

FIT Health Care Clinic

Face Sheet & Consent

I agree that FIT Health Care may use and/or release my health information to other health care providers and staff for treatment purposes, to other third party payors and/or to other persons as necessary to obtain payment for services I have received and/or for FIT Health Care operations as needed.

I authorize and consent to medical treatment, examination, laboratory procedures and referral that may be considered advisable or necessary in the judgment of the healthcare provider.

I understand that I am responsible for paying cost of services at the time they are provided and that I may be responsible for obtaining reimbursement from other third party payors for services rendered. If FIT Health Care does seek third party reimbursement for services provided, I understand that I am responsible for co-payments and other costs of services that are provided at the time of treatment. I agree to pay my account with this office in accordance with the regular rates and payment terms of this office. If my account is referred to collections, I agree to pay reasonable collection expenses including attorney fees. I acknowledge that I am responsible for all payments for services provided by FIT Health Care. There is a return check charge of \$20.

I acknowledge that I have received FIT Health Care's Notice of Privacy Practices and if I decline to accept them, I have provided a written reason for refusal of the Notice of Privacy Practices.

Signature _____

Date _____

Patient's Name _____

Other/Stage Name: _____

Street Address _____

Contact Phone: (_____) _____

City _____ State _____ ZIP Code _____

Email Address: _____

ID or Driver's License Number _____ State & Exp. Date _____

Social Security #: _____

Date of Birth _____ Age _____

Med. Allergies: _____

Emergency Contact and Phone # _____

Reason for Visit: _____

Race (Check all that apply): Black White Asian Pacific Islander Native American Other Unknown

Ethnicity: Hispanic Non-Hispanic Unknown

Sex: Male Female Transgender

State law requires FIT Health Care to notify the Maricopa County Department of Health Services if you test positive for an STD (if applicable)

How did you hear about us?

PATIENTS: PLEASE DO NOT WRITE IN THIS BOX

Visit: _____

Meds: _____

Labs: _____

Total Due: _____