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*: _____

Voluntary Consent

I voluntarily request and consent to the evaluation, examination, testing, procedures, specimen collection, and/or ancillary services to be performed by Transcend Medical LLC dba Injury Care Associates, including its employees, affiliated practices, designees, and other service providers ("ICA"). I understand that:

- This service is requested and paid for by my employer or prospective employer. ICA is performing it for the employer, not for the purpose of providing me treatment.
- This service does not create an ongoing treating provider relationship between me and ICA or its providers. ICA will not provide me ongoing medical care, prescribe treatment, or manage any health condition as a result of this service.
- The results or findings will be reported to my employer or its designated representative. If my service is a DOT or other federally regulated exam or test, results will also be reported to the agencies that the applicable regulations require, such as the FMCSA National Registry of Certified Medical Examiners or the Federal Aviation Administration. These reports are required by law and are made whether or not I agree.
- I may decline the evaluation or test. If I do, ICA may be unable to complete the service or release results, and my employer decides what follows. *For Drug and alcohol testing:* I understand that refusing to test, or tampering with a specimen, may be treated as a refusal under the rules that apply to my test and reported to my employer.
- ICA cannot guarantee any particular result or outcome. Decisions about my employment are made by my employer, not by ICA. For DOT and other certified exams, the medical determination of whether I meet the applicable medical standards is made by the examiner under the regulations that apply.
- If a provider notices a finding that may need medical attention, the provider may tell me so that I can follow up with my own health care provider. I should see my own health care provider for any medical concerns and treatment.
- **Drug and alcohol testing only:** A Medical Review Officer may contact me to review a result, including to ask about medications I take. Collection and testing will follow the procedures that apply to my test, including DOT rules if the test is DOT-regulated.

Signature of Patient or Representative: _____

Acknowledgment of Notice of Privacy Practices

I received a copy of the Injury Care Associates HIPAA Notice of Privacy Practices. I understand it describes how my health information may be used and disclosed and explains my rights, and that the current notice is also posted in the clinic, available on request, and available at www.injurycareco.com.

Signing is an acknowledgment of receipt and is not a condition of treatment.

Signature of Patient or Representative: _____