PCA Primary Care Associates

Consumer Health Patient Information

Reason for visit: _____

Last Name:_____First Name:_____MI: _____

Date of Birth (MM/DD/YYYY): _____ ❒ Female ❒ Male

Patient SS#: _____ ❒ Married ❒ Single

Military DBN (DoD Benefits Number): _____

Patient Address:_____ Apt #:_____City:_____State:_____Zip: _____

Home Phone:_____Cell phone: _____

Patient Email Address: _____

For security of your records, all emails containing protected health information (PHI) are sent encrypted.

PCA may leave detailed voice messages about your visit or future appointments unless you object by checking the "No" box. No❒ Contact Phone (best number): _____

Employer Name: _____ Employer Address: _____

Guarantor Information: If the guarantor (person financially responsible) is anyone other than the patient, complete this section.

Last Name:_____First Name:_____MI: _____

Address:_____Apt #:_____City:_____State:____Zip: _____

DOB:_____Guarantor SS#: _____

Phone:_____

Relationship to patient: (Check one) ❒ Self ❒ Spouse ❒ Parent/Guardian ❒ Other: _____

Subscriber Information: If the insurance subscriber (person carrying the insurance) is anyone other than the patient, complete this section.

Last Name:_____First Name:_____MI: _____

DOB:_____Phone: _____

Address:_____Apt #:_____City:_____State:____Zip: _____

Relationship to patient: (Check one) ❒ Self ❒ Spouse ❒ Parent/Guardian ❒ Other: _____

Emergency Contact Name:_____ Emergency Contact Phone: _____

PCA's external survey partner may contact you to participate in a satisfaction survey about this visit. We rely on your feedback to help us improve the patient experience. May we contact you for a brief survey? Yes❒ No ❒

Consent for Medical Treatment

I give permission to PCA to perform the following services that the physicians and other non physician providers and assistants may deem to be necessary: (a) medical, surgical, and diagnostic (*e.g.*: including, but not limited to, x rays, blood draws, and laboratory tests) processes, treatments, and procedures; (b) administration of injections, medications, and immunizations (with immunizations to occur after my receipt of any applicable vaccine information statements ("VIS" or "VISs")); and (c) completion of medically appropriate tests for communicable and other diseases.

✍ **Signature**: _____ Date: _____

Consent for Wellness and Preventative Health Screening

I give permission to PCA to perform a wellness and/or preventative health screening. I understand that I am solely responsible for following up with my personal physician or other healthcare provider about the results of my screening. In performing the wellness screening, Concentra does not assume any responsibility for ongoing treatment or management of care.

✍ **Signature**: _____ Date: _____

Today's Payment

Payment made today will be paid by:

How will you be paying for today's bill?

❒ Patient Pay – I will be paying today using:
❒ Cash ❒ Check ❒ VISA ❒ MasterCard ❒ Discover ❒ Debit Card ❒ American Express

❒ Insurance – I will present my insurance card and an approved form of ID.

Financial Policy

Unless you are here for employer paid services, you will be responsible for either full payment or payment as indicated by your insurance plan. If PCA has a contract with your insurance company we will file today's charges with that insurance company. You will be responsible for your co payment and/or deductible, and the cost of any services not covered by insurance. You may receive a bill from PCA for any unpaid balance.

If you have insurance…

➲ I understand that I am financially responsible for all charges not covered by my insurance. **Initials** _____

If you do not have insurance…

If you do not have insurance coverage or PCA does not have a direct contract with your insurance company, you will be required to pay in full for your visit today. You can expect to pay an initial payment for medical care/treatment based on posted pricing in the center. This will be collected at check-in.

➲ If your treatment requires more complex evaluations, lab tests, vaccines, medications, X-rays, or supplies, you will be charged for those in addition to the appropriate office visit fee. These fees will be collected after service and treatment have been provided.

➲ I do not have insurance and I acknowledge that I am responsible for all costs. **Initials** _____

Release of Medical Records, Assignment of Benefits, Financial Responsibility

PCA will submit claims to my insurance carrier as well as medical records needed to evaluate the claims for payment. I further assign payment of benefits, otherwise payable to me, to be made payable to PCA.

➲ I understand that I am financially responsible for all charges not covered by my insurance.

Print Name: _____

✍ **Signature:** _____ Date: _____

Primary Care Physician

Name: _____ City: _____

State: _____ Telephone Number: _____

Notice of Privacy Practices

Your name and signature below indicate that you have been made aware of PCA's Notice of Privacy Practices (NOPP) on the date indicated. You understand that the NOPP 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 PCA, please indicate this to the front desk receptionist and he/she will provide you a copy of the NOPP.

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Name: (please print) _____ Date Notice Received: _____

✍ **Signature:** _____