Franciscan HEALTH

Name: _____
First Middle Last

Home Address: _____

City: _____ State: Zip: _____

Social Security #: _____ Sex: ☐ M ☐ F

Home Phone #: _____ Cell Phone #: _____

Date Of Birth: _____ Age: _____ Race: _____ Marital Status: _____

Company Name: _____ Time you started work on injury date: _____ A.M. / P.M.

Brief Reason for Visit _____

_____

_____

_____

_____

If Injured, Date of Injury: _____ Time Injury Occurred: _____ ☐ A.M. ☐ P.M.

I understand and consent to the drawing of a sample of blood and/or the collection of a sample urine or a sample of hair to determine the presence of alcohol, other toxins, and/or drug levels.

I consent to any necessary medical diagnosis and treatment. I consent to the release of any medical information to my employer, their Workers 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 Practices" is posted in this facility, I have had an opportunity to review the information, and I have received a printed copy.

I agree that in consideration of the 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 Franciscan Health Occupational Medicine/Working Well in accordance with the regular rates and terms. Should the account need to be referred to collection, I agree to pay Working Well for its expenses in collecting the money I owe, including attorney fees. I have read this form, or have had it read to me and I understand it.

I will not complete or sign this form

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

_____ _____

Signature of patient Witness signature

_____ Time: _____am/pm

Date