality of care I receive.

☐ YES — I consent to the use of the ambient AI scribe tool during my visit(s) at this practice.

☐ NO — I do not consent to the use of the ambient AI scribe tool. My visit will be documented using standard methods.

Patient / Guardian Signature

Date

Office Use Only — Staff Verification

Insurance Verified By

Date Verified

Front Desk Initials