PATIENT INFORMATION

Name:____
Last Name First Name Middle Initial
Address:____
City:____________________**State**:____________**Zip Code:** ______________
Home Phone #: __________________ **Cell Phone #:** ______________________
Social Security #:________________ **Date of Birth**:__________**Age:** _________
Sex [ ] M [ ] F **Race:**______**Ethnicity:**______**Preferred Language:**____________
Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widow [ ] Other

E-mail Address:____

How did you hear about FastCare?

Physician/Hospital_____Employer______Pharmacy/Hotels/Magnet/Drive by______
Insurance Co______Web/Yelp/Facebook______Family/Friend______
Other (please specify)____

Reason for today's visit:____

Name of Pharmacy:____

Pharmacy address:____

Pharmacy phone #:____

EMPLOYER

Company Name: ____
Address:____
City, State, & Zip:__________________________Phone #: ______________

CONTACT INFORMATION (IN CASE OF AN EMERGENCY WHO SHOULD BE NOTIFIED?)

Name:_______________Relationship:______________Phone #:__________
Address:____
Name of Nearest Relative not living with you:______________Phone #:__________

FAMILY PHYSICIAN

Name:____
Address:____
City, State, & Zip:__________________________Phone #: ______________
AS A COURTESY, YOUR MEDICAL NOTES WILL BE FAXED TP YOUR PHYSICIAN UNLESS YOU INDICATE OTHERWISE__

INSURANCE INFORMATION (MUST BE COMPLETED ENTIRELY)

Primary Insurance: ____
Name of Insured:__________________________Date of Birth: ______________
Policy #:______________Group #:____________Relation to Patient: __________

WORKERS COMPENSATION INSURANCE

If you have a work related injury or illness, please complete the following:
Date of Injury:_________Supervisor______________Phone #: __________
Are you represented by a lawyer? [ ] Y [ ] N
Name:_____________________________Phone #:________________

FINANCIAL RESPONSIBILITY

All professional services rendered are charged to the patient and are due at the time of service. Necessary forms will be completed to file for insurance carrier payments. I hereby assign all medical/surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my

Insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to FastCare, LLC. I also understand that I am responsible for any balances that may be due to FastCare, LLC because of:

- Co-insurance or co-pay amounts
- Yearly deductible amounts
- Non-covered charges
- Terminated or no insurance coverage
- Exhausted auto benefits
- Denied Worker's Compensation claims
- Failure to respond to insurance carrier correspondence

X____ Date: ____________

Signature of Patient, Parent, Guardian or Personal Representative

X____ ___________________

Print name of Patient, Guardian or Personal Representative Relationship to Patient

ASSIGNMENT, RELEASE, AND FINANCIAL RESPONSIBILITY

I authorize release of medical information to process claims to my insurance company and request that benefits be paid directly to FastCare, LLC. I understand and agree that regardless of my insurance sources, I am ultimately responsible for the balance of my account for any professional services rendered. I authorize the use of my signature on all insurance submissions. I have read all the information on this sheet and certify this information to be true and correct to the best of my knowledge. **I ALSO HEREBY CONSENT AND GRANT PERMISSION TO FASTCARE, LLC AND ITS MEDICAL STAFF TO VIEW AND DOWNLOAD MY PRESCRIPTION HISTORY FROM EXTERNAL SOURCES.**

X____ Date: _____________

Signature of Patient, Parent, Guardian or Personal Representative

X____ ___________________

Print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Section A:

Patient Consent

Name: ____

Address: ______________________________________

Phone #:____________ Social Security #:______________

Section B:

Please read the following information

Purpose of Consent: By signing this form you will consent to our use and disclosure of your protected health information to carry treatment, payment activities, and health operations, and to your employer for workers compensation purpose if needed.

Notice of Privacy Practices: You have the right to read our Notice of Privacy practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of our protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain. You may obtain a copy of our notice of Privacy Practice, including any revisions in our Notice, at any time by contacting our office at:

20601 E. Dixie Highway, Suite 340, Aventura, Fl. 33180 or 825 Arthur Godfrey Road, Suite 100, Miami Beach, Fl. 33140 Phone #: 786-923-4001

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of revocation submitted to the contact person listed above. Please understand the revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

I _________________have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature: _____________________________________ Date:________________