2UMedical

PATIENT INFORMATION/MEDICAL HISTORY

Name:_____ Date:_____ Age:_____

Address:_____
Street City State Zip Code

Phone: _____Email: _____

Date of Birth:_____ Occupation:_____

Emergency Contact:_____ Relationship:_____

Emergency Contact Phone:_____

Primary Care Provider:_____

Pharmacy:_____Phone:_____

Health History

Medication (prescription and over the counter; vitamins, herbal medications)

_____
_____
_____

Allergies:_____

Surgeries/Dates:_____
_____

Have a History of?

_____Heart Disease	_____Mental Disease	_____Neuro-muscular Disease
_____Excessive Bleeding	_____Auto-immune Disorders	_____Diabetes
_____High Blood Pressure	_____Liver Disease	_____Cold Sores/Fever Blisters
_____Other		

If female, are you? Pregnant_____ Nursing_____

Do you? Smoke_____ Drink Alcohol_____ Amount per day_____

The above information is true and accurate to the best of my knowledge.

_____ _____
Patient Signature or Patient Guardian Signature / relationship Date

2UMedical, Inc. Privacy Protection Policy

I hereby give my consent 2UMedical, Inc. to use and disclose Protected Health Information about me to carry out treatment, payment and healthcare operations. 2UMedical, Inc. Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. 2UMedical, Inc. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by contacting 2UMedical, Inc. by calling the main office number (404)858.3834.

With this consent, 2UMedical, Inc. may call my home or other designated alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, or operations, such as physician referrals, appointment reminders, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, 2UMedical, Inc. may mail to my home or alternative location any items that may assist the practice in carrying out treatment, payment, or operations as long as they are marked Personal and Confidential.

With this consent, 2UMedical, Inc. may e-mail any items that assist the practice in carrying out clinical operations and treatment, such as appointment reminders and patient statements. I have the right to request that 2UMedical, Inc. restrict how it uses or discloses my protected health information to carry out treatment, payment, and operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to 2UMedical, Inc. use and disclosure of my protected health information to carry out treatment, payments, and operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or late revoke it, 2UMedical, Inc. may decline to provide treatment to me.

_____

Patient Signature / Patient Guardian & Relationship Date

_____

Patient Name (Printed) / Patient Guardian & Relationship

Consent for Medical Services & Financial Agreement

1. Medical Consent: The undersigned consent to and authorize any medical treatment, examination, laboratory procedure, taking of medical photographs, and any specialty services that may be considered advisable or necessary for the patient in the judgment of the attending healthcare provider.
2. Financial Agreement: The undersigned agree, whether signing as a patient or as representing agent, that in the consideration of the healthcare services to be rendered to the patient, the undersigned shall have the obligation to pay the agreed upon annual fee to 2UMedical, Inc.
3. Release of Information: 2UMedical, Inc. may disclose all or any part of the patient's record to any person or corporation designated in the *Release of Information Consent* via all communication modalities according to the 2UMedical, Inc. Privacy Protection Policy.

_____ _____

Patient Signature Date

_____

Patient Name (Printed)

2UMedical

Cancellation Policy

As part of our continued effort to provide you with the best care and accommodate all appointment requests, we have implemented a Cancellation Policy.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel or reschedule an appointment, you may be preventing another patient from getting the care they need. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.
If an appointment is not cancelled at least 24 hours in advance you will be charged a one hundred dollar ($100) fee.

_____

Patient Signature Date

Fee for Service Policy

By signing this statement, I understand this is a fee for service medical practice. I understand that my insurance is not going to be billed for services rendered by 2UMedical. I understand that fees may be incurred for medication call-ins ($45) as well as for Telemedicine ($65).

_____

Patient Signature Date