TOTAL HEALTH URGENT CARE

73015 Hwy 25- Covington, LA, 70435- P: 985-400-530 F: 985-400-5041

Return Patient Information

Is this a result of an accident? Yes NO

Motor vehicle accident car, ATV, motorcycle, etc? Yes NO

Is this a work-related injury? Yes NO

Have you traveled out of the country in the last 30 days or exposed to Covid? Yes NO

Patient Name: _____ Date of Birth: _____

Pharmacy for today's visit: _____

Reason for today's visit: _____

Address if different from previous:

_____

Phone: _____

Medication: _____ Allergies: _____

_____ _____

_____ _____

_____ _____

Consent to treat, billing, privacy

I consent to treatment for myself or above-named minor child. I understand that the examination and/or medical treatment I will receive is not intended to replace complete medical care by my personal primary physician/provider. I am aware that I will be responsible for co-payment or full payment at time of service. Any pre-certification that my insurance company requires is my responsibility to make. Furthermore, I allow Total Health Urgent Care to release my insurance company treatment and billing information as requested, to process my claim. I allow Total Health Urgent Care to accept assigned payments made by my insurance company on my behalf. I understand that any lack of payment by my insurance company is my responsibility, for the services rendered. Total Health Urgent Care may have additional fees that your normal primary care office does not. We are an urgent care and therefore a specialty clinic. My failure to pay may result in my account being delinquent or getting sent to collections, and at this time a $50 dollar fee may be added to my bill. I authorize Total Health Urgent Care to release information to my primary care provider related to my treatment at this clinic.

Patient/Guardian Signature:_____

Females only: Date of Last menstrual cycle_____

Pregnant? Yes No Maybe Breast feeding? Yes NO

B/P_____ Pulse_____ O2% Sat_____ Temp_____Wt _____ Ht _____