WorkFitMedical
Occupational Health Services

New Patient Welcome Sheet

Date: _____ Time: _____

WHY ARE YOU HERE TODAY?

Reason for Visit: ☐ Urgent Care ☐ Work Injury ☐ Physical Therapy/Fitness ☐ Occupational Health ☐ Drug Test

Employer Name: _____ Self Pay: ☐ Yes ☐ No

Was your visit today scheduled in advance? ☐ Yes ☐ No If yes, what was your scheduled time? _____

What are you here for Today? (Reason for Visit) _____

For Work Injury:

Explain HOW injury happened and what BODY PART was affected:

_____

_____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Social Security: _____

Street Address: _____ Birth Date: _____ Age: _____

City, State, Zip: _____ Primary Phone: _____

Other Address: _____ Secondary Phone: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married DL#: _____

Person to Contact in Case of Emergency: _____ Phone: _____

ASSIGNMENT OF BENEFITS – FINANCIAL AGREEMENT:

I hereby authorize WorkFit Medical and its staff and providers to examine and treat my condition as the providers deem appropriate and I give authority for those procedures to be performed. I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my behalf. Should collection of past due amount(s) become necessary, I will be responsible for all charges, fees, and attorney fees. I (we) hereby authorize the provider to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Patient/Guardian: _____ Date: _____

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

178 Washington Avenue
Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-0769 Fax

Consent for
Examination, Treatment, Testing &
Release of Information

I consent to the use or disclosure of my confidential health information by WorkFit Medical, LLC for the purpose of diagnosis or treatment, obtaining payment for services rendered, and conducting operations of WorkFit Medical, LLC. My signature below is evidence of my consent for evaluation, diagnosis, or treatment by WorkFit Medical, LLC.

I understand that I have the right to request a restriction as to how my confidential health information is used or disclosed while providing treatment, payment, or health care operations of the practice. WorkFit Medical, LLC is not required to agree to the restrictions that I may request. However, if WorkFit Medical, LLC agrees to a restriction I request the restriction is binding on WorkFit Medical, LLC and the providers contracted or employed by WorkFit Medical, LLC. I have the right to revoke this consent in writing, at any time, except to the extent WorkFit Medical, LLC has taken action in reliance on this consent.

My confidential health information includes my demographic information provided by me as well as information provided by or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This confidential health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

The Notice of Privacy Practices for WorkFit Medical, LLC is provided on the wall in the waiting area. I understand I have a right to review WorkFit Medical, LLC's Notice of Privacy Practice prior to signing the document. The WorkFit Medical, LLC's Notice of Privacy Practice has been provided or offered to me.

The Notice of Privacy Practice describes the types of use and disclosures of my confidential health information that will occur pursuant to treatment, payment, or in the performance of healthcare operations of WorkFit Medical, LLC. This Notice of Privacy Practice also describes my rights and the duties of WorkFit Medical, LLC with respect to my confidential health information. WorkFit Medical, LLC reserves the right to amend the Notice of Privacy Practice at any time. I may obtain a revised copy of Notice of Privacy Practice upon request.

I agree to undergo clinical examination, diagnostic tests, medical treatment, and drug and/or alcohol testing consistent with the accepted standards of care and practice. The information obtained will be used to carry out treatment plans, to determine my fitness for work, or for billing purposes. I understand that the services routinely provided by WorkFit Medical, LLC are not meant to replace medical care provided by my personal healthcare provider. I am granting permission to WorkFit Medical, LLC to release the results of the examination/treatment and drug and/or alcohol results to the company specified above.

Patient Signature: _____ Date: _____

CONSENT TO TREAT A MINOR: YOU MUST HAVE DOCUMENTATION OF GUARDIANSHIP OR CUSTODY PAPERWORK WHEN BRINGING IN A MINOR

I (we) being the parents, guardian, or custodian of the minor being:
Last Name: _____ First Name: _____ M.I.: _____, Age: _____ do hereby request, and direct WorkFit Medical, LLC, its providers, and staff to perform examinations, diagnostic X-Rays, laboratory tests, and any treatment that in their judgement is deemed advisable or is required while said minor child is under care of this office's providers and staff until legal age. All charges for service and care given to said minor child will be charged directly to me (us) and I(we) will be personally responsible for payment of them. I (we) hereby authorize the provider to release all information necessary to secure payment of benefits. I authorize the use of this signature of this signature on all insurance submissions.

Parent, Guardian, or Custodian Signature: _____ Date: _____

Relationship to Patient: _____ Witness: _____ Date: _____

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(518) 452-2526 Fax

WorkFitMedical
Occupational Health Services

Non-DOT Physical Examination

Patient Name: _____ Address: _____ Date: _____ SS#: _____

Sex: ____ Job Title: _____ Company: _____ DOB: _____ Age: _____

Have You Had Any of the Following:

	Y	N
Allergy or Hay Fever	☐	☐
Anemia	☐	☐
Asthma	☐	☐
Backache or Back Injury	☐	☐
Herniated or Bulging Discs	☐	☐
Blood Clot	☐	☐
Bowel/Bladder Disorder	☐	☐
Broken Bone or Dislocation	☐	☐
Coughing Up Blood	☐	☐
Depression/Psychiatric	☐	☐
Diabetes	☐	☐
Ear Trouble	☐	☐
Epilepsy (Seizures)	☐	☐
Eye Injury or Disease	☐	☐
Fainting/Dizzy Spells	☐	☐
Head Injury	☐	☐
Heart Trouble	☐	☐
Hernia	☐	☐
High Blood Pressure	☐	☐
Kidney Trouble	☐	☐
Sleep Disorder	☐	☐
Loss of Sensation	☐	☐
Lung Trouble	☐	☐
Prolonged Cough	☐	☐
Rheumatic Fever	☐	☐
Rheumatism or Arthritis	☐	☐
Sinus Trouble	☐	☐
Skin Disease/Rash	☐	☐
Surgery	☐	☐
Ulcer/Heartburn	☐	☐
Varicose Veins	☐	☐
Weight Changes	☐	☐
Tobacco Use	☐	☐
Alcohol Use	☐	☐
Drug Use	☐	☐
OTHER (write below)	☐	☐

Other Past/Current Injury(s): _____

Allergies to Medication(s): _____

Current Medication/Dose: _____

Name of Doctor: _____ Doctor's Address: _____ Doctor's Phone: _____

Last Tetanus: ____ ☐ Unknown FEMALES ONLY: Are you Pregnant? ☐ Yes ☐ No Date of Last Normal Menstrual Period: _____

I understand that any intentional incorrect statement or omission may be sufficient grounds for my dismissal.

Patient Signature: _____ Date: _____