Date: _____

Patient Information, Consent and Release for Health Screening

Please Print

Patient Information

Legal First Name | Legal Last Name | Suffix | Preferred First Name | Primary Care Provider (PCP)

RESPONSIBLE PARTY'S INFORMATION: (if insured is someone other than patient)

Legal Name of Responsible Party | Social Security # | Address | City | State | Zip

MEDICAL INSURANCE INFORMATION:

Insured's Birth Date | Insurance ID Number

Patient Demographics

Permanent Address | Apt. # | City | State | Zip

Phone # | Social Security # | Gender | Birth Date

Language | Marital Status | Email Address (We will never rent or sell your email address – we value your privacy.)

Race: ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic ☐ Mixed Race ☐ White ☐ Other ☐ Refuse to Report

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Refuse to Report

Emergency Contact Information

Contact Name | Phone # | Relationship to Patient

Name of a Relative not Residing With You | Phone #

Consent and Release

1. Purpose of the Screening. The primary purpose of this health screening is to increase awareness and knowledge of your personal health and wellness. Participants of this screening are encouraged to seek specific wellness resources and health care to assist with establishing and achieving health goals.

2. Explanation of the Screening and Associated Risks. This health screening will include one or more of the following tests: Blood Pressure Check, Body Mass Index (BMI), Comprehensive Metabolic Profile (CMP), Lipid Panel, and Thyroid Panel. Some of the tests being performed require a small blood sample to be drawn by needle from your arm. In some instances members could experience signs and symptoms related to the testing that could require calling for emergency assistance using 911. By signing you hereby understand the risks involved and release Doctor's Care, your employer and any other organization(s) associated with this screening and/or health fair, their affiliates, directors, officers, employees, successors and assigns, from any liability arising from or in any way connected with your participation in any of these tests.

3. Confidentiality and Use of Personal Information. You may revoke this authorization of consent by providing written notice to Doctors Care at any time. Any personally identifiable health information obtained in conjunction with your health screening will be protected and will only be used in accordance with this consent agreement and applicable laws pertaining to the use of personal health information. Your information in aggregate form may be used for research, educational, or statistical purposes so long as the data does not personally identify you.

4. Responsibilities of the Participant. By choosing to participate in this screening you certify that you are in good health and that you have accurately completed the Health Screening Questionnaire presented to you by the health screening staff. If the participant is not the insurer, they are responsible for providing accurate and complete insurance information. If the participant is a self-pay or does not provide adequate insurance information, the participant will be responsible for payment before services are rendered.

Consent and Release (continued)

5. Release of Claims. In consideration of your participation in this health screening, you hereby agree to assume full responsibility for your personal outcomes. You understand that your results are intended to be used for educational purposes only and are not designed to replace the care or advice of a medical provider. If you have a disease condition, fall into certain high health risk categories, and/or receive abnormal laboratory tests, you should promptly consult with a physician. Doctors Care, PA nor any of its staff or affiliates is liable for any health consequences resulting from your participation in this program, and neither Doctors Care, PA nor any of its staff or affiliates is responsible for ensuring that you have consulted with your physician regarding any recommendations you may receive as a result of your participation. Your results **will NOT** be automatically sent to a healthcare provider on your behalf. Your signature below authorizes Doctors Care to seek immediate medical assistance on your behalf if warranted, in the sole discretion of Doctors Care. **YOU HEREBY RELEASE THE PROGRAM AND ALL OF ITS PERSONNEL AND AGENTS FROM ANY AND ALL DAMAGES AND CLAIMS CAUSED BY OR RESULTING FROM YOUR PARTICIPATION IN THIS HEALTH SCREENING.** This release shall also be binding upon your heirs, executors, and administrators.

6. Freedom of Consent. This notice contains our policy with respect to our security and privacy practices. This policy and notice may change at any time, but material modifications will only be effective after you have been given the opportunity to (i) review the amended policy, and (ii) withdraw your consent. You acknowledge that you have read this document in its entirety (or that it has been read to you), and that you understand and agree to the above. If you are under age 18, you agree not to participate in this health screening without the written consent of your parent or legal guardian. Your permission to perform this health screening is given voluntarily and extends to all screening personnel, including volunteers. You understand that you are free to stop the tests at any point, if you so desire. You also fully understand the attendant risks and discomforts, and have had an opportunity to ask questions that have been answered to your satisfaction.

7. Follow Up Opportunities. There is a possibility that information revealed during this health assessment may make you aware of physical and emotional challenges you are facing. For assistance with such concerns, Doctors Care offers the following resources: physicals, referrals, and other ancillary health services. Your health screening results may also make you eligible for additional health improvement interventions such as: tobacco cessation counseling and treatment, weight management, and diabetes education programs.

To agree to participate in this health screening, please sign and date this consent and release form. We cannot process your health questionnaire unless you have signed and dated below. Thank you.

X _____ _____

Signature of Participant — Date

X _____ _____

Signature of Parent or Legal Guardian if Participant is under 18 years of age. — Date

X _____ _____

Signature of Doctors Care Staff — Date

Additional Tests Offered (Please Select)

	Test	Cost
☐	ABO Grouping / Rho(d) Typing	$15.00
☐	C-Reactive Protein	$23.00
☐	CA-125	$70.00
☐	Hemoglobin A1c	$15.00
☐	Homocysteine	$26.00
☐	Prostate Specific Antigen (PSA)	$18.00
☐	Thyroid Panel (TSH)	$18.00
☐	Vitamin D, 25 - Hydroxy	$50.00
	TOTAL:	**$0.00**

FOR OFFICE USE ONLY

Receipt: _____ Staff Initial: _____

EMR DOCUMENT TYPE: Patient Information