ImmediateClinic

Staff Use Only

PID#:_____ Scanned By: _____

Clockwise – Arrival Time:	Clockwise – "Ready" Time:	Clockwise "Call Back" Time:	Clockwise "Discharge" Time:
☐Receptionist Initials	☐Receptionist Initials	☐MA/RT Initials	☐MA/RT Initials

PATIENT NAME (Nombre del Paciente):_____ AGE (Edad):_____

ADDRESS (Direccion):_____

CITY (Ciudad):_____ State (Estado):_____ ZIP:_____

SOCIAL SECURITY (SSN#):_____ DATE OF BIRTH (Fecha de Nacimiento):_____ Sex (O): ☐M☐F

TEL. CELL (Celular):_____ TEL. HOME (Casa):_____

EMAIL ADDRESS (Direccion de Correo Electronico):_____

CURRENT OR PROSPECTIVE EMPLOYER (Empleador): _____

JOB POSITION (Posicion): _____

VISIT FOR (Visita para):

☐Pre-Employment Exam (Examen de Trabajo)

☐ DRUG TEST (Examen de Drogas)

☐ Other (Otro): _____

FOR OFFICE USE ONLY / SOLO PARA USO DEL MEDICO

SCREENING SERVICES:	EXAM SERVICES:	**ADDITIONAL SERVICES:**
DRUG: ☐ DOT ☐ NON-DOT ☐ INSTANT: PANEL: _____ ☐ HAIR ALCOHOL: ☐ BREATH DOT ☐ BREATH NON-DOT	PHYSICAL: ☐ DOT ☐ NON-DOT (Basic) ☐ MEDICAL SURVELLANCE (Extensive) ☐ MERCHANT MARINER (USCG) ☐ RETURN TO WORK/FIT FOR DUTY ☐ PHYSICAL ABILITIES TEST ☐ FAA ☐ RESPIRATOR ☐ OSHA ☐ HAZMAT ☐ OTHER: _____	ANCILLARIES: ☐ AUDIOGRAM ☐ TB SKIN TEST ☐ IMMUNIZATIONS ☐ Requested: _____ ☐ TRAVEL MEDICINE ☐ TITERS/LABS ☐ Requested: _____ ☐ X-RAY ☐ Focus Area:_____ ☐ OTHER: _____
☐ Reported by:	☐ Reported to:	Method of report: ☐FAX ☐EMAIL ☐ GIVEN TO PATIENT

Employer Paid Services

Authorization to Disclose

Patient Health Information to Employer

PID: _____

Your present or prospective employer has requested testing, evaluation or treatment to be completed by DRX WA Urgent Care Providers PLLC, dba Immediate Clinic ("IC").

Consent to Medical Treatment

I voluntarily present for testing, evaluation or treatment and consent to my Immediate Clinic provider to provide my testing, evaluation and treatment. Such care may include, but is not limited to, drug screening, exams, diagnostic procedures, x-rays, blood draws, laboratory tests, medication administration, and other procedures considered advisable in my screening, treatment, diagnosis and course of care.

I acknowledge that my treatment is intended to satisfy the request of my employer or prospective employer, as well as address specific, episodic illnesses or injuries. It is not intended as a substitute for a primary care physician or other specialized physician and no guarantee can be made or has been made as to the results of treatments or examinations at Immediate Clinic.

Consent to Release Information

- (Required) **Name of current or prospective employer**: _____
- If I have been sent to Immediate Clinic for only a drug screen, my protected health information *only includes the results of that drug screen.*
- Otherwise, my protected health information includes the results of tests, evaluations, and treatment including diagnoses and medical history relevant to the tests, evaluations and treatment completed, that was required or requested by my current or prospective employer.
- Immediate Clinic has permission to disclose the results of my testing, evaluation and treatment to my present employer, prospective employer, or to an entity designated to evaluate my suitability for (1) initial or continued employment or (2) other activity required by my employer, prospective employer or any other disclosure required by law.
- I understand that the results of my test, evaluation or treatment may not be protected from further disclosure by some entities receiving my information under this authorization, and that Immediate Clinic has no control over subsequent disclosures by other entities.

PRIVILEGES PROVIDED ME IN CONNECTION WITH THIS AUTHORIZATION

- This authorization will expire one year from the date of when I am no longer employed by the above named employer or one year from the date below, whichever is later.
- I can request a copy of my protected health information that will be disclosed. A processing and /or copying fee may apply as permitted by law.
- My treatment may not be conditioned on my signing of this authorization unless the sole purpose of my visit to Immediate Clinic is for my employer or prospective employer to obtain the results of my test, evaluation or treatment.
- I have a right to not sign this authorization or to limit the results I authorize to be disclosed. However, refusal to sign this authorization may violate a condition of employment or prospective employment. For details, I may contact my employer or prospective employer.
- I may revoke this authorization at any time, but must do so in writing to the Immediate Clinic office where I received services. My revocation will not apply to disclosures that have already occurred under this authorization. Revocation of this authorization may carry consequences related to my employment or prospective employment. For details, I may contact my employer or prospective employer.
- I have the right to receive a copy of this authorization.

By signing below, I, (Print Full Name) _____ authorize Immediate Clinic to disclose the results of my testing, evaluation, or treatment in accordance with the following consent, terms and conditions:

Patient Signature: _____

Date of Birth: _____

Today's Date: _____ (Date of Visit)

Visit Follow-up Communication

TEXT MESSAGE AND INFORMED CONSENT: In order to enhance patients' care and experience Immediate Clinic may contact you after your visit in order to request feedback on your experience by phone call, SMS text message, e-mail, voicemail, or mobile application, some of which may be via automated means. By signing below you understand and agree to be contacted in this manner with communications related to this visit, and any future visits.

In the future, you may opt-out of receiving text messages by notifying us in writing (including responding via text message). Standard telephone minute and text charges may apply if we contact you.

MOBILE SAFETY TIPS: While we work hard to protect your information, remember that electronic communication is never 100% secure. It's very unlikely, but information you send via text, email or mobile application, or that you leave on your mobile device, could be exposed to people other than your Doctor. Here are a few safety tips to follow:

(1) Use a password on your mobile device to prevent strangers from seeing what is on your phone.

(2) Limit the amount of sensitive health information you send. You can always call your provider to discuss something private or sensitive.

(3) If you are worried about those close to you seeing your messages, you can delete them from your email or messaging app. This won't erase them completely, but will make it hard for others to see them.

Patient Signature: _____

Date: _____