



PATIENT INFORMATION

Name, Address, City, State, Zip, Mobile PH., 2nd Phone, SS#, DOB, Primary Physician, Address, Phone, Pharmacy, Phone

Sex: M F, Marital Status: Sing. Mar. Div. Sep. Wid., Employer: Phone: How did you hear about us? Word of mouth Drove By Web Insurance Billboard Other

We are required to ask the following based on governmental regulations: African American, American Indian or Alaska Native, Asian, Caucasian\ White, Native Hawaiian, Prefer not to answer, Latino or Hispanic, Non-Latino or Non-Hispanic, Preferred Language: English Spanish Other

Yes / No If I am unavailable, I authorize Peachtree Immediate Care to contact me by phone or text to discuss Personal Health Information at the phone numbers provided.

EMERGENCY CONTACT

Name, Address, City, State, Zip, Mobile Phone, 2nd Phone, Relationship, I do / do not authorize the disclosure of Personal Health Information to certain designated individuals other than myself as listed below: Same as above Name Relationship Phone

ACKNOWLEDGEMENTS

I have been advised of and provided access to Peachtree Immediate Care's Notice of Privacy Practices and I agree to the authorization to treat and financial policies on the back of this page. Initial Here I hereby do / do not authorize Peachtree Immediate Care to release my Sports Physical results to South Cobb High School for this physical provided on April 13, 2019.

STUDENT Signature, Printed Name

Date

PARENT Signature, Printed Name

Date

**These authorizations, acknowledgements, and waivers cover all services rendered for today's services and for all future dates of service.**

### **AUTHORIZATION TO TREAT**

You agree to give authorization to receive treatment by our medical staff and release **Peachtree Immediate Care (PIC)**, its Owners, Physicians, Physician Assistants, and Nurse Practitioners, and/or any clinical staff member from any liability claims that may result from any treatment, medications, and/or procedures that have been provided to you.

You may be seen by a Nurse Practitioner or Physician Assistant, who are highly qualified to meet the medical needs of our patients. If you do not wish to be treated by a Nurse Practitioner or Physician Assistant, please inform the front desk personnel.

### **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

In signing this document, you acknowledge your understanding that Privacy Practices are posted for your information. To note, you have the right to opt out of the health information exchange that **PIC** participates in as a member of the Emory Healthcare Network. A copy of the Privacy Practices can be provided to you upon request.

### **TEXT MESSAGING**

By providing a mobile number, you consent to receive text messages regarding your experience and medical care from our automated system. You can choose to opt out of receiving text messages regarding your experience; but you may continue to receive messages regarding your medical care. To opt out of all messaging, you can choose not to give us your mobile number. Giving us your mobile number is not a condition of service; however, we do ask that you give us a way to contact you quickly so that we are better able to communicate with you regarding your medical care.