Concentra®

Employer Services Patient Information

About You
Reason for Today's Visit

☐ Injury care ☐ Physical exam ☐ DOT (CDL) certification ☐ Drug screen ☐ Other: _____

Social security number or Military DBN: _____ **Date of birth (MM/DD/YYYY):** _____

Last name: _____ **First name:** _____ **Middle initial:** ____

Address: _____ **Apartment number:** ____ **City:** _____ **State:** ____ **ZIP:** ____

Home phone: _____ **Work phone:** _____ **Cell phone:** _____

☐ Male ☐ Female ☐ Single ☐ Married

Email address: _____ **Concentra may send a detailed email:** ☐ Yes ☐ No

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

*** Consent to Receive Text Messages:** By providing your personal cell phone number to Concentra, you are agreeing to receive text messages from Concentra, its related companies, and/or vendors regarding medical services. Your consent to receive such communication is not a condition of the provision of medical services.

Signature: _____ **Date:** _____

About Your Employer
Employer Requesting Services

Company name: _____ **Location/store number:** _____

Address: _____ **Suite number:** _____ **City:** _____ **State:** _____ **ZIP:** _____

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

Name of agency: _____ **Agency phone:** _____

Notice of Privacy Practices

Your name and signature below indicates 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: _____ **Date:** _____

Consent

(If you are ONLY here for a Department of Transportation drug screen or breath alcohol test, skip this section. For all other services, please complete.)

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

Signature: _____ **Date:** _____

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; and (d) completion of a pelvic examination, if medically appropriate.

Signature: _____ **Date:** _____