NEW PATIENT INFORMATION AND CONSENT

Patient Information				
Name (First, middle, Last)		Birth Date	Age	Social Security #	Birth Gender ☐ M ☐ F
Mailing Address	Apt #	City, State, ZIP		
Email Address		Primary Phone		OK to leave message? ☐ Yes ☐ No
Employer (or parent/guardian employer if patient is a minor)		Work Phone		
Primary Care Provider (Where you go for your routine medical care)		☐ None ☐ UniPlus Health is my Primary Care		
Preferred Language		☐ Black or African American ☐ Asian ☐ White Race		
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino				

Emergency Contact		
Contact Name	Phone Number	Relationship to Patient

Guarantor/Responsible Party (person responsible for payment)		
Legal Name of Responsible Party (First, Middle, Last)	Social Security #	Date of Birth

Medical Insurance (please present your ID and insurance card to the receptionist)		
PRIMARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
Insurance Company Address (usually on back of insurance card)		Phone

SECONDARY	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
Insurance Company Address (usually on back of insurance card)		Phone

Worker's Compensation	**Is your visit today for a worker's compensation claim** ☐ YES ☐ NO
Worker's Compensation Billing Address	
I hereby authorize UniPlus Health to speak to a rehabilitation specialist, my employer, my insurance carrier, or other professionals involved in my care of rehabilitation, regarding my medical records and the treatment I have received or will receive. X _____ _____ Patient or Authorized Person's Signature Date	

Accident/Injury Information Not Applicable ☐

Where did the injury occurred? (Example: park): _____

Where you struck by an object? Yes __ No __ If yes, what type of object? _____

Where did you fall? (Example: kitchen, bathroom, garage): _____

Where did you fall from? (Example: ladder, roof, steps): _____

If you were in a motor vehicle accident, where you the driver or passenger? _____

Authorization for Release of Information

May we leave testing results or referral info in email or voicemail? Yes__ No __

Who may receive information on your behalf regarding testing or referrals? Name _____

Patient Consent for Treatment

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by UniPlus Health and its associated physicians, clinicians, and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at UniPlus Health.
2. I agree to be contacted via email or SMS with information related to my visit, like: a patient portal invitation, post-visit satisfaction survey, appointment or checkup reminders, health tips, or new services that relate to me or my family.
3. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment, and health care operations consistent with the UniPlus Health Notice of Privacy Practices.
4. I authorize payment of medical benefits to UniPlus Health physicians or their designee for services rendered.
5. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

I have received a copy of the Notice of Privacy Practice and Financial Policy Notice. Yes ___ No ___ Initial _____

_____ _____

Patient or Authorized Person's Signature Date