TrustCareHealth™

Thank you for choosing TrustCare for your healthcare needs!

Reason for visit* ____

Is your medical problem the result of an on the job 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* ________________ Marital Status* (circle) S M D W

Address* ________________________________ Apt # ____ City* ______________ State* _____ Zip* ________

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

Student Status (please circle) FT / PT Employment Status (please circle) FT / PT / Retired / Not Employed

Email* ____ Employer __________________________________

Pharmacy Name and Address* ____

How did you hear about us?* ____

PRIMARY CARE PHYSICIAN

Name _______________________

Phone _______________________

IN CASE OF EMERGENCY

Name _____________________ Relationship _______________

Phone _____________________

* *Required information*

GUARANTOR INFORMATION/LEGAL GUARDIAN* ☐ Same as Patient

Last Name ______________________________ First Name ______________________________ MI ______

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

Address __________________________________ Apt # ____ City ______________ State ______ Zip ________

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

Email _____________________________________ Employer ____________________________________

RELEASE OF INFORMATION

Last Name ______________________________ First Name _____________________________ MI ______

Address _________________________________ Apt # ____ City ______________ State ______ Zip ________

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

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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