Existing Patient Information and Consent

What is the reason for your visit today?

Patient Information

Name (First, Middle, Last)	Birth Date	Age	Social Security #

Birth Sex ☐ M ☐ F | Primary Care Provider ☐ None ☐ Doctors Care is my primary care provider

Mailing Address	Apt. #	City	State	Zip

Email Address	Primary Phone ☐ Home ☐ Cell	Okay to leave message? ☐ Yes ☐ No

EMERGENCY CONTACT	Name	Relationship	Primary Phone

Preferred Pharmacy

Are you interested in using the Doctors Care In-Center Pharmacy? ☐ Yes ☐ No

Pharmacy Name	Pharmacy Location

Insurance | Please present your ID and insurance card to the receptionist.

PRIMARY INSURANCE CARRIER	SECONDARY INSURANCE CARRIER
Insurance Company Name	Insurance Company Name
Address	Address
City / State / Zip	City / State / Zip
Phone / Policy Number	Phone / Policy Number
Group Number / Name	Group Number / Name
Insured Name & DOB	Insured Name & DOB
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Dependent	Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Dependent

Authorization for Release of Information

May we leave testing results or referral info in email or voicemail?

☐ Yes ☐ No

Who may receive information on your behalf regarding testing or referrals?

Name: _____

Workers' Compensation

I hereby authorize Doctors Care to speak to a rehabilitation specialist, my employer, my insurance carrier or other professionals involved in my care of rehabilitation, regarding my medical records and the treatment I have received or will receive.

X _____ _____

Patient or Authorized Person's Signature | Date

Patient Consent for Treatment

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Doctors Care and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Doctors Care.
2. I agree to be contacted via email or SMS with information related to my visit, like: a patient portal invitation, post-visit satisfaction survey, appointment or checkup reminders, health tips, or new services that relate to me or my family.
3. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Doctors Care Notice of Privacy Practices.
4. I authorize payment of medical benefits to Doctors Care physicians or their designee for services rendered.
5. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

I have received a copy of the Notice of Privacy Practice and Financial Policy Notice. ☐ Yes ☐ No Initial _____

X _____ _____

Patient or Authorized Person's Signature | Date

FOR INTERNAL USE ONLY

DocuTAP Visit ID: _____ Co-Pay Collected: $ _____