Primary Care Medical Center, PLLC

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DATE _____ HOME PHONE ☐ ( ) _____

NAME _____ CELL PHONE ☐ ( ) _____

ADDRESS _____ WORK PHONE ☐ ( ) _____

CITY/STATE/ZIP _____ EMAIL ☐ _____

CHECK PREFERRED METHOD OF CONTACT

SSN _____

SEX _____ BIRTHDATE _____ CIVIL STATUS

DRIVER'S LICENSE NUMBER _____ ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

EMPLOYER _____

NAME OF PERSON LEGALLY RESPONSIBLE (IF MINOR) _____

DRUG SCREEN and/or BREATH ALCOHOL CONSENT AND RELEASE COVENANT NOT TO SUE AND INDEMNITY AGREEMENT

I hereby CONSENT to allow PCMC to take a specimen of my hair, urine, blood or breath and submit it for a pre-employment, random, reasonable suspicion, post accident, or court order drug screen or breath alcohol test. I FURTHER CONSENT to allow the laboratory testing service to make the results of such screen available to the prospective or current employer, attorney or court office.

In consideration for such services being rendered on my behalf, I hereby RELEASE the laboratory testing service and/or PCMC, its officers, agents, and employees, from any and all claims which I might otherwise have due to such results being made so available. I hereby CONSENT NOT TO FILE ANY ACTION at law or in equity against PCMC, the laboratory testing service, their respective officers, agents or employees in connection with the results of such screen being made so available, and I hereby agree to INDEMNIFY and SAVE HARMLESS PCMC, the laboratory testing service, their respective officers, agents, and employees from all damages, expenses, reasonable attorney's fees, and costs of court which they or any of them may suffer or incur, jointly or severally, due to the results of such screen being made so available.

HIPAA NOTICE ACKNOWLEDGEMENT FORM

****A NOTICE OF THE HIPPA PRIVACY POLICY IS AVAILABLE IN THE LOBBY. PLEASE TAKE ONE.****
OR PRINT A COPY FROM OUR WEB SITE: www.primarycaregpt.com

PRIMARY CARE MEDICAL CENTER OF GULFPORT, PLLC reserves the right to modify the privacy practices. I am aware of the HIPAA NOTICE OF PRIVACY PRACTICES FOR PRIMARY CARE MEDICAL CENTER OF GULFPORT, PLLC, and copies of the notice are available for me to take if I choose to have one.

I acknowledge that I have read and understand all the information outlined in this document that applies to my visit and that my signature below signifies my agreement to comply with the terms.

_____ _____
(PRINT PATIENT NAME) (SIGNATURE OF PATIENT)

_____ _____
(SIGNATURE OF PATIENT REPRESENTATIVE) (RELATIONSHIP TO PATIENT)
(Required if the patient is a minor or adult unable to sign form)

(DATE) _____