Patient Demographic Information

Name: (Last)_____(First)_____(MI)_____

Address:_____

City:_____State:_____ZIP:_____

Telephone:(HOME)_____(WORK)_____(CELL)_____

E-mail:_____

Birth Date:_____Race:_____

Social Security Number:_____

Gender Identification: Male Female Other:(Identify)_____

Marital Status:_____

Medical Insurance: Yes No

Primary Care Physician (PCP)**:**_____

Insurance Card Holder: Self Spouse Other (Identify):_____

If other than self, please provide the **Insurance Card Holder** information:

Name:_____ Date of Birth:_____

If you do not have a physical copy of insurance:

Insurance Plan Name:_____

ID #_____Group #_____

NAME: _____ ***DOB***:_____

Recent COVID-19 Exposure? Yes No **When?**_____

SYMPTOMS	YES	NO	DURATION
Fever			
Loss of Taste /Smell			
Body / Muscle Aches			
Stuffy / Runny Nose			
Sore Throat			
Nausea / Vomiting			
Diarrhea			
Cough			
Shortness of Breath			
Other			

***For Office Use Only:**
Administer the following test:

[ ] COVID Antigen **[ ]** FLU A / B Antigen

Attending Provider Signature: _____ Date:_____

Patient's First Name: _____ Patient's Last Name:_____ DOB:_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

1. I understand that this authorization will expire 1 year from the signature date
2. I understand that I may revoke this authorization prior to the release of results
3. I understand that I can refuse to sign and my service or care will not be affected
4. I may inspect or copy any information used or disclosed under this agreement
5. I authorize the release of medical information to other physicians and/or facilities involved in my health care.
6. I understand that if the person or organization that received the information is not a health care provider, the information described above may be redisclosed and would no longer be protected under these regulations.

I voluntarily authorize the disclosure of information from my health record to myself and other entities involved in my care.

×Signature:_____ **Date:**_____

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You have the right to inspect and copy your own health care information, and that of an individual of whom you are a legal guardian or next of kin. Please provide the necessary information to access your lab results or simply decline this service below.

☐ I **DECLINE** access to my own lab results

OR

☐ **PORTAL ACCESS**: Please provide your e-mail address to receive a registration code to view all of your lab results online through our secure patient portal

E-MAIL:_____

☐ **MAIL RESULTS:** Receive results at your mailing address on file within 2 weeks of result completion.
This service costs $2.00 as the time of specimen collection

☐ I am next of kin requesting on behalf of the patient and our relationship is:

_____

TruChoice Diagnostics LLC

135 Midway Drive, Suite A
Dubois, PA 15801
Phone (814) 200-9791
Fax (814) 414-3726

AUTHORIZATION FOR RELEASE OF INFORMATION & PAYMENT POLICY

1) I hereby authorize direct payment of surgical/medical benefits to TruChoice Diagnostics LLC and any of its affiliated providers for any services rendered.
2) I understand I am responsible for any balances not covered by my insurance.
3) I understand I am responsible for any balances not paid due to lack of providing correct and timely billing information.
4) I authorize the release of any medical information necessary for the processing of medical bill claims.
5) I authorize the release of medical information to other physicians and/or facilities involved in my health care.
6) I acknowledge I have been given a copy of the "Notice of Privacy Practices."

Name (print): _____

Signature:_____ Date:_____

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135 Midway Drive, Suite A
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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/15/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we mad the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of the Notice, please contact us using the information listed at the beginning of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations.

For example:
Treatment: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare of with payment for your healthcare, but only if you agree that we may do so.
Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only heath information that is directly relevant to the person s involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may use or disclose your health information when we are required to do so by law.