REGISTRATION AND CONSENT FORM

☐ Care Station I
☐ Care Station II
☐ Care Station III
☐ Care Station IV

Date: _____

First Name: _____ M ____ Last: _____

Address: _____ Marital Status: ☐ Single ☐ Married ☐ Other

City/State/Zip: _____ Sex: ☐ Male ☐ Female

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail Address: _____ Date of Birth: _____ Soc .Sec. #: _____

Contact person in case of emergency: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

RESPONSIBLE PARTY: First Name: (if under 18) _____ M __ Last: _____

SS#: _____ Phone #: _____

Address/City/State/Zip: _____

Primary Insurance Carrier: _____ ID#: _____

Insured's Name: _____ DOB: _____

Secondary Insurance Carrier: _____ ID#: _____

Insured's Name: _____ DOB: _____

CONSENT FOR TREATMENT AND RELEASE OF MEDICAL RECORDS

I give my permission to Care Station and its staff to perform upon me the following procedures IF DEEMED NECESSARY: the taking of health history, physical examination or diagnostic procedures including x-ray, electrocardiogram, audiogram, pulmonary function and venipuncture (drawing of blood) for laboratory tests and treatment for my injury / illness. If I should become ill while undergoing treatment by Care Station and its staff, I give Care Station and its staff my permission to administer treatment which they consider necessary for my well being.

I understand that information regarding the results of my physical exam, diagnostic procedures and/or nature of my illness will be released to the insurance carrier providing coverage to me. I consent to have my medical information transferred to any physical and/or health care institution that I am referred to by Care Station. I understand medical information will be communicated to a designated representative of my employer (only if this is a workers' compensation or an employer paid physical examination service).

My signature or mark indicates that I have read and understood this consent, and I consent to treatment.

NOTICE OF PRIVACY PRACTICES & PERMISSION OF PATIENT CONTACT

Due to privacy laws, we cannot discuss your healthcare information with anyone not listed below.

Name: _____ Phone: _____

Name: _____ Phone: _____

My signature below indicates my consent for treatment and release of medical records, and that I have received and reviewed the Care Station Notice of Privacy Practices. I authorize Care Station to obtain my prescription history from the electronic database of pharmacies through the electronic medical records system used by Care Station. I understand that this history, once obtained, will become part of my medical record.

Patient / Guardian Signature: _____