OnSite Care Clinics
560 S. 300 E. Suite 275
Salt Lake City, Utah, 84111
801-441-1002

Patient Information Form

Please print all information in the spaces provided. Be sure to complete and sign the statement.

Last name: ________________________ Maiden Name___________________ First Name: _____________________ MI _______

Home Address: ____ City________________ State____________ Zip________

Home Phone: ___________________________ Cell Phone _________________________ Work Phone _______________________

Date of Birth: ________________________ Sex ______ _____ Martial Status: □ Married □ Single □ Divorced □ Widowed

Employer Name:_____________________________________ Email Address: ____

Pharmacy Name: _________________ Address/Cross streets & City: _________________________ Phone ____________________

Responsible Party □ Self

□ Please Check box if Patient is a minor
□ Please check box if parents of minor Patient are divorced or legally separated. In the event of divorce, parents may be responsible for providing a court-adopted parenting plan or other legal document evidencing legal decision making authority of the parent(s) regarding the minor Patient's health care.

Name: ____________________________ Relationship: ____________________ D.O.B: _____________Phone: ________________

Emergency Contact Information:
Person to contact in the case of an emergency
Name: _____________________________________ Relationship: ____________________ Phone Number: ____________________

Primary Insurance
Insurance Name & Phone Number: ____
ID Number: ____ Group Number:____
Name of Insured:___________________________________ Relationship to Patient:____________________________________
Address of Insured:____
Date of Birth of Insured: ____

Secondary Insurance

Insurance Name & Phone number: ____
ID Number: ____ Group Number:____
Name of Insured:___________________________________ Relationship to Patient:____________________________________
Address of Insured:____
Date of Birth of Insured: ____

I accept responsibility for all services received by myself and all family members. I also accept responsibility for payment for any service(s) provided that is note covered by my insurance. I agree to pay all co-payment, coinsurance and deductibles as determined by my health insurance plan. I understand that there will be a $20.00 fee for any check that is not honored by my financial institution and that I could be subject to a payroll deduction and/or collection fees up to 40% for any outstanding balances.

I authorize OnSite Care to view my prescription history through external sources.

____ _______________________
Signature of Patient/Parent, Guardian or Person Requesting Care Date

Your name and signature on this sheet indicates that you have received, or been offered a copy of the Joint Notice of Privacy Practices.

____ _______________________
Signature of Patient/Guardian Date

OnSite Care
Affordable Healthcare at Work

Standard Authorization of Use and Disclosure of Protected Health Information

Patient Name: ____
Date of Birth: _________/____________/____________

Information to be Used or Disclosed

The information covered by this authorization includes:
Medic al and health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment.

Purposes of Disclosure

Information listed below will be disclosed for the following purposes:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means for a third-party payer to verify that services were billed as actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professions

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:
OnSite Care Clinics

Persons to Whom Information May be Disclosed

To whom the information described above may be disclosed is covered thoroughly in the Notice of Privacy Practices. Your signed acknowledgment of receipt is filed in the patient's chart

Expiration Date of Authorization

This authorization is effective until the patient provides written notice of revocation.

Right to Revoke or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to OnSite Care Clinics.
You should contact the Privacy Official to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once OnSite Care Clinics discloses it to another party.

Rights of the Individual

You may inspect or copy information used or disclosed under this authorization
You may refuse to sign this authorization

Effect of Refusing Authorization

If you refuse to sign this authorization, OnSite Care Clinics will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others. I request the following restriction to the use and/or disclosure of my health information

____
Who can we speak to

____
Signature of Patient or Patient Representative

____
Relationship of Patient Representative to Patient/Date

The Arizona Department of Health Services Licenses this office.

As required by Arizona Department of Health rules and other statues, rules and requirements, this office has made a copy of your Patient Rights available to you.

By your signature below, you acknowledge receipt of your patient rights.

Per my request, I read the laminated copy of the Patient Rights in the office and do not want to take a copy home. ______ (initial)

Per my request, I was given a paper cop of the patient rights to take home with me. ______ (initial)

Print Name: ____

Relationship to patient: ______________________________

Signature: ____

Date and Time Received: _____________________________