

## E-Care Emergency Center General Consent Form

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

**Sex:** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Patient Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Home Phone#:** (\_\_\_\_\_) \_\_\_\_\_ **Work #:** (\_\_\_\_\_) \_\_\_\_\_ **Cell #:** (\_\_\_\_\_) \_\_\_\_\_

**Primary Insurance Holder:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

**Employer of Insurance Holder:** \_\_\_\_\_

### Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

\_\_\_\_\_  
Patient or Patient Representative Signature

\_\_\_\_\_  
Date

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### Please initial:

\_\_\_\_\_ **IMPORTANT:** WE WILL MAKE EVERY EFFORT TO PROCESS YOUR INSURANCE CLAIM; HOWEVER, YOU WILL BE RESPONSIBLE FOR ALL OR ANY PART OF SERVICES NOT COVERED BY YOUR INSURANCE COMPANY.

**Primary Care Physician** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Primary Care Physician's address** \_\_\_\_\_

**IMPORTANT: Is this a work related injury?** \_\_\_\_\_ **MVA injury?** \_\_\_\_\_ **(Please initial)** \_\_\_\_\_

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I hereby request admission to this facility and authorize my attending physician, and any and all other attending physicians and surgeons, including radiologists, emergency physicians, pathologists and anesthesiologists to order or administer any treatment, procedures, tests, examinations or other services of a routine or medical or surgical nature, or health or physical condition.

I understand that the physicians, surgeons, and/or physician assistants who may treat my condition are employees of E-Care Emergency Care Center. I understand that these physicians are independent physicians engaged in the private practice of medicine that is authorized to use the E-Care facility while being treated for my medical condition. The physician may be one attending physician, such as radiologist, anesthesiologist, cardiologist, or other specialist. This medical center is not responsible for recommending my treating physicians and I have not relied upon E-Care representative in selecting my independent physician.

I authorize E-Care, its employees and agents to perform nursing care, diagnostic procedures and medical treatment requested by my attending physician and his/her assistant. I understand this may include, but is not limited to diagnostic x-ray procedures, venipunctures for lab, intravenous procedures and clinical photos, videotapes, or film for substantiation or clarification. All prints, negatives, or film will be considered part of the confidential record and will be treated as confidential information related to the diagnosis, treatment or prognosis of the patient. I further authorize E-Care to release my medical records to entities that utilize this information for peer review, quality management, trend and outcome studies or other educational or research purposes. I authorize E-Care to transmit electronically or via facsimile any medical data pertaining to my care.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me to the result of treatments or examinations in E-Care.

I hereby acknowledge that I have been provided materials about my rights as a patient and my rights to execute advance directives. I understand that I am not required to have an advance directive in order to receive medical treatment at this health facility. Advance directive data will not be available for outpatient services or procedures.

\_\_\_\_\_  
Patient or Patient Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relation to Patient

\_\_\_\_\_  
Reason Patient is Unable to Sign