Roswell Urgent Care Center

EMPLOYEE SECTION

Employee Last Name_____ First Name _____ M.I._____

Date of Birth_____ Social Security_____ ❒Male ❒Female

Home Telephone_____ Alternate Telephone_____ ❒Cell ❒Work

Street Address_____ City, State_____ Zip_____

Medical Consent - I hereby consent to the diagnostic and/or therapeutic medical treatments requested by my employer. I acknowledge that no guarantee can be made regarding the result of any medical treatment provided.

HIPAA/Medical Release Authorization - I understand that it may become necessary to release my protected health information to another entity for treatment, follow-up, continuation of care, quality assurance, collection purposes and when required by law. Such entities may include but are not limited to primary care and consulting physicians, diagnostic laboratories and specialists. Employers maintain the right to request any information for services provided under workers' compensation or any other Employer-Paid Service. In addition, I have had the opportunity to receive the Privacy Notice which contains detailed information about how Roswell Urgent Care Center may use and disclose my protected health information.

Safety - I agree, that if any healthcare worker is exposed to my blood or other bodily fluid, I will willingly submit to testing of my blood or other bodily fluid to determine the presence of any communicable diseases. I understand that the results of any such test will not be made part of my medical record.

Certification - I certify that any information I have provided is true and correct to the best of my ability. I further understand that knowingly providing false information constitutes fraud on behalf of the responsible party.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Witness **Date**

EMPLOYER SECTION

EMPLOYER INFORMATION

Company Name_____ Authorizing Party_____

Company Address_____ City, State_____ Zip_____

Company Telephone_____ Fax Number_____

Company E-mail Address_____

I would like all results delivered via: ❑ Secure Fax ❑ Secure E-mail ❑ Other_____

I hereby request that Roswell Urgent Care Center perform the specified services for the employee mentioned above. I understand that payment for such services is due upon receipt of an invoice. If an invoice is not received within 30 days of service, I agree to contact Roswell Urgent Care Center regarding my account. Payments may be made with cash, a major credit card or a company check. In the event that my check is returned due to insufficient funds, I agree to pay a $35.00 fee.

_____ _____

Signature of Authorized Company Representative **Date**

❒Physical ❒UDS (In-House) ❒UDS (DOT/Federal) ❒Flu Vaccine ❒PPD ❒Other_____