Injury Care Associates
www.injurycareco.com

Patient Information

Patient Name/*Nombre del paciente*: _____ Date of Birth/ *Fecha de nacimento*: _____

SSN: _____ Gender/ *Género*: ☐ Male/ *Varón* ☐ Female/ *Hembra*

Phone/*Teléfono*: _____ Email: _____

Street Address/ *Dirección*: _____ Unit/ *Unidad*: _____

City/*Ciudad*: _____ State/*Estado*: _____ Zip Code/*Codigo Postal*: _____

Employer/*Empleador*: _____ Occupation/*Oficio*: _____

Employer Contact/*Contacto de trabajo*: _____ Employer Phone/*Teléfono de trabajo*: _____

Employer Address/*Dirección de trabajo*: _____

City/*Ciudad*: _____ State/*Estado*: _____ Zip Code/*Código Postal*: _____

Emergency Contact/*Contacto de Emergencia*: _____ Phone/*Teléfono*: _____

Consent to Receive Treatment
I hereby voluntarily request and consent to the rendering of medical services by Injury Care Associates, LLC, including its employees and other service providers affiliated with Injury Care Associates, LLC. I consent to the rendering of procedures and/or ancillary services, which may be administered or performed by the clinic's employees under the general or specific instruction of my physician or his or her designees. I acknowledge that no guarantees have been implied or made to me as to the results of my treatment or the outcome of services rendered by Injury Care Associates, LLC.

_____ _____
Signature of Patient or Responsible Party Date

Authorization for the Use and Disclosure of Medical Information
For patients requesting employment related physical evaluations, drug or alcohol testing, other Occupational Health or Workers' Compensation services to be performed by Injury Care Associates, LLC. I authorize Injury Care Associates, LLC and its affiliated practices to use and disclose health information and results about me acquired in the course of my evaluation or testing to my employer or potential employer. The information to be used and disclosed may include medical records, treatment records, surgical records, diagnostic records, psychiatric and/or psychological records, information pertaining to past or current drug or alcohol use, or previous work-related injuries. I also authorize Injury Care Associates, LLC to disclose any testing results that I have submitted to including; drug and alcohol testing, or other diagnostic testing. Information obtained throughout the course of my evaluation may also be reported to any authorized regulatory agencies including but not limited to: The Department of Transportation, the State of Colorado Division of Workers' Compensation, State of Colorado Department of Public Health or other government agencies as required by law.

_____ _____
Signature of Patient or Responsible Party Date

HIPAA Disclosure
I have been provided with and read the HIPAA Notice of Privacy Practices for Injury Care Associates, LLC. I consent to allow my Protected Health Information (PHI) and other information collected by Injury Care Associates, LLC to be used in accordance with the HIPAA Notice of Privacy Practices I have been provided.

_____ _____
Signature of Patient or Responsible Party Date