                                    **Employer Services and Patient Information**

**PATIENT** First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #: \_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: (MM/DD/YY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Female \_\_\_\_\_\_ Male \_\_\_\_\_\_\_

The information provided above is correct to the best of my knowledge. I will not hold OHP, its health providers, or its employees responsible for any errors or omissions that I may have made in completing the information on this form.

 **Please sign and date below**

 **Sign:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Medical Treatment**

I give permission to Occupational Health Partners to perform the following services that the health care provider and assistants may deem to be necessary: (1) medical, minor surgical and diagnostic ( i.e.: including but not limited to x-rays, blood draws, laboratory tests) process, treatments and procedures; (2) administration of injections, medications and immunizations (with immunizations to occur after my receipt of any applicable vaccine information statement ("VIS" or "VISs"); and (3) completion of medically appropriate tests for communicable and other diseases. **Please sign and date below**

**Sign:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice of Financial Responsibility**

The patient, or the patient’s guardian, if a minor, is ultimately responsible for the payment for treatment and care. Occupational Health Partners will bill worker’s compensation insurance company or your employer for you. If worker’s compensation or your employer denies your claim or bill you, the patient, or guardian, if the patient is a minor, will be responsible for any and all procedures, treatments and office visits provided by Occupational Health Partners. Payments are due within 30 days from receipt of billing. Patients may incur, and are responsible for payment of additional charges, if applicable. **Please sign and date below**

**Sign:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice of Privacy Practices**

Your name and signature below indicate that you have been made aware of OHP's Health Insurance Portability & Accountability Act (HIPAA) on the date indicated. You understand that HIPAA is posted in the center and a copy will be provided to you if you request it. If this is your first date of service with OHP, please indicate this to the front desk receptionist and s/he will provide you a copy of the HIPPA statement. **Please sign and date below**

**Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Notice Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_

**Release of Information**

Your name and signature below give Occupational Health Partners permission to release or request your medical records to allow for a continuity of care or at the request of your employer. Furthermore, your signature indicates your understanding that any information released is confidential and protected by law. This law prohibits further disclosure of this information without specific written consent of the patient.  **Please sign and date below**

**Sign:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witness:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_