Concentra®

Improving America's health, one patient at a time.

Employer Services
Patient Information

The Reason for Today's Visit ❒ Physical exam ❒ Drug Screen ❒ Physical and Drug Screen ❒ Injury ❒ DOT (CDL) certification ❒ Other: _____

Patient

Last name:_____ First name:_____ M.I.: _____

Social Security # OR Military DBN:_____ Date of birth (MM/DD/YYYY): _____

Address:_____ Apt. #_____ City:_____ ST:_____ ZIP: _____

Home phone:_____ Work phone: _____

❒ Female ❒ Male ❒ Single ❒ Married Occupation: _____

Patient Email address:_____ Concentra may send a detailed email: ❒ Yes ❒ No

For security of your records, all e-mails containing protected health information (PHI) are sent encrypted.

Concentra may leave detailed voice messages about your visit or future appointments unless you object by checking the "No" box. ❒ No Contact or cell phone (best number) _____

Are you a Concentra colleague? ❒ No ❒ Yes *(Needed for internal purposes to limit access to PHI)*

Employer

Employer Requesting Services

Company Name:_____ Location/store number: _____

Contact name:_____ Contact phone: _____

Address:_____ Ste. #_____ City:_____ ST:_____ ZIP: _____

Is your employment arranged through a temporary hire agency? ❒ No ❒ Yes

Name of agency: _____ Agency phone: _____

The information provided is correct to the best of my knowledge. I will not hold Concentra, its health providers, or its employees responsible for any errors or omissions that I may have made in completing the information on this form.

Signature: _____ Date: _____

Consent for Medical Treatment and/or Testing Services

I give permission to Concentra to perform the following services that the physicians and other non-physician providers and assistants may deem to be necessary: (a) medical, surgical, and diagnostic (*e.g.*: including, but not limited to, x-rays, blood draws, and laboratory tests) processes, treatments, and procedures; (b) administration of injections, medications, and immunizations (with immunizations to occur after my receipt of any applicable vaccine information statements ("VIS" or "VISs"); and (c) completion of medically appropriate tests for communicable and other diseases.

Signature: _____ Date: _____

Noticeof Privacy Practices

Your name and signature below indicate that you have been made aware of Concentra's Notice of Privacy Practices (NOPP) on the date indicated. You understand that the NOPP is posted in the center and a copy will be provided to you if you request it. If this is your first date of service with Concentra, please indicate this to the front desk receptionist and he/she will provide you a copy of the NOPP. If you have any questions regarding the information in Concentra's Notice of Privacy Practices, contact Concentra's Privacy office at 800-819-5571 or privacyoffice@Concentra.com.

Name: (please print) _____ Date Notice Received:_____

Signature: _____