PrimeCARE MEDICAL CLINIC

W/C DEMO/HIPAA

Patient Information Record

Today's Date: _____

☐ Workers Compensation Injury Date: _____
☐ Drug Screen
☐ Physical

Patient Name: _____ Date of Birth: _____
First Middle Last

Mailing Address: _____
Street Apt # City State / Zip

Home Phone #: _____ Cell Phone #: _____ Sex: ☐ M ☐ F

SSN: _____ Race: ☐ Asian ☐ Black /African-American ☐ Caucasian ☐ Hispanic ☐ Other

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Cell Phone #: _____

Employer Name: _____

Employer Contact Person: _____ Employer Contact Phone #: _____
First Last

CONTINUE ON NEXT PAGE →

OFFICE USE ONLY

EMPLOYER INFORMATION

Employer Name: _____

Address: _____
Street Apt # City State / Zip

Employer Contact Person: _____ Employer Contact Phone #: _____
First Last

Billing Address *(if different)*: _____
Street Apt # City State / Zip

WORKER'S COMPENSATION INSURANCE CARRIER *(Complete if employer wants to file with workers' comp insurance)*

*WC Insurance Company Name: _____ Phone Number: _____

Claims Mailing Address: _____
Street Apt # City State / Zip

Claim Number: _____ Fax Number: _____

SERVICES *(Please CIRCLE the desired option)*

☐ **Drug Screen** Required: **Yes** / **No**
- If Required, we offer:
  - In house (12 Panel Rapid DS)
  - Send Out (Quest Lab)
  - DOT or Non DOT
  - Pre-Employment or Random

☐ **Physical** Required: **Yes** / **No**
- If Required, we offer:
  - DOT or Non DOT
  - Pulmonary Function Test: **Yes** / **No**

**Please provide a list of any testing required during the physical examination to meet your employer's requirements. (Labs, Breathing Tests, EKG, X-Ray, TB skin Test, etc.)*

OFFICE VERIFICATION OF EMPLOYER INFORMATION	Verified By: _____ Employer Representative Contacted: _____

Patient Authorization:
I authorize PrimeCare Medical Clinic to apply for benefits on my behalf for services rendered. I certify that the information I have reported to PrimeCare with regard to my insurance is correct. I also authorize the release of any necessary information, including medical information if requested by the workers' compensation insurance. I permit a copy of this authorization to be used in such instances. By signing below, I agree to pay all charges for services rendered by PrimeCare which are not covered by my workers' compensation policy. If it becomes necessary for PrimeCare to seek judicial action to enforce the above agreement, I agree to pay all collection fees and all attorney's fees of PrimeCare for such action.

Policy Regarding Medical Records:
I hereby authorize PrimeCare Medical Clinic to release my medical information as I have directed. I understand that PrimeCare Medical Clinic does not copy records and that such record copying services are subject to a copying charge. I also understand that said records must be requested at least one week in advance of desired receipt date. I understand that the cost for copying/printing medical records is $ 0.50/page for the first 25 pages and $0.25 for each additional page. Additionally, a labor charge of $15.00 may be added for each medical record request. I understand I will be billed by PrimeCare Medical for copying those records. Patients or other parties authorized by the patient to request records for legal issues, insurance, disability (not workman's comp), physician change, or relocation are subject to a copying charge. There will be no charge for copying records for a referral to another physician made by a PrimeCare Medical Clinic provider, or workman's compensation issues or any other situations covered by Arkansas Law.

Telemedicine:
At the recommendation of the PrimeCare medical provider and with my permission, I hereby authorize my consent to receive Telemedicine services at PrimeCare Medical Clinic. I understand that my image and my protected health information will be transmitted electronically through the videoconference platform to authorized PrimeCare medical personnel for the purpose of providing medical diagnostic assessment and treatment services. I understand that I can withdraw this permission at any time prior to the videoconference, of which shall carry no negative impact on my ability to continue care at PrimeCare. I understand that there are limits to Telemedicine technology and there is no guarantee that a Telemedicine session will eliminate the need for me to see a provider in person in order to receive appropriate or additional treatment for my current condition.

Patient Right to Privacy/Confidentiality:
PrimeCare is committed to patient privacy and confidentiality in compliance with HIPAA. Please complete the following so we can ensure the privacy and confidentiality of your information to the degree required under existing regulations. I authorize PrimeCare Medical Clinic to leave medical information pertaining to my care by the following methods and know that it is my responsibility to update this information should the information change:

Please provide the best contact number to reach you:

_____

Okay to leave message? ☐ Yes ☐ No

Okay to text phone? ☐ Yes ☐ No

List any people authorized to receive your health information with relationship and phone number:

	Name	Relationship	Phone #:
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

I have read and understand the above information:

X: _____ _____

Signature of Patient Parent/Guardian Date

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. This Notice describes the types of uses and disclosures of my protected health information (PHI) that might occur in my treatment, payment of my bills, or in the performance of health care operations. This form will be filed in the patient's medical record.

Please Print the Patient's name _____ Date _____ Please Sign your name _____

Legal Representative or parent's name if patient is a minor _____ Relationship to Patient _____