



General Drug Screen & Injury Consent / Release of Information

***If you have symptoms of chest pain, seizures, head injury, severe bleeding, shortness of breath, chemical in eye, or anything of concern, please notify the receptionist immediately so appropriate action can be taken!

Patient Information	Last Name _____ First _____ Middle _____ Address _____ City _____ State _____ Zip _____ Home Phone () _____ Cell phone # () _____ Birth date ____/____/____ Age: _____ Male / Female Social Security # _____ - _____ - _____
Company Information	<p align="center">If you are here for <u>pre-employment</u> reasons, please list the company to which you are applying. If this is <u>NOT</u> a pre-employment visit, list the company for which you currently work.</p> Company name: _____ Occupation: _____ Company address: _____ City, State, Zip: _____ Company Phone Number: () _____ Department: _____ Supervisor's Name: _____
Injury Information	<p align="center">If you are here for treatment for an injury, please complete this section.</p> Have you reported your injury to your employer? Yes _____ No _____ Reason for today's visit: _____ Date of injury: _____ Please describe how, when and where the injury occurred: _____ _____
General Consent for Treatment and Release of Information	<p>I consent to have treatment or physical examination, drug screening/testing performed by the Physician, Nurse Practitioner, Physician's Assistant and/or professional staff at this clinic. I permit the provider, the clinic, and its employees and all other persons caring for me to treat me in ways they judge are beneficial to me or have been requested by my employer or prospective employer. I understand this care may include tests, examinations, x-rays, drawing of blood and urine drug screening.</p> <p>I further consent the medical information and results of such tests or treatments that relate to my job and the performance of essential job functions may be released to the company authorizing and paying for the medical services, and/or the worker's compensation carrier of the company.</p>
Signature	Signature: _____ Date: _____ Parent or Guarantor Signature: _____ Date: _____ <p align="center"><i>(if patient is 17 or under)</i></p>



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Personal Health Insurance

If you are claiming a work related injury, FirstMed will treat you for your injury. The Utah Labor Commission requires you to notify your employer of this injury and provide the necessary information to your employer to file a workers' compensation claim within the required 180 days of the accident. A claim must be filed and approved in order for the medical benefits to be paid.

If your injury is ruled NOT work related, you will be responsible for the payment of your bill and all medical services provided by FirstMed clinic.

Please provide your personal health insurance information in case your workers' compensation insurance denies your claim. This will ensure you are not billed, unless your health insurance denies it as well.

Insurance name: _____

Insurance claim address: _____

City, State, Zip: _____

Insurance phone number: _____

Group number: _____ Member ID number: _____

Name of the insured: _____ Date of birth of insured: _____

Contract to Pay for Medical Services & Authorization to Release Medical Information

In consideration of professional services rendered to the above patient, I/we agree to pay the customary charge for these services in full at the time of service, unless other arrangements have been made with FirstMed. I/We authorize FirstMed to receive assignment of insurance payments for services rendered. If the customary charges are more than the benefits allowed under any insurance plan I/we hold, I/we agree to pay the difference.

I/We, the undersigned, recognize FirstMed cannot accept responsibility for collecting any insurance claims or negotiating any settlement on a disputed claim. I/We also agree that in event of default in the payment of any amount due, and if this account is placed in the hands of an agency or attorney for collection or legal action, I/We agree to pay an additional charge of the cost of collection including agency and attorney fees and court costs incurred and permitted by the laws governing these transactions.

I/We hereby authorize FirstMed to release any medical or incidental information necessary for either medical care or the process application for financial reimbursement.

I/We have read and understand the Contract to Pay for Medical Services and give Authorization to Release Medical Information.

Signature: _____ Date: _____

Parent or Guarantor Signature: _____ Date: _____

(if patient is 17 or under)