Consent for Treatment & Registration Form

All fields must be completed unless otherwise noted

PLEASE NOTIFY THE STAFF IMMEDIATELY IF YOU ARE EXPERIENCING CHEST PAIN, DIZZINESS OR DIFFICULTY BREATHING

Describe the reason for your visit today

Urgent Care ☐ **Work-Related Injury** ☐ **Physical** ☐ **Vaccination** ☐ **Drug Test** ☐

Describe Illness/Injury

Type of Illness, Injury, Physical, Test or Vaccine:

If injury, complete the following section:

Date of Injury:	Time of Day:	Body Part:

Describe How Injury Occurred:

If a work-related injury, did you report this to your employer? **Yes** ☐ **No** ☐

If you are claiming a work-related injury, you MUST NOTIFY your employer of this injury before coming in for treatment and provide ExpressMED/BOAC with the information needed in order to bill your employer's workers' compensation insurance. A claim must be filed by your employer in order for medical benefits to be paid. If your injury is ruled as NOT work-related, or you fail to follow the required procedures for making a claim, you will be responsible for the payment of your bill for all medical services.

Is your visit related to an auto accident? **Yes** ☐ **No** ☐

Personal Information - PLEASE PRESENT YOUR INSURANCE CARD AT CHECK-IN

IN ACCORDANCE WITH FEDERAL GUIDELINES, WE REQUIRE POSITIVE PHOTO IDENTIFICATION

Legal Name:		
Street Address:		
City:	State:	Zip:
Home #:	Cell #:	
Email Address:	Date of Birth:	
SS# *(optional)*:	Gender Male ☐ Female ☐	
Emergency Contact:	Phone #:	

Turn over to complete form

When requested by your employer, a copy of the physical exam & medical history will be sent to them for their records.

Employer Information *(required for work-related injury only)*

Name of Employer:	
Location/Store #:	Phone #:
Job Title:	Supervisor:

Are you a Member Medical member? Yes ☐ No ☐

Insurance / Medical Information *(if applicable, Self-pay pricing is available)*

Insurance Company:	
Group #:	Policy #:
Subscriber:	Relationship:
Primary Care Physician:	
Practice Name:	PCP Office #:

How did you hear about us?

Website ☐ **Online Search ☐** **Social Media ☐**
Family/Friend ☐ **Community Event ☐** **Employer ☐**
Referral ☐ **Sign/Convenience ☐** **Advertisement ☐**
Other ☐ ________________________________

Assignment of Benefits

I hereby assign all medical benefits, including medical benefits to which I am entitled, to ExpressMED/Bedford Occupational & Acute Care (BOAC). I hereby authorize and direct my insurance carrier(s), including Medicare, Medicaid, private or commercial insurance and any other health plan, to issue payment directly to ExpressMED/BOAC for medical services rendered to myself or to those for which I have placed my signature as guarantor. I understand that I am personally responsible for any amount not covered by my insurance, including co-payments, co-insurance and deductibles. I have requested medical services from ExpressMED/BOAC on behalf of myself and/or my spouse or dependents and understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred immediately upon presentation of the appropriate statement.

Consent & Acknowledgement

I have received the notice of Health Information Privacy Practices adhered to by this office under federal HIPPA rules, and the NH Patients' Bill of Rights and grievance procedures.

I consent to be treated by ExpressMED/BOAC providers and clinic staff. Treatments may include, but are not limited to, physical exams, procedures, medication administration and ancillary testing.

Signature:	Date:

IF PATIENT IS UNDER 18 OR HAS A LEGAL GUARDIAN, PARENT OR GUARDIAN MUST SIGN & COMPLETE LOWER SECTION

Parent/Guardian Name:	Phone #:	
Street Address:		
City:	State:	Zip: