Concentra®

Consumer Health Patient Information

Reason for visit: _____

Last Name: _____ First Name: _____ MI: _____

Date of Birth (MM/DD/YYYY): _____ ☐ Female ☐ Male

Patient SS#: _____ ☐ Married ☐ Single

Military DBN (DoD Benefits Number): _____

Patient Address: _____ Apt #: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell phone*: _____

Patient Email Address: _____

For security of your records, all emails containing protected health information (PHI) are sent encrypted.

***Consent to Receive Text Messages:** By providing your personal cell phone number to Concentra, you are agreeing to receive text messages from Concentra, its related companies, and/or vendors regarding medical services. Your consent to receive such communication is not a condition of the provision of medical services.

Signature: _____ **Date:** _____

Concentra may leave detailed voice messages about your visit or future appointments unless you object by checking the "No" box.

☐ No Contact Phone (best number): _____

Employer Name: _____ Employer Address: _____

Guarantor Information

If the guarantor (person financially responsible) is anyone other than the patient, complete this section.

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt #: _____ City: _____ State: ____ Zip: _____

DOB: _____ Phone: _____

Guarantor SS#: _____

Relationship to patient: (Check one): ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Subscriber Information

If the insurance subscriber (person carrying the insurance) is anyone other than the patient, complete this section.

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt #: _____ City: _____ State: ____ Zip: _____

DOB: _____ Phone: _____

Relationship to patient: (Check one): ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Concentra's external survey partner may contact you to participate in a satisfaction survey about this visit. We rely on your feedback to help us improve the patient experience. May we contact you for a brief survey? ☐ Yes ☐ No

Concentra®

Consent for Medical Treatment

I give permission to Concentra to perform the following services that the physicians and other non-physician providers and assistants may deem to be necessary: (a) medical, surgical, and diagnostic (e.g.: including, but not limited to, x-rays, blood draws, and laboratory tests) processes, treatments, and procedures; (b) administration of injections, medications, and immunizations (with immunizations to occur after my receipt of any applicable vaccine information statements ("VIS" or "VISs")); (c) completion of medically appropriate tests for communicable and other diseases; and (d) completion of a pelvic examination, if medically appropriate.

Signature: _____ **Date:** _____

Consent for Wellness and Preventative Health Screening

I give permission to Concentra to perform a wellness and/or preventative health screening. I understand that I am solely responsible for following up with my personal physician or other healthcare provider about the results of my screening. In performing the wellness screening, Concentra does not assume any responsibility for ongoing treatment or management of care.

Signature: _____ **Date:** _____

Today's Payment

How will you be paying for today's bill?

Payment made today will be paid by:

☐ Patient Pay – I will be paying today using:

☐ Cash ☐ Check ☐ VISA ☐ MasterCard ☐ Discover ☐ Debit Card ☐ American Express

☐ Insurance – I will present my insurance card and an approved form of ID.

Financial Policy

Unless you are here for employer paid services, you will be responsible for either full payment or payment as indicated by your insurance plan. If Concentra has a contract with your insurance company we will file today's charges with that insurance company. You will be responsible for your co-payment and/or deductible, and the cost of any services not covered by insurance. You may receive a bill from Concentra for any unpaid balance.

If you have insurance…

I understand that I am financially responsible for all charges not covered by my insurance. **Initials** _____

If you do not have insurance…

If you do not have insurance coverage or Concentra does not have a direct contract with your insurance company, you will be required to pay in full for your visit today. You can expect to pay an initial payment for medical care/treatment based on posted pricing in the center. This will be collected at check-in.

If your treatment requires more complex evaluations, lab tests, vaccines, medications, X-rays, or supplies, you will be charged for those in addition to the appropriate office visit fee. These fees will be collected after service and treatment have been provided.

I do not have insurance and I acknowledge that I am responsible for all costs. **Initials** _____

Release of Medical Records, Assignment of Benefits, Financial Responsibility

Concentra will submit claims to my insurance carrier as well as medical records needed to evaluate the claims for payment. I further assign payment of benefits, otherwise payable to me, to be made payable to Concentra.

I understand that I am financially responsible for all charges not covered by my insurance.

Print Name: _____ **Signature:** _____ **Date:** _____

Primary Care Physician Name: _____ **City:** _____

State: _____ **Telephone Number:** _____

Notice of Privacy Practices

Your name and signature below indicate that you have been made aware of Concentra's Notice of Privacy Practices (NOPP) on the date indicated. You understand that the NOPP is posted in the center and a copy will be provided to you if you request it. If this is your first date of service with Concentra, please indicate this to the front desk receptionist and he/she will provide you a copy of the NOPP. If you have any questions regarding the information in Concentra's Notice of Privacy Practices, contact Concentra's Privacy office at 800-819-5571 or privacyoffice@Concentra.com.

Name: (please print) _____ **Date Notice Received:** _____

Signature: _____