



iMed Urgent Care & Occupational Health Services

Patient Name: _____ Address: _____

Date of Birth: ____/____/____ City: _____ State: ____ Zip: _____

SSN: _____-_____-_____ Home Phone: (____) _____-_____

Gender (*please circle one*): M F Cell Phone: (____) _____-_____

Marital Status (*please circle one*): E-mail: _____

M S D W Emergency Contact: _____

Parent/Guardian Name: Relationship: _____

_____ Phone: (____) _____-_____

Pharmacy Preference & Address: _____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Policy Holder Name: _____ Policy Holder Name: _____
 DOB: ___/___/___ SSN: _____-____-____ DOB: ___/___/___ SSN: _____-____-____
 Address: _____ Address: _____
 City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____
 Phone Number: (____) _____-_____ Phone Number: (____) _____-_____
 Relationship: _____ Relationship: _____

I am the (*please circle one*): patient | patient guardian

By signing below, I understand that I am responsible for services that are considered non-covered expenses by my insurer.

Signature: _____ Date: _____



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Patient Name: _____ Date of Birth: ___/___/___

HIPPA

I understand that, under the Health

Insurance Portability and Accountability Act of 1996 (**HIPPA**), I have certain rights to privacy regarding my Protected Health Information, I understand that the information can and will be use to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payors.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I understand that I may request in writing that you restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are required to agree to my requested restrictions, and if agreed, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I am the *(please circle one)*:

patient | patient's guardian

Signature: _____

Date: _____

**Consent for Evaluation and/or
treatment**

By signing below, I am giving my consent to the practice of iMed Urgent Care

Care for evaluation and/or treatment. Once I have been examined, I understand that I will be informed of any medically recommended diagnostic procedures and/ or treatments and given the option to accept or decline. **The consent will remain fully effective until it is revoked in writing. You can have the right at any time to discontinue services.**

I am the *(please circle the one)*:

patient patient's guardian

Signature: _____

Date: _____

Contact Information

Please list the person(s) with whom we can discuss your health information.
