MyCare
HEALTH CENTER

Today's Date: _____ Name: _____

Date of Birth: _____ Address: _____

Phone: _____ City/State & Zip _____

Sex M/F_____ Age_____ County _____

Primary Care Provider_____ Primary Language: _____

Race (please check the boxes below):

❑ Asian	❑ American Indian/Alaska native
❑ Native Hawaiian	❑ White
❑ Other Pacific Islander	❑ More than one race
❑ Black African American	❑ Other_____

Ethnicity (Circle one):	Non-Hispanic	Hispanic

Emergency Contact Name: _____

Phone Number: _____

Is the Patient a minor? _____ If so Parent's First and Last Name: _____

Do you have the following signs and symptoms (circle all that apply)

Fever Cough Sore throat Shortness of Breath Fatigue Chills Vomiting

New loss of taste/smell Headache Muscle aches Vomiting Abdominal pain

Congestion or runny nose Diarrhea Other_____

Are you a health care worker? _____

Have you had close contact with a person who is under investigation for 2019-nCoV while that person was ill? _____

Have you had close contact with a laboratory-confirmed 2019-nCoV case while that person was ill? _____

Please circle all that apply:

Pregnancy Diabetes Cardiac Disease Hypertension

Chronic pulmonary disease Chronic kidney disease Immunocompromised

Other_____

Please present insurance card and identification card.

Insurance Subscriber's Name:

_____

Date of Birth: _____

Marital Status (circle one):

Married Divorced Single

Veteran Status (circle one):

Active Retired N/A

Referred by/How did you hear about us?

_____

I, the undersigned, am providing this consent form to MCHC (MyCare Health Center) to have COVID-19 testing completed. I, the undersigned, understand that, by signing this consent, I waive any other preventive treatments/screenings offered by MCHC. I understand that, by consenting to receiving COVID-19 testing at MCHC, I will receive the COVID-19 testing results, and the results will be shared with the appropriate state and federal authorities. I understand that if my COVID-19 test is negative I will be contacted by MCHC for follow-up options. I give MCHC permission to bill my insurance for the COVID-19 testing. I understand that I am not responsible for a co-pay or any payment. I release MCHC, its employees, representatives, and agents from any liability for administering the COVID-19 test. I agree to indemnify, defend, and hold MCHC harmless from any claim. I accept responsibility for seeking medical attention if my symptoms worsen in accordance with the MyCare Health Center COVID-19 information sheet that I have received.

Parent/Patient Signature: _____Date:_____

General Consent to Treatment

I, _____, grant permission to MyCare Health Center and its medical personnel to provide me
Patient Name
with any medical care they may deem reasonably necessary for my health and well-being.

I understand that treatment at MyCare Health Center involves a team approach, and I understand my care may be discussed with medical personnel involved in my care.

I understand MyCare Health Center will bill my insurance plan for medical services, and understand certain care may not be covered or billable to my insurance plan. If this is the case I agree I am responsible for all medical services provided which are not covered by my insurance plan, which includes co-payments, deductibles, and co-insurance charges.

I understand that unless other arrangements are made prior to receiving medical services, payment is expected at the time of service.

I understand MyCare Health Center may request information from insurance companies as needed to receive payment.

By consenting to treatment I acknowledge and understand that at no time have I been provided with any guarantee as to the specific outcomes of medical services.

By consenting to treatment, I acknowledge my willingness to accept known risks and complications, no matter how slight the probability of occurrence.

I understand that it is very important that I provide the MyCare medical personnel with accurate personal and health information before, during, and after treatment.

I understand it is important for me to follow MyCare Health Center's medical personnel's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other physicians or specialists, and return for scheduled appointments.

I understand if I fail to follow the advice of MyCare medical personnel, I may increase the chances of a poor outcome.

By signing this Consent, you (or your legal representative) understands and agrees to the above statements. This consent is effective today until rescinded or changed by me, in writing.

IF THE PATIENT IS AN ADULT

I hereby consent to treatment at MyCare Health Center.

_____ _____
Patient signature Date

IF THE PATIENT IS LESS THAN 18 YEARS OF AGE OR NOT LEGALLY COMPETENT

I, _____, on behalf of the patient consent to treatment at MyCare Health Center.
Name of Parent / Legal Representative

Signature _____ _____
Date

Relationship to Patient _____

IF THE PATIENT IS UTILIZING TELEHEALTH SERVICES

I, _____, have reviewed the information above and have received verbal consent to treat.
Name of Staff / Provider

Signature _____ _____
Date

MyCare
HEALTH CENTER

Notice of Privacy Practices Acknowledgment Form

PART A

Name: _____ Date: _____

I received a copy of MyCare Health Center's Notice of Privacy Practices

Signature: _____ Date: _____

If signed by a Parent or Legal Representative:

_____ Relationship to Patient: _____
Print Name (Parent, Legal Representative, Guardian)

Witness: _____ Date: _____

PART B

I can be contacted regarding appointment and medical information by the following methods. Mark all that apply.

☐ Text Message to _____

☐ Email Address _____

☐ Cell Phone _____ May We Leave A Message ☐ YES ☐ NO

☐ Home Number _____ May We Leave A Message ☐ YES ☐ NO

☐ Work Number _____ May We Leave A Message ☐ YES ☐ NO

PART C

Who May We Share Your Medical Information With?

Name	Phone	Relationship

Office Use Only

Reason Individual or Legal Representative Did Not Sign This Form:
We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual Declined to Sign

☐ Communication barriers prohibited obtaining the Acknowledgement

☐ An Emergency Situation Prevented us From Obtaining Acknowledgement

☐ Other (Please Specify) _____