DOCS MEDICAL INC
DOCSMEDICALGROUP.COM

PATIENT INFORMATION

NAME: _____ DOB: _____ SEX: _____

ADDRESS: _____ APT#: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE (HOME): _____ (CELL): _____ E-MAIL: _____

SOCIAL SECURITY#: _____ EMPLOYER: _____ OCCUPATION: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

ETHNICITY: ☐ HISPANIC/LATINO ☐ NOT HISPANIC RACE: _____ LANGUAGE: _____

EMERGENCY CONTACT

NAME: _____ PHONE: _____ RELATIONSHIP: _____

GUARANTOR/PARENT INFORMATION

NAME: _____ DOB: _____ RELATIONSHIP: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ POLICY HOLDER: _____ DOB: _____

SECONDARY INSURANCE: _____ POLICY HOLDER: _____ DOB: _____

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Have you had your annual physical in the past 12 months? ☐ YES ☐ NO

MEDICAL HISTORY OUTLINE: (PLEASE FILL AND COMPLETE, ALL INFORMATION IS REQUIRED**)**

REASON FOR VISIT: _____ **DATE:** _____

NAME: _____ **DOB**: _____

LAST PRIMARY CARE VISIT: ☐ LESS THAN 6 MONTHS ☐ MORE THAN 6 MONTHS ☐ MORE THAN 1 YEAR

WOULD YOU LIKE YOUR OFFICE VISIT NOTE FAXED? ☐ YES ☐ NO

PREFERRED PHARMACY: _____ LOCATION: _____

CURRENT MEDICATIONS: ☐ NONE

DRUG: _____ **DOSE**: _____ **FREQUENCY**: _____

DRUG: _____ **DOSE**: _____ **FREQUENCY**: _____

DRUG: _____ **DOSE**: _____ **FREQUENCY**: _____

MEDICATIONS ALLERGIES: ☐ NONE _____

OTHER ALLERGIES: ☐ NONE _____

WOULD YOU LIKE A SLEEP EVALUATION? ☐ YES ☐ NO **HAVE YOU HAD AN ALLERGY TEST**? ☐ YES ☐ NO

MEDICAL HISTORY: ☐ NON-CONTRIBUTORY

☐ DEPRESSION • ☐ KIDNEY DISEASE • ☐ HEART DISEASE • ☐ ANEMIA • ☐ DIABETES • ☐ HIGH BLOOD PRESSURE

☐ SEIZURES • ☐ ASTHMA • ☐ THYROID DISEASE • ☐ CANCER: (TYPE) _____ • ☐ OTHERS: _____

SURGICAL HISTORY: ☐ NON-CONTRIBUTORY

TYPE: _____ **DATE**: _____

FAMILY HISTORY: ☐ NON-CONTRIBUTORY

☐ DEPRESSION • ☐ HIGH CHOLESTEROL • ☐ HEART DISEASE • ☐ DIABETES • ☐ HIGH BLOOD PRESSURE • ☐ ASTHMA

OTHERS: _____

SOCIAL HISTORY: ☐ NON-CONTRIBUTORY

SMOKER: ☐ YES ☐ NO **# PACKS PER DAY**: _____ **SUBSTANCE ABUSE:** ☐ YES ☐ NO **ALCOHOL ABUSE:** ☐ YES ☐ NO

OFFICE USE ONLY:

WT_____ HT_____ TEMP_____ RR_____ HR_____ O2_____ BP_____

AUTHORIZATION OF TREATMENT
Authorization and release for DOCS Medical Inc. and its subsidiaries (DOCS of CT, DOCS Urgent Care, DOCS Now, Zen Health and Wellness and Urgent Care Center), hereby referred as DOCS Medical Inc. I consent to providers and licensed professions to provide telehealth services and the use of audio and video telehealth services for myself or my dependent. I voluntarily consent to the administration and costs of medical and surgical procedures for both in-person and virtual for myself or my dependent.

ASSIGNMENT OF INSURANCE BENEFITS/GUARANTEE OF PAYMENT
I authorize payment directly to DOCS Medical Inc. and its subsidiaries (DOCS of CT, DOCS Now, DOCS Urgent Care, Zen Health and Wellness, and Urgent Care Center) for all benefits payable to me. I understand that I am financially responsible and agree to pay all charges that are not paid or billed to my insurance or any third-party payer. I understand that I must pay in full today for all services rendered for both in-person and virtual visits unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance co-payments, co-insurance, or deductible for services. I understand all services, both in-person and virtual, rendered are non-refundable under any circumstance. I understand that if I do not pay within 90 days upon receiving my billing statement; my account will be transferred over to "American Adjustment Bureau."

RELEASE TO RECORDS
I authorize DOCS Medical Inc. and its subsidiaries (DOCS of CT, DOCS Now, DOCS Urgent Care, Zen Health and Wellness and Urgent Care Center) to release (verbal or written) confidential medical information to any person or entity including my insurance carrier, employer (if treatment is related to employer purposes), or other health care operations which may be liable to me or my practitioner(s) for changes in treatment, for quality management, utilization review, transfer, and follow-up purposes.

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Authorization and release for DOCS Medical Inc. and its subsidiaries (DOCS of CT, DOCS Now, Zen Health and Wellness, DOCS Urgent Care and Urgent Care Center), hereby referred to as DOCS Medical Inc.

This document is to be signed by the person legally responsible for the patient's medical decisions relative to the treatment situation.

I hereby acknowledge that DOCS Medical Inc. has provided me with a copy of its notice of privacy policies that describe how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have question or complaints, I may contact DOCS Medical Inc. Administration Directors at 203-874-3682 or by e-mailing contact@DOCSofct.com.

I also understand that I am entitled to receive updates upon request when for DOCS Medical Inc. and its subsidiaries (DOCS of CT, Zen Health and Wellness, DOCS Urgent Care and Urgent Care Center), amends or changes its notice of privacy practices material in any way.

I allow DOCS Medical Inc. and its subsidiaries (DOCS of CT, Zen Health and Wellness, DOCS Urgent Care and Urgent Care Center), to obtain prescription history from an external source.

CONSENT FOR NOTIFICATION OF TEST RESULTS

I give permission to DOCS Medical Inc. and its subsidiaries (DOCS of CT, Zen Health and Wellness, DOCS Urgent Care, DOCS Now and Urgent Care Center) to notify _____ (relationship to patient) _____ about my health information.

I give permission to DOCS Medical Inc. and its subsidiaries (DOCS of CT, Zen Health and Wellness, DOCS Urgent Care, DOCS Now and Urgent Care Center) to share health information via voicemail or text message.

SIGNATURE: _____ DATE: _____

NAME: _____ _____
RELATION TO THE PATIENT IF SIGNED BY SOMEONE OTHER THAN THE PATIENT

PRIVACY POLICY

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES HAS ESTABLISHED A "PRI*V*ACY POLICY" TO HELP ENSURE THAT PERSONAL INFORMATION IS PROTECTED FOR YOUR PRI*V*ACY. THE PRIVACY RULE WAS ALSO CREATED IN ORDER TO PROVIDE A STANDARD FOR USES AND DISCLOSURES OF HEALTH INFOR*M*ATION ABOUT THE PATIENT TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS.

AS OUR PATIENT, WE WANT YOU TO KNOW THAT WE RESPECT THE PRI*V*ACY OF YOUR PERSONAL MEDICAL INFOR*M*ATION. WE STRIVE TO AL*W*AYS MAKE REASONABLE PRECAUTIONS TO PROTECT YOUR PRIVACY. WHEN IT IS APPROPRIATE AND NECESSAR*Y*, WE PROVIDE THE MINIMUM INFORMATION NECESSAR*Y* TO ONLY THOSE WE FEEL ARE IN NEED OF YOUR HEALTH CARE INFORMATION, AND INFORMATION REGARDING TREAT*M*ENT, PAYMENT, OR HEALTH CARE OPERATIONS IN ORDER TO PROVIDE HEALTH CARE THAT IS IN YOUR BEST INTEREST. WE ALSO WANT YOU TO KNOW THAT WE SUPPORT YOUR FULL ACCESS TO YOUR PERSONAL MEDICAL RECORDS.

WE MAY HAVE INDIRECT TREATMENT RELATIONSHIPS WITH YOU SUCH AS LABORATORIES THAT ONLY INTERACT WITH PHYSICIANS AND NOT PATIENTS. WE MAY HAVE TO DISCLOSE PERSONAL HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT OF HEALTH CARE OPERATIONS. THESE ENTITIES ARE MOST OFTEN NOT REQUIRED TO OBTAIN PATIENT CONSENT. YOU *M*AY REFUSE TO CONSENT TO THE USE OR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION; HOWE*V*ER, THIS MUST BE IN WRITING. UNDER THE LAW*,* WE HAVE THE RIGHT TO REFUSE TO TREAT YOU, SHOULD YOU CHOSE TO REFUSE DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION (PHI) IF YOU CHOSE TO GIVE CONSENT AT A FUTURE TIME YOU MAY REQUEST TO REFUSE ALL OR PART OF YOUR PHI.

YOU HAVE THE RIGHT TO REVIEW OUR PRI*V*ACY NOTICE, TO REQUEST RESTRICTIONS AND REVOKE CONSENT IN WRITING AFTER YOU HAVE REVIEWED OUR PRIVACY NOTE.