MUST HAVE ID TO BE TESTED

EVERYDAY HEALTH CARE

www.everydayhc.com

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staff@everydayhc.com

Date:	Email Address:			Would like to link your email to your medical profile? ☐ Yes ☐ No
First Name:	Last Name:			Middle Initial:
Social Security: (Needed for billing purposes)	DOB:	Age:	Sex: ☐ Male ☐ Female	
Martial: ☐ Single (Widow, Divorced, Not Married) ☐ Married		Driver License/ ID:		
Address:	Apt:	City:	State:	Zip Code
Home Phone:	Cell Phone:	Message Phone:		
Emergency Contact Name:	Relation:	Phone Number:		
Do you have medication allergies? ☐ Yes ☐ No	If yes, please list allergies.			

I _____, understand Everyday Health Care will be billing your medical insurance for the services rendered. I understand if my insurance does not pay, I will be held responsible for the services rendered under contracting price. All results/services will be released to the contracted medical insurance. I give Everyday Health Care consent to proceed with my treatment requirements. Everyday Healthcare does not refuse services; however, we do require payments when due. ***After 5pm, weekends and holidays, we charge an additional $50 fee to your insurance company.*** All no-show appointments and those that are not cancelled with a full 24-hour notice will be subject to a $25 fee. We will send you a confirmation text message of your appointment.

Patient signature: _____ Date: _____

By signing this form, you are granting consent to Everyday Health Care to use and disclose your protected health information (PHI) for the purpose of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose these protected practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our facility at (559) 225-4706

You have the right to request us to restrict how we use and disclose your protected health information (PHI) for the purpose of treatment, payment, or health care operations. We are not required by law to grant your request. However, if you refuse to sign this consent, or revoke this consent, Everyday Health Care may refuse to treat you as permitted by section 164.506 of the code of Federal Regulations.

You have the right to revoke this consent in writing, except to the extent we already have used, or disclosed your protected health information (PHI) in reliance on your consent.

Patients Name: _____ Date: _____