# W.T.I.P

## WEST TEXAS INJURY PREVENTION

Name: _____, _____ _____ Today's Date: ___/___/___

Last Name First Name Middle Initial

Social Security Number __ __ __ - __ __ - __ __ __ __ Birth Date: ___/___/___ AGE _____ Gender M F

Marital Status: Married ___ Separated ___ Widowed ___ Single___ Email:: _____

CURRENT ADDRESS

Street _____

City_____State _____ Zip _____

Phone (_____) _____

Your Occupation _____Employer _____

Work Address _____

Work Phone _____

Who should we contact in the event of an emergency?

Phone (_____) Relationship to this person:_____

Address of contact person _____

How did you learn about us? ___ Media ___ Employer ___ Family/Friend ___ Website ___ Former Patient ___ Other

**PATIENT CONSENT FORM**

For the purposes of this Consent Form, "Office" shall refer to: **West Texas Injury Prevention**

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form. HIPAA policy available upon request.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

I certify that the information given on the health history form is complete, accurate and true to the best of my knowledge. I understand that inaccurate, false or missing information may invalidate the exam or other testing performed. I also give the Office permission for this medical examination, testing, and the results sent to the employer (or designated company) that has authorized/paid for these services. I understand that if my employer does not pay for these services I am liable for the charges incurred. If I am here as a private pay not representing a company no results will be disclosed other than to the undersigned.

Signature: _____ Date:_____/_____/_____