TrustCareHealth™

Thank you for choosing TrustCare for your healthcare needs!

Reason for visit ____

Is this a work-related injury? ☐Yes ☐No If yes, ask the front desk for a Workers' Compensation form.

PATIENT INFORMATION

Last Name ______________________________ First Name _______________________________ MI _____

DOB ______ /______ /______ Gender ☐Female ☐Male SSN ______________________

Address ___________________________________ Apt # ____ City _____________ State _____ Zip ________

Phone (Cell) ______________________ (Work) _____________________ (Home) ____________________

Student Status ☐FT ☐PT Employment Status. ☐FT ☐PT ☐Retired ☐Not Employed

Employer ______________________________________ Email ___________________________________

How did you hear about us? ____

PRIMARY CARE PHYSICIAN

Name ________________________

Phone ________________________

IN CASE OF EMERGENCY

Name _____________________ Relationship ______________

Phone _____________________

GUARANTOR INFORMATION/LEGAL GUARDIAN

☐ Same as Patient

Last Name ______________________________ First Name ______________________________ MI ______

DOB ______ /______ /______ Gender ☐Female ☐Male SSN ______________________

Address ___________________________________ Apt # ____ City _____________ State _____ Zip ________

Phone (Cell) ______________________ (Work) _____________________ (Home) ____________________

Employer ______________________________________ Email ___________________________________

RELEASE OF INFORMATION

Last Name ______________________________ First Name ______________________________ MI ______

Address ____ City _____________ State _______ Zip _______

Phone (Cell) ______________________ (Work) _____________________ (Home) ____________________

Feel Better Faster™

TrustCareHealth™

A DETAILED COPY OF THE POLICIES BELOW IS AVAILABLE UPON REQUEST OR AT trustcarehealth.com.

INSURANCE POLICY: By signing below, I acknowledge that I have been provided an opportunity to review TrustCare's Insurance Release and Out of Network Policy. I hereby agree with and accept all terms.

FINANCIAL POLICY & PATIENT AGREEMENT: By signing below, I acknowledge that I have been provided an opportunity to review TrustCare's Financial Policy and Patient Agreement. I hereby agree with and accept all terms.

CONFIDENTIALITY POLICY: By signing below, I acknowledge I have been provided an opportunity to review TrustCare's Confidentiality Policy. I hereby agree with and accept all terms.

MEDICAL RECORDS RELEASE POLICY: By signing below, I acknowledge I have been provided an opportunity to review TrustCare's Release of Medical Records Policy. I hereby agree with and accept all terms.

CONSENT FOR TREATMENT: By signing below, I acknowledge I have been provided an opportunity to review TrustCare's Informed Consent. I hereby agree with and accept all terms.

HIPAA: By signing below, I acknowledge that a copy of the Notice of Privacy Practice is available to me upon request. I understand a copy of this consent form may be used with the same effectiveness as the original.

X ____ Date ____ /____ /____

(Signature of patient or patient guardian)

AUTHORIZATION TO PAY BENEFITS TO PHYSICIANS: I authorize the release of any information concerning my (or my child's) health care and treatment for the purposes of evaluating and administering claims of insurance benefits. I hereby authorize payment of insurance benefits, otherwise payable to me directly, to the Physician. We will file a claim with your insurance company for services provided. In the event of non-payment, you will be responsible for the charges incurred today.

X ____ Date ____ /____ /____

(Signature of patient or patient guardian)

I have read the above statements, understand the contents I have read and agree to the terms thereof. I am aware a copy of all policies is available to me upon request.

Print Patient Name ______________________________________ Date ____ /____ /____

X ______________________________________ Relationship ________________

(Signature of patient or patient guardian)

Signature of Witness X ____________________________________ Date ____ /____ /____

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