LANE PHYSICIAN GROUP

EMPLOYEE VERIFIED:_____DATE_____

PATIENT INFORMATION SHEET

ALLERGIES_____
LAST NAME_____ BIRTHDAY _____
FIRST NAME_____ HOME PHONE_____
ADDRESS_____ WORK PHONE_____
CITY_____LA_____ZIP_____ CELL PHONE _____
EMPLOYER/SCHOOL(ATTENDING)_____ SOCIAL SEC. # _____
FULL TIME STUDENT? _____YES____ NO DRIVER'S LICENSE#_____
SPOUSE_____SPOUSE DOB_____
PATIENT E-MAIL ADDRESS_____
DOES PATIENT HAVE A LIVING WILL?_____ YES_____NO
RESPONSIBLE PARTY INFORMATION (Parent or Guardian)
LAST NAME_____ DRIVER'S LICENSE#_____
FIRST NAME_____ HOME PHONE_____
ADDRESS_____WORK PHONE_____
CITY_____LA_____ZIP_____BIRTHDAY_____
EMPLOYER/SCHOOL (ATTENDING)_____ SOCIAL SEC. # _____
FULL TIME STUDENT? _____YES____ NO

INSURANCE CARRIER
1). INSURANCE NAME_____ INSURED'S NAME_____
GROUP# _____ POLICY # _____
ADDRESS_____
PHONE#_____
INSURED'S DOB_____ INSURED'S SS#_____
PATIENT RELATIONSHIP TO INSURED_____(Self, Spouse, Child)
IF YOU HAVE MORE THAN ONE INSURANCE, PLEASE ALLOW THE RECEPTIONIST TO COPY ALL OF THE CARDS.
EMERGENCY NOTIFICATION
NAME_____ RELATIONSHIP_____
PHONE_____ CITY_____

PLEASE READ AND SIGN
I understand that all services are charged to the patient, and as the patient, I am responsible for all charges not paid by my insurance. I hereby authorize Lane Physician Group to obtain my medication history by means of electronic access which becomes part of my permanent record. I hereby indemnify the physician office and its agents from any and all responsibility relative to obtaining such information. I acknowledge and give consent for treatment. I authorize Lane Physician Group to release my medical and financial information to my insurance carriers as necessary to receive payment. I authorizes payment to be made to Lane Physician Group. If I have no insurance, full payment is made it time of service. As of Nov. 1, 2017 our office will charge a fee of $35.00 for not showing up for your appointment. When a time slot is left open because a patient does not call and cancel their appointment there is not enough time to notify another patient that is in need of being seen.

Date_____ Signature_____

FAST Lane

After Hours Urgent Care by Lane Regional Medical Center

COVID Questionnaire

Name _____ Date _____

Please read and circle the answer at the end of each question.

Do you have any symptoms of a respiratory infection such as cough, sore throat or shortness of breath? **Yes or No**

Have you had fever greater than 100 degrees in the last 24 hours? **Yes or No**

In the past 14 days, have you had contact with someone with a confirmed diagnosis of COVID-19, or are you ill with a respiratory illness? **Yes or No**

Do you live in a community where there have been multiple confirmed COVID-19 cases? **Yes or No**

Have you traveled internationally within the last 14 days to countries with sustained community transmission? **Yes or No**

Have you previously been tested for COVID-19? **Yes or No**

FAST Lane

After Hours Urgent Care by Lane Regional Medical Center

FastLane Patient Policy Sheet

FastLane Urgent Care is an Urgent Care facility that treats many mild illness and injuries but FastLane Urgent Care is not an Emergency Room or Primary Care Provider so there are some illnesses and injuries that FastLane Urgent Care does not treat.

FastLane Urgent Care will give courtesy ONE-time refill of blood pressure, diabetes, cholesterol, thyroid, allergy, arthritis medications and several other illnesses that may be managed by a Primary Care Physician. After this ONE-time courtesy the patient should follow-up with prescribing provider because these illnesses require consistent medical management.

FastLane Urgent Care does treat Urinary Tract infections and provides Sexually Transmitted Disease testing.

FastLane Urgent Care does NOT treat…

ADD/ADHD
Anxiety
Chest Pain
Chronic pain
Depression
Erectile dysfunction
Insomnia
Loss of consciousness
Menopause
Numbness
Paralysis
Pregnancy
Severe bleeding
Severe shortness of breath
Tooth extraction
Vaginal bleeding

FastLane Urgent Care does not back date school or work excuses. As a general policy patient may receive an excuse for the date of the visit and one date after to recover from illness. Exceptions include but are not limited to a positive Strep. Pharyngitis test, a positive influenza test and a documented temperature at FastLane Urgent Care of 100.4 or greater.

FastLane Urgent Care providers do not fill out short or long-term leave of absence forms. Patients can present the work excuse form to their employers as proof of their visit to FastLane Urgent Care.

FastLane Urgent Care providers do not refill prescriptions from previous visits. Patients must return to be examined and diagnosed to receive treatment and appropriate medication prescriptions.

Patients have a 2-day window to call or return to clinic if symptoms have not improved at no charge. After this time period, patients must return to be reexamined and will be charged for the visit.

Patient Signature _____ Date _____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please Review it carefully.

We respect your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations.

Examples of Use and Disclosures of protected Health Information for Treatment, Payment, and Health Operations

For Treatment:

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing your care. This will help them stay informed about your care.

For Payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For Health Care Operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including:
    - Medical quality review by your health plan;
    - Accounting, legal, risk management, and insurance services;
    - Audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request. But we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice");
- Request that you be allowed to see and get a copy of your protected health information. You may also make this request in writing. We have a form available for this type of request.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, (Patient), acknowledge that Lane Regional Medical Center (LRMC) has provided me with a copy of its Notice of Privacy Practices.

_____ _____

Signature of Patient or Authorized Representative Date

(OPTIONAL: To be completed if Patient desires to request restrictions on the use or disclosure of health information.)

I understand that LRMC may use and disclose my health information in any manner set forth in the Notice of Privacy Practices.

I further understand that I may request restrictions on the uses and disclosures of my health information in the situations described in the Notice of Privacy Practices.

I understand that LRMC is not obligated to agree with the restrictions. I also understand that if LRMC does agree, such restrictions may be terminated by me or LRMC in appropriate circumstances.

I further understand that I am not required to request restrictions at this time and that I may request restrictions at a later date by submitting a written request to LRMC.

Accordingly, I wish to request the following restrictions on the use and disclosure of my health information.

_____

_____

_____

_____ _____

Signature of Patient Date

_____ _____

Signature of Legally Authorized Representative (if applicable) Date

_____ _____

Phone

_____

_____

Address

LANE PHYSICIAN GROUP
An Affiliate of Lane Regional Medical Center
AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION

I hereby authorize _____ to obtain from _____ at _____ the following Protected Health Information (PHI) from the medical records of the patient listed below.

Please fax or email to: _____

_____

_____

_____

Patient's Name: _____

Patient's DOB: _____

Patient's SSN: _____

Patient's Address: _____

_____

Disclose the following PHI for treatment dates: _____

Please check the type of PHI to be released:

☐ Entire Medical Record	☐ Face Sheet	☐ Discharge Summary
☐ History & Physical	☐ Op Notes	☐ Consultation
☐ Lab Reports	☐ X-Rays	☐ Progress Notes
☐ Doctor's Orders	☐ ER Report	☐ Other/Specify Below

The above information is disclosed for the following purposes: (Check All That Apply)

☐ Marketing (Reimbursement expected from recipient) ☐ Marketing (No Reimbursement Expected)

☐ Medical Care ☐ Legal ☐ Personal ☐ Insurance ☐ Other/Specify Below

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_____ I acknowledge, and hereby consent to such, that the released information may contain alcohol and drug abuse, psychiatric, HIV, or genetic information.
Initials

This authorization shall expire upon this expiration date or event: _____
If I fail to specify an expiration date or event, this authorization will expire six (6) months from the date on which it was signed.

I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to the Privacy Officer at Lane Regional Medical Center. I understand that the revocation will not apply to information that has already been released pursuant to this authorization.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

I understand that I do not have to sign this authorization and my treatment or payment for services will not be denied if I do not sign this form. However, if health care services are being provided to me for the sole purpose of collecting information to provide to a third party or for research purposes, treatment may be denied if this authorization is not signed.

I have read the above and authorize the disclosure of Protected Health Information as stated.

Signature of Patient or Legal Representative: _____ Date: _____

If signed by a legal representative, describe this person's authority to act on behalf of the patient :

_____