JUPITER MEDICAL CENTER
Urgent Care Center

5430 Military Trail, Ste 64
1335 W. Indiantown Road
Jupiter FL, 33458
Office (561) 263-7010 Fax (561) 744-8215

Date_____/_____/_____ **Reason For Visit:**_____

Patient Name: _____
Last First Middle

Date of Birth_____/_____/_____ Social Security # _____-_____-_____ Sex: ☐Male ☐ Female

Mailing Address _____
City State Zip

Home Phone (____) _____ Cell Phone (____) _____ Email Address: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated
Race: ☐ Black ☐ White ☐ Asian ☐ Other
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Employer _____ Phone (____) _____

NOTIFICATION OF FAMILY AND FRIENDS
I hereby authorize Jupiter Medical Center Urgent Care to discuss my health information with the following persons:

1. _____ (____)_____
   Name Phone Number Relation
2. _____ (____)_____
   Name Phone Number Relation

Do you have a Primary Care Physician? ☐ YES ☐ NO **If Yes, please list name below**

_____ (____)_____
Name Phone Number

Do you want the details of today's visit sent to the above listed Primary Care Physician? ☐ YES ☐ NO

NOTIFICATION OF OTHER PHYSICIANS
I hereby authorize Jupiter Medical Center Urgent Care to disclose my health information to the following physicians
(Name, Phone Number & Fax, if available)

1. _____ (____)_____
   Name Phone Number
2. _____ (____)_____
   Name Phone Number

PHARMACY INFORMATION- If you are prescribed any medications from us, where would you like us to send it?

Pharmacy Name: _____ Address/Location: _____

If you did not seek care here, where would you have gone? _____

How did you hear about us?_____

_____ _____
Patient/Guardian Signature **Date**

Revised- 07/08/15

JUPITER MEDICAL CENTER
Urgent Care Center

First Name:_____ Last Name:_____ Initial:_____

Date of Birth:_____ Reason for Visit Today:_____

***Are there any prescription medications that you take daily?** Yes_____ No_____

Medication Name:	Strength/Dose:	Instructions:

***Do you have any allergies to Medication?** Yes _____ No, NKDA_____

If yes, please list allergies: _____ _____ _____ _____

*Have you had or do you currently have any of the following problems/diseases? (Please add any not listed)

Anemia		Coronary artery disease		Cancer:		Reflux	
Autoimmune disease		Diabetes; type_____		Gallbladder disease		Prostate	
Arthritis		Hypertension		Heart attack		Stroke	
Alcoholism		Kidney disease		Osteoporosis		Seizure disorder	
Asthma		High cholesterol		Depression		Thyroid disease	
Alzheimer's		Emphysema		Hepatitis		Urinary tract infections	
Bleeding or clotting disorder		Heart disease		Irritable bowel syndrome		Glaucoma	
COPD		Migraines		Obesity		Liver Disease	
Diverticulitis							

*Have you had any surgeries or procedures done? Yes_____ none _____ (please include dates)

Surgery/Procedure	Date	Surgery/Procedure	Date

***Do you smoke?** Yes_____ No_____ Former_____ How many packs per day?_____

***Do you drink alcohol?** Yes_____ No_____ How many Drinks per week? _____ Socially only? _____

Occupation:_____

*Females Only-

Date of Last Menstrual Period _____ Are you currently pregnant? _____ Breastfeeding?_____

***Do any of the following diseases run in your family's medical history?**

Diabetes		Stroke		Coronary artery disease	
Cancer:_____		High cholesterol		Heart attack	
Heart disease		High blood pressure		Kidney disease	
Asthma		Thyroid disease			

JUPITER
MEDICAL
CENTER

Why are we asking for your email?

As a part of your visit at Jupiter Medical Center, we are requesting your preferred email address so that we can send you an invitation to become a part of the MyJupitermed network. Your preferred e-mail will become part of your medical record and will be treated in the same manner that all medical record demographic information is secured. ** We advise that individual email accounts be used for registration purposes. Jupiter Medical Center will not be responsible for the confidentiality of information sent to jointly shared email addresses.*

What are the benefits of participating in Myjupitermed?

Through Myjupitermed you can create a personal health record that will allow you and your providers to manage your healthcare needs. Jupiter Medical Center will automatically send items such as laboratory results, radiology results, operative reports, medications lists and a variety of other information to your Myjupitermed personal health record. By logging on to the system, you will be able to access this information and share it with your other healthcare providers. The service requires a sign in name and password, and can only be accessed by registered users.

I am interested in participating in Myjupitermed, powered by Relay Health. I consent to Jupiter Medical Center contacting me via e-mail. I understand that e-mail is not a secure form of communication, therefore Protected Health Information should not be transmitted by e-mail. Instead MyJupitermed will provide me with a secure access to my medical record information.

My preferred e-mail address is: _____

Signature: _____ DOB: _____

Printed Name: _____ Date: _____

1ACK

JUPITER MEDICAL CENTER

Jupiter, Florida 33458

Ebola Virus Disease (EVD) Screening Jupiter Medical Center Emergency Department

Criteria I. Foreign travel within last month?

- ☐ No
- ☐ Unable to obtain
- ☐ Yes, other than West Africa
- ☐ *Yes, West Africa (Guinea, Liberia, Nigeria, or, Sierra Leone)

If yes to West African travel, Initiate Ebola Virus Screening below

Criteria II. Ebola Virus Screening

Symptoms (Select all that apply)

- ☐ None
- ☐ * Bleeding
- ☐ * Diarrhea
- ☐ * Fatigue
- ☐ * Fever
- ☐ * Headache
- ☐ * Joint / Muscle Ache
- ☐ * Lack of Appetite
- ☐ * Stomach Pain
- ☐ * Vomiting
- ☐ * Weakness

If one or more starred symptoms were selected, then met criteria.

If both criteria I & II are met initiate Ebola Precautions :

- ✓ Put mask on patient
- ✓ Put patient in treatment room with closed door
- ✓ Call EMS to transport to ER
- ✓ Call ahead to ER to let them know patient coming.

_____ _____ _____

Date Time Signature

Jupiter Medical Center
Consent for Treatment - General

CONSENT TO TREATMENT: The undersigned, as the patient, or as the guardian or representative of the patient, consents to such laboratory, diagnostic and treatment procedures/examinations considered reasonably necessary for the care and treatment of my condition during my admission for outpatient or inpatient care as rendered to the patient under the instructions of a licensed physician or other health care practitioner.

AGREEMENT TO PAY CHARGES: I hereby assign to the health care entity my right to payment for healthcare services and supplies I receive from the health care entity. I direct anyone paying or receiving money for services or supplies I receive, to pay the money to Jupiter Medical Center or their affiliates. I understand that the health care services I receive may not be covered or paid for, or may only be partially covered or paid for, by my healthcare insurance company or any other third party payer. In the event that the billed charges for the healthcare services I receive are not covered or paid for on my behalf, or are only partially covered or paid, I understand and agree that I am responsible for the payment of the billed charges, or the remaining balance of billed charges for an such service or, if the health care entity has a contractual payment arrangement with my insurance company or third party payer, I will be responsible for the payment of any co-payments, deductibles, and co-insurance for covered services and billed charges for any non-covered services. Any phone number I have provided may be used for the purpose of collecting payments in connection with any services provided by any Jupiter Medical Center provider or affiliate.

PATIENT INFORMATION DISCLOSURE FOR TREATMENT, OPERATIONS AND PAYMENT: The undersigned, as the patient or as the guardian or authorized representative of the patient, authorizes JMC to release any and all information regarding the hospital services and supplies, for the purpose of treatment, operations or payment to any payer or other entity or person deemed necessary by JMC. This includes authorization to release information pertaining to psychiatric and/or psychological care (but not psychotherapy notes), alcohol and/or substance abuse and serologic test results including HIV. JMC may also obtain prescription history from the patient's insurance company and healthcare providers for the purpose of treatment.

MEDICARE AND MEDICAID BENEFITS: I certify that the information given by me in applying for payment under Medicare is correct (including the answers given by me in response to the questions of the Medicare Secondary Payer (MSP) questionnaire), I request payment of authorized Medical benefits on my behalf for services furnished to me by or in Jupiter Medical Center, including physician services, I authorize any holder of medical and other information about me to release to Medicare and its agents my information needed to determine these benefits or benefits for related services.

RELEASE OF LIABILITY AND RESPONSIBILITY FOR PERSONAL VALUABLES: I understand that I am responsible for all articles and personal property (money, documents, radios, jewelry, dentures, eyeglasses, hearing aids, etc.) and/or clothing which I retain in my possession (on my person or in my room) and for any other articles and/or clothing which may be brought to me while I am a patient in JMC. I hereby release JMC, physician(s) and team members from any claim for loss, damage to or complete destruction of such property, which is not deposited with the hospital for safekeeping in the hospital safe.

NOTICE OF PRIVACY PRACTICES: I hereby acknowledge that a copy of the " Notice of Privacy Practices" has been made available to me.

INDEPENDENT CONTRACTORS: I acknowledge that some physicians and other providers operating and practicing in this hospital are not agents or employees of the hospital. These include but are not limited to the following groups: Emergency Physicians, Anesthesiologists, Pathologists, Radiologists, Staff and/or Contract Providers. Physicians and other providers bill separately for their services and may or may not accept my insurance.

STUDENT HEALTH CARE PROVIDERS: I understand healthcare may be provided to me in the form of services rendered by a student health care provider such as a student nurse, respiratory therapist, and pharmacy intern or radiology technology student participating in my care. I understand that by signing this form I am consenting to the supervised care rendered by such health care providers.

DIAGNOSTIC PHOTOGRAPHY AUTHORIZATION: I authorize radiographic films, x-rays, mammograms and other diagnostic films including still, movie or television photography to be taken of me during my hospital stay and consent to the use of such films for medical, scientific or educational purposes.

WORKERS COMPENSATION: According to Florida Statute section 440.105(7): "Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in **s.817,234."**

TOBACCO FREE ENVIRONMENT: I understand that Jupiter Medical Center is a tobacco-free environment and that I may not use tobacco products including cigarettes, cigars, pipes, herbal tobacco products, and chewing tobacco on the hospital campus or at any facility owned, [eased or operated by Jupiter Medical Center. I understand the use of electronic cigarettes or vapor is not recognized by Jupiter Medical Center as a nicotine replacement therapy and their use is also prohibited,

ADVANCE DIRECTIVE QUESTIONS:

1. Do you have an Advance Directive? ___yes ___no ____Unable to respond
2. If yes, is it on file? ___yes ___no. If no, copy requested? ___yes ___no
3. If no Advance Directive, copy given? ___yes ___declined

ACKNOWLEDGEMENT

The undersigned certifies that he/she has read and understood the foregoing and agrees to its terms:

Signature of Patient or Legally Authorized Representative	Printed Name of Patient
Relationship to Patient if signing on Patient's Behalf	Reason Patient Unable to Sign
Witness	Date and Time ____am/pm