Franciscan WORKINGWell

PATIENT DEMOGRAPHIC AND CONSENT*

***THIS CONSENT FORM DOES NOT APPLY TO DOT FEDERALLY REGULATED DRUG AND / OR BREATH ALCOHOL SCREENING.**

Date ______ Time ______

Soc Sec # ______ Drivers License # ______

First Name ______ Middle Initial ______ Last Name ______

Address ______ City ______ State ______ Zip ______

Phone ______ Cell ______ Birth Date ______

Sex ______ Company ______ Injury Date ______

Reason for Visit ______

<u>*If Billing Private Health Insurance please provide below information:</u>**

Insurance Carrier: ______

Subscriber Name: ______

Member ID: ______ Relationship: Self ☐ Spouse ☐ Dependent ☐

I understand and consent to the collection of a sample of blood, hair, breath, or urine to determine the presence of alcohol, drugs, and/or other toxins. NOTE: THIS CONSENT FORM DOES NOT APPLY TO DOT FEDERALLY REGULATED DRUG AND / OR BREATH ALCOHOL SCREENING.

I consent to any necessary medical diagnosis and treatment. I consent to the release of any medical information to my employer, their Worker's Compensation Insurance Carrier, and any consultant involved in my care.

I have been provided with and acknowledge my understanding of how this facility meets all HIPAA requirements and regulations. The "Notice of Privacy Policies" is posted in this facility. I have had an opportunity to review the information and have received a printed copy.

I agree that in consideration of services to be provided, if the services are not covered by worker's compensation or services pre-authorized by/for my employer as a requirement of employment, I obligate myself to pay WorkingWell for its expenses in collecting the money that I owe, including attorney's fees.

I have read this form, or have had it read to me and I understand it.

Important: Medical care cannot be provided unless this form is signed. Your health care provider cannot examine you, advise you, or bill your payment source unless you authorize him/her to do so.

Patient Signature ______ Date ______

Witness Name ______ Witness Signature ______