



PATIENT INTAKE INFORMATION

CLOCK IN ARRIVAL

CLOCK IN COMPLETION
OF FORMS

NAME _____ SS# _____ SEX _____

ADDRESS _____ CITY _____

AGE _____ DATE OF BIRTH _____ STATE _____ ZIP _____

POSITION APPLIED FOR _____ TELEPHONE (_____) _____

EMAIL ADDRESS _____

COMPANY NAME _____

Below to be filled out by U.S. HealthWorks only

TYPE OF PHYSICAL EXAM _____ EMPLOYER NO. _____
PROTOCOL NO. _____

VISION ACUITY: SNELLEN _____ RETURN FORMS WITH EMPLOYEE _____
TITMUS _____ BY MAIL _____

AUDIOGRAM _____ REQUIRES WRITTEN SUMMARY _____

URINALYSIS: DIPSTICK _____ OTHER _____
LABORATORY _____

BACK EVALUATION _____

EKG _____

X-RAYS _____ COMMENTS _____

PFT _____

DRUG SCREEN _____

LAB _____

CLOCK OUT/DISCHARGE

CLOCK IN FOR M.A.



AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing below, I authorize U.S. HealthWorks Medical Group (“USHW”) to disclose my protected health information in accordance with the following terms and conditions.

RECIPIENTS OF INFORMATION/PURPOSE OF DISCLOSURE

USHW may disclose my health information to: (PLEASE CHECK ALL THAT APPLY)

- My employer or prospective employer, (NAME) _____ for the purpose of evaluating my suitability for employment, and any other entities assisting my employer or prospective employer in carrying out this activity.
- My employer, (NAME) _____, for the purpose of evaluating or processing my claims for workers’ compensation benefits, and any insurance companies or other entities providing services or insurance coverage to my employer in connection with this activity.
- My health insurance company for purposes of paying USHW for health care services provided to me.

INFORMATION DISCLOSED

USHW may disclose all of my health information in USHW’s medical and billing records. These records may include, but are not limited to, information regarding the diagnosis and treatment of mental health conditions, genetic diseases, alcohol or drug abuse, infectious diseases and sexually transmitted diseases. USHW will NOT disclose HIV test results or psychotherapy notes under this authorization. USHW will obtain a separate consent form if necessary for either of these purposes.

MY RIGHTS IN CONNECTION WITH THIS AUTHORIZATION

- This authorization will expire on/or upon the later of; (A) one (1) year from the date of my signature or (B) the date upon which my case has been closed and USHW has received full and final payment for services rendered.
- I may review or obtain a copy of the health information that will be used or disclosed pursuant to this authorization (with the possible exception of some mental health records), upon payment of processing/copying charges that may apply as permitted by law.
- Unless the sole purpose of my visit(s) to USHW is for my employer or prospective employer (or another third party) to obtain health information about me, my treatment may not be conditioned on my signing of this authorization.
- I may revoke this authorization at any time, but I must do so in writing and submit the revocation to a clinic where I receive health care services. My revocation will take effect upon receipt, except to the extent that others may have already acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.

RISK OF RE-DISCLOSURE

I understand that my health information could be re-disclosed if any of the entities receiving my information under this authorization are not subject to state and federal medical confidentiality laws, including the Health Insurance Portability and Accountability Act (“HIPAA”).

SIGNATURES

Patient / Representative / Spouse/ or Responsible Party (PRINT NAME): _____

If signed by someone other than the patient, state legal relationship to the patient: _____

Signature: _____ Date: _____ Time: _____



PATIENT AUTHORIZATIONS

AUTHORIZATION FOR EVALUATION AND TREATMENT

I hereby authorize U.S. HealthWorks Medical Group, its affiliates, physicians, employees, and designated agents, to perform a physical examination and/or any medical treatment deemed necessary by the physician(s). These may include, without limitation, any required examination, medical, diagnostic or laboratory tests and medical procedures ordered by the physician(s) to be performed by the designated U.S. HealthWorks staff. I understand that certain special medical exams such as annual, executive, fitness for duty, school/sports physical exams, and other similar services are not intended for purposes of medical diagnosis and/or treatment, or to replace the medical care of my personal physician.

CONSENT FOR NON-REGULATED SUBSTANCE ABUSE TESTING (If applicable)

When applicable, I voluntarily authorize U.S. HealthWorks to obtain a specimen of my urine, blood, saliva, breath, hair and/or other specimen, to determine the presence of drugs and/or alcohol, and subsequent release of the results to my employer/prospective employer, or the following party: _____.

ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT

I hereby authorize and assign to U.S. HealthWorks any and all benefit payments for services rendered under the terms of my insurance policies, and hereby individually obligate the payer to pay the account to U.S. HealthWorks in accordance with the standard and customary charges incurred during my period of treatment. I understand that I am responsible to pay for all charges for services rendered but not covered by my insurer. If I am liable for payment, a list of charges will be made available to me within sixty (60) days from the date U.S. HealthWorks becomes aware of my insurance ineligibility. I understand this may take up to 12 months as U.S. HealthWorks attempts to collect from my insurer. Should the account be referred for collection, I understand that I shall pay any collection expenses incurred by U.S. HealthWorks, without limitation, court costs and attorney's fees.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed or have been given an opportunity to review and offered a paper copy of the U.S. HealthWorks Medical Group Notice of Privacy Practices and I am aware that I may view it electronically at <http://www.ushealthworks.com>.

By signing this authorization form I acknowledge that I fully read or had this form read and/or explained to me and I fully understand its contents. I have been given ample opportunity to ask questions, and any questions have been answered satisfactorily.

SIGNATURES

Patient Name: _____ Signature: _____ Date: _____

Address: _____ City/State/Zip: _____ Tel: _____

Representative: _____ Signature: _____ Relationship: _____