OCCUPATIONAL MEDICINE PATIENT DEMOGRAPHICS

Patient Information:

Social Security:________________________

First Name: ________________________

Last Name:________________________

Middle Name: ________________________

Preferred Name: ________________________

☐ **Check if information below is the same as check-in log.**

Birthday:____________ Gender: ☐ Female ☐ Male

Address:____________ Apt#:____________

City:__________ State:__________ Zip:__________

Additional Information:

Preferred Pharmacy: ________________________

Pharmacy Phone: ________________________

Pharmacy Address:________________________

Emergency Contact Name:

Name: ________________________

Relation to Patient: ________________________

Phone:________________________

☐ **Check if address is the same as patient info.**

Address: ________________________

City:__________ State:__________ Zip: __________

Home Phone:________________________

Cell Phone:________________________

Email: ________________________

Marital Status:

☐ Child ☐ Divorced ☐ Married ☐ Single ☐ Widowed

On-The-Job Injury\ Occupational Testing Employer Info:

Employer Name: ________________________

Address: ________________________

City:____________ State ____ Zip________

Employer Phone:________________________

Fax #: ________________________

Employment Status: ☐ Disabled ☐ Full Time ☐ Part Time

☐ Self Employed ☐ Retired ☐ Student ☐ Not Employed

Additional On-The-Job Injury Information:

If Injury, Exact Date of Injury: ________________________

Is your employment through a temporary service?

Name of Temporary Service: ____

Name of Contractor: ________________________

Authorization for treatment, Assignment of Insurance benefits, Guarantee of payment, Consent to Wireless Telephone Calls, Release of records: I consent to the administration and costs of medical and surgical procedures, x-ray, and medication which physicians, physician assistants, and nurse practitioners deem necessary. I authorize the release and transfer of records or information regarding my treatment or medical condition to other providers for treatment purposes, to my insurance carrier or any other payer for payment, to my employer if my treatment is related to employment purposes, for other healthcare operations, and as otherwise specified in the Notice of Privacy Practices, which I do hereby acknowledge receiving. If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls (including autodialed calls and prerecorded messages) at the wireless number from the facility, its successors and assigns, and the affiliates, agents and independent contractors, including services and collection agents, of each of them regarding the office visit, the services rendered, or my related financial obligations. I hereby guarantee payment of all center and physician charges incurred by the above named patient for this visit (except for an authorized and qualified work related expense).

__________ ***(initial)*** ***CareNow will not screen patients for existing Advanced Directive nor implement Advanced Directives due to our patient population and scope of care.***

____

Printed Patient\Legal Guardian

________________________ ________________

Patient\Legal Guardian Signature **Date**

CARENOW URGENT CARE
PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name (Printed): ________________________ **Date of Birth:**________________________

Notice of Privacy Practice/clinics

________ (**Patient/Representative initials)** I acknowledge that I have received the practice's/clinic's Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Communications about My Healthcare

I agree I may be contacted by the Provider or an agent of the Provider or an independent physician's office for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide the Practice/Clinic an email or text address at which I may be contacted, I consent to receiving instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained or, at any text number forwarded or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at anytime. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: *This clinic uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.*

Patient/Parent/Guardian/Patient Representative Signature________________________Date: ______________

Patient/Parent/Guardian/Patient Representative Name (Printed)______________________

Patient Name (Printed): _______________________ Date of Birth:_______________________

Revised 6.11.2018

NON DOT Drug Screen / Physical / TB Form- *Patient Authorization for Disclosure of Protected Health Information*

Clinic Stamp Here

Please print all information. Sign and date the form at bottom.

Patient Name (please print): ______________________ **Date of Birth:** ______________

I authorize *CareNow* to disclose or provide my protected health information to the entity or individual identified below.

Release to (Please print):
Name of Company / Person / Requesting Entity:

Description of information to be disclosed
Date of NON DOT Drug Screen / Physical / TB:
I authorize CareNow to disclose information pertaining to the NON DOT Drug Screen / Physical / TB Results indicated above to my employer or the entity or person identified above.

- ☐ **NON DOT Drug Screen Testing**
- ☐ **TB Results**
- ☐ **DOT Employment Physical**
- __ **NON DOT Employment Physical**
- **Other:** ______________________

Purpose of disclosure – Please list the purpose of the disclosure or check patient request.

☐ **Patient Request** ☐ **Other (please specify):** ______________________

Inclusions – I understand the disclosure of individually identifiable health information may include information concerning communicable diseases such as HIV or AIDS testing and/or results, mental illness information (excluding psychotherapy notes), and drug/alcohol/substance abuse information.

Expirations or termination of authorization – This authorization will expire one year from the date of your signature below, unless you specify an earlier termination. A photocopy of this authorization will be treated in the same manner as the original. You must submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date. (Please list an earlier expiration if less than one year): ______________

Right to revoke or terminate – As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization, except to the extent that we have taken an action in reliance to the authorization prior to your termination. You may terminate this authorization by submitting a written request addressed to CareNow Privacy Manager, P. O. Box 9101, Coppell, TX 75019.

Redisclosure – We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of CareNow.

Non Conditioning – There is no restriction of your treatment as a condition for signing this authorization.

Participants in the Department of Transportation (DOT) Drug Screen and Breath Alcohol testing program are not required to sign this form.

Patient or Guardian Signature: ______________________ **Date:** ______________

Relationship to Patient: ______________________

Internal Use - Released By: ______________ **Date:** __________ **Time:** ________ **Acct. #:** __________

Revised 04/12/17