WORKER'S COMPENSATION PATIENT REGISTRATION INFORMATION
DRUG SCREEN CONSENT
HIPAA NOTICE ACKNOWLEDGEMENT

Primary Care Medical Center of Gulfport, PLLC is herein referred to as PCMC.

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

NAME OF PERSON LEGALLY RESPONSIBLE (IF MINOR)

INJURY DESCRIPTION

DESCRIBE HOW YOU WERE INJURED AND BE SPECIFIC: HOW DID THIS HAPPEN, WHAT CAUSED THIS TO HAPPEN, WHAT LOCATION AT WORK DID THIS HAPPEN

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DATE OF ACCIDENT: ______________________

OFFICE TO COMPLETE BELOW

TIME ____________ AM/PM DATE ____________ VERIFIED BY ____________

DOA ☐ YES ☐ NO

ALCOHOL TESTING ☐ YES ☐ NO (BREATH) ☐ YES ☐ NO (BLOOD)

Has the patient previously been seen? If so, where? ______________________

Patient to bring records? ☐ YES ☐ NO

EMPLOYER ______________________

ADDRESS ______________________

COMPANY REPRESENTATIVE ______________________ PHONE ( ) ____________

INSURANCE COMPANY ______________________ PHONE ( ) ____________

ADDRESS ______________________

ADJUSTER CLAIM NUMBER

DRUG SCREEN CONSENT
AND RELEASE COVENANT NOT TO SUE AND INDEMNITY AGREEMENT

I hereby CONSENT to allow PCMC to take a specimen of my hair, urine, or blood and submit it for a pre-employment, random, reasonable suspicion, post accident, or court order drug screen. 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.

I acknowledge that I have read and understand the foregoing information and that my signature signifies my agreement to comply with the above terms.

PAYMENT RESPONSIBILITIES

1. I hereby authorize PCMC to perform any and all examinations, test or procedures determined by the licensed physician or the licensed nurse practitioner, for the purpose of administering medical treatment determined to be necessary for my welfare.
2. I authorize the release of all information pertinent to my work related injury or illness to the insurance company, claims adjuster, my employer or attorney involved in the diagnosis or treatment of this work related case.
3. In the event that this medical treatment is determined NOT to be work related, I understand and acknowledge that I am financially responsible to PCMC for all charges for services provided to me not covered by any insurer or third party payers.
4. I acknowledge that PCMC can charge a service fee of $40.00 to my account in the event that I remit payment for services with a check that is returned due to insufficient funds.
5. I understand PCMC reserves the right to collect all charges related to patient accounts placed into collections including but not limited to collection agency fees, attorney fees and court costs.
6. I agree to pay the charges for care provided to me within 60 days of the date of the first monthly bill.
7. I authorize the treating doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
8. I understand that I cannot retract this authorization for the release of medical records until my account balance is fully satisfied.
9. A photocopy of this assignment shall be considered as effective and valid as the original.

No Show Policy: Patients who do not show up for a scheduled office or lab visit, or who do not cancel the appointment the day before, will be charged a $25.00 fee.

I acknowledge that I have read and understand the foregoing information and that my signature signifies my agreement to comply with the above terms.

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.

These terms and conditions constitute my complete agreement and may be modified only by written agreement signed by an authorized official of PCMC. 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. I understand that I can request a copy of this agreement.

______________________________	______________________________
(PRINT PATIENT NAME)	(SIGNATURE OF PATIENT)
(SIGNATURE OF PATIENT REPRESENTATIVE)	(RELATIONSHIP TO PATIENT)
(DATE)	