IMMEDIATE MED ENCOUNTER FORM *DATE*: ____________________

PLEASE COMPLETE ENTIRE FORM *M.R.#* ____________________

APPOINTMENT TIME: __________________ Arrival *Time* ________________

PATIENT NAME: ____ New Patient Yes ______ No ______

MAILING ADDRESS:____

CITY: ________________________ST:______ ZIP:_____________

BIRTH DATE ____ / ____ / ________ Phone: HOME: ____________________CELL:__________________

EMAIL ADDRESS: ____

METHOD OF PAYMENT: **CO-PAY ______ CASH/CHECK ______ CREDIT CARD ______ WC ______ ORP ______**

Name of Insurance Co: ________________________________ **Preferred Lab ____________________**

REASON FOR VISIT:

Monthly/Regular __________ Pre-Employment __________ Physical: Sports __________ DOT __________ FAA _________

Injury _____________________________Date of Injury: _______________ Illness: ______________________________

Other ____

Please list ALL medications including the dosage, over the counter & Herbal medicine you are taking:

ALLERGIES:

____

My signature below gives authorization to treat the above named patient.

I authorize the physician to administer such treatment as he/she deems advisable for my diagnosis and condition.

I understand that these services are voluntary and that I have the right to refuse these services.

I authorize Immediate Med to release any information regarding my examination or treatment for the purpose of obtaining insurance, workers compensation payments, medical records, certification or collection expenses.

I authorize payment of medical benefits to Immediate Med when claims are filed on my behalf. When applicable, I authorize Immediate Med or my insurance company to release any information necessary to process my claims.

I understand that I may be billed for additional laboratory/radiology/office services performed but not charged today.

I understand that I am responsible for all amounts due should my insurance company not pay within 30 days.
I agree I will be responsible for any additional fees should my account go to a collection agency.

SIGNATURE: ____________________________________CLERK ID: _______________________

==**FOR OFFICE USE ONLY**==

HT:_________ WT:________ BP:________ T:________ P:________ R:_________ O2: _________