COMMUNITY HEALTHCARE SYSTEM®
Occupational Health

REGISTRATION/CONSENT

Do you need an interpreter? Yes☐ No☐

Date of Birth: _____/_____/_____ Age: _____ Social Security Number: _____ -- _____ -- _____

First Name: _____ Middle: _____ Last: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____)_____ Cell: (____)_____ Gender (circle one): male female

Employer Name: _____ Employer Phone: (____)_____

Address: _____ City: _____ State: ____ Zip: _____

Employment Status: Full-time____ Part-time____

Reason for visit: Physical _____ Accident/Injury _____ Drug Screen_____ Other_____

Date of Injury: _____ Time of Injury: _____ Location: _____

How: _____

Consent for Treatment: I hereby consent to the physicians, NP and/or the staff of Community Healthcare System Occupational Health to conduct such examinations, perform such procedures as are medically required, and administer such treatment and medication as deemed necessary or advisable, as ordered by the physician and/or NP during this episode of care. I am aware that the practice of medicine and surgery is not an exact science, and I hereby acknowledge that no guarantees have been made to me as to the results of such treatments, examinations, or medical procedures. I authorize the release of any employment related physical exam or test results to the employer (who requested the evaluation), their agent or representative. I understand that this form will be valid for a period of 90 days from the date signed for all Occupational Health Services. If I wish to withdraw my consent prior to that time, I must do so in writing.

Release of Information: I hereby consent to Community Healthcare System Occupational Health, all physician(s) and/or NP providing services and any other authorized persons, to release to its authorized billing agents, any physician who treated me, my insurance carrier, employer's workers' compensation company, or other category of third party payer, the Social Security Administration under Title XVII (18) of the Social Security Act, the Professional Review Organization, or other intermediaries responsible for payment of my clinic charges a complete report of services rendered including diagnosis, findings and details of treatment and progress for the purpose of receiving payment of my event of care. I understand that any charges incurred on my behalf for work related injuries shall be paid by my employer pursuant to the Indiana's Worker's Compensation Law and any required testing shall be paid for my employer. I understand that I am financially responsible for charges denied by my employer for injuries, employer paid services, determined not to be work related. I hereby authorize that this information may be disclosed to and used by the above named company.

Release of Information– DOT Physicals: I hereby consent to Community Healthcare System Occupational Health Services, all physician(s) and/or NP providing services and any other authorized persons, to release a copy of my DOT physical long form and medical examiner card to my employer for recordkeeping purposes.

Assignment of Benefits to Community Healthcare System Occupational Health: For medical services provided, I hereby assign, transfer, and set over to Community Healthcare System Occupational Health and physician and/or Nurse Practitioner who may have treated me, all my rights, title and interest to medical reimbursement. I further agree that I shall be responsible for any expenses paid by Community Healthcare System Occupational Health, including reasonable attorney fees, to collect amounts guaranteed.

HIPAA: I acknowledge that I ACCEPT ☐ DECLINE ☐PREVIOUSLY RECEIVED ☐ a copy of Community Healthcare System Occupational Health's Notice of Privacy Practices in accordance with HIPAA regulations.

X_____ _____

Patient Signature **Date**

EAST CHICAGO
4320 Fir Street
Suite 313
East Chicago, IN 46312
Phone: 219-392-7424
Fax: 219-392-7450

HOBART
1354 South Lake Park Avenue
Hobart, IN 46342
Phone: 219-947-6495
Fax: 219-947-6408

MUNSTER
9200 Calumet Avenue
Suite N-502
Munster, IN 46321
Phone: 219-440-5286
Fax: 219-703-6571

PORTAGE
3170 Willowcreek Road
Portage, IN 46368
Phone: 219-947-6628
Fax: 219-947-6629

VALPARAISO
1051 Southpoint Circle
Suite A
Valparaiso, IN 46385
Phone: 219-286-3830
Fax: 219-703-6760