



Bethesda Care Arrow Springs
 Phone: 513-282-7075
 Fax: 513-282-7076

Bethesda Care Queensgate
 Phone: 513-241-4135
 Fax: 513-241-6510

Bethesda Care Butler County
 Phone: 513-874-3990
 Fax: 513-860-5071

Bethesda Care Sharonville
 Phone: 513-563-1505
 Fax: 513-769-4776

Bethesda Care Eastgate
 Phone: 513-752-3695
 Fax: 513-752-3039

Good Samaritan
 Phone: 513-862-2875
 Fax: 513-862-2860

Bethesda Care Norwood
 Phone: 513-731-3399
 Fax: 513-731-2882

OCCUPATIONAL MEDICINE SERVICES
NON-INJURY PATIENT REGISTRATION

NAME: _____
 (First Name) (Middle Initial) (Last Name) (Jr, Sr, II, etc.)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY #: _____ - _____ - _____ SEX: MALE FEMALE

BIRTH DATE: ____/____/____ AGE: _____ CELL PHONE: (____) _____-

HOME PHONE: (____) _____-_____ WORK PHONE: (____) _____-

COMPANY REQUESTING SERVICES: _____	ID CONFIRMED: <input type="checkbox"/> PHOTO ID <input type="checkbox"/> COMPANY REPRESENTATIVE:
COMPANY ADDRESS: _____	
REASON FOR TODAY'S VISIT: _____	

GENERAL CONSENT FOR TREATMENT, MEDICAL EXAMINATION AND SERVICES AND RELEASE OF INFORMATION

- I do hereby voluntarily agree and consent to treatment, performance of a medical examination and/or services within any Bethesda Healthcare, Inc. Occupational Medicine Center or Work Capacity Service (the "Centers"), including those referenced on the front page of this form. During the treatment, medical examination, and/or services, I permit the Centers and their employees, students in health care training programs and all other persons treating and/or examining me to perform the treatment, examination and/or services in ways they deem appropriate. I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me as to the result or accuracy of the treatment, examination and/or services.
- I will inform the staff of any special needs I may have during any treatment, examination, and/or services.
- I understand that the Centers will not be responsible for the loss or damages of my personal property during the treatment, examination and/or services performed at the Centers.
- If the purpose or one of the purposes of my visit is to seek a medical examination or service that is authorized and paid for by my employer or future employer ("Employer"), I understand that: (a) the Centers have an agreement with the Employer to perform the medical examination or service for a fee, (b) physicians performing the examination or service are acting as agents of the Employer, (c) the Employer is paying for the examination or service, (d) the purpose of the examination or service is as identified on the front page of this form; (e) physicians performing the examination or service are not obligated to provide treatment or discuss treatment options with me respecting any condition discovered during the examination or service or monitor my health condition on a continuous basis; it is up to me to seek appropriate follow-up care for my condition, which can be provided at a Bethesda or Good Samaritan facility; and (f) the medical examination or service will be performed objectively by the staff.
- I consent to the release of all records and accounts generated or maintained at any of the Centers to the Employer as specified on my "Authorization for Use or Disclosure of Protected Health Information" form, including medical information, medical history and the results of tests or examinations performed at the Centers. The scope of the consent covers information regarding treatment of drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological condition and/or psychiatric/mental health treatment and/or HIV related conditions to the extent such information is contained in the records and accounts generated or maintained at any of the Centers.
- I consent to the release of all records and accounts generated or maintained at any of the Centers if necessary to obtain payment for the treatment I received, and/or the medical examination or services performed at any of the Centers.
- I understand that the Centers have no knowledge or control of nor influence over and shall not be held responsible for the Employer's use or further disclosure of information released by the Centers pursuant to this consent.
- A copy of the Patient Rights and Responsibilities has been provided to me.

The above has been fully explained to me and I certify that I understand the contents of this consent.

 (Patient signature) (Witness) (Date/time)

The patient is unable to consent because: _____ I therefore consent for the patient:

 (Relationship to patient) (Signature) (Witness) (Date/time)

I have received a copy of the Centers' Notice of Privacy Practices ("Notice"). I acknowledge and agree to the terms in the Notice. Patient Signature: _____