Phone/Email Consent Form

Healthfast Medical would like the ability to use email, text, and voice reminders for your appointments scheduled through our office and to communicate health information.

The SMS service should NOT be solely relied upon, as the responsibility of attending and cancelling appointments still rest with you, but we hope this will make things easier. By signing below, I indicate I am the person legally responsible for all use of mobile accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services.

I understand Healthfast Medical uses a variety of electronic communication methods including phone, text, and email to communicate with me for the limited purposes of appointments, available services and other healthcare related communications. I authorize Healthfast Medical to disclose limited protected health information to other persons who may answer my electronic communications such as phone, text messages, or email. These may include information about appointments, available services or other healthcare related communications.

I CONSENT to the practice contacting me by text message, voicemail or e-mail for the purpose of health information and appointment reminders. **I will ensure that I keep the practice informed of my up to date number at all times, or if the number is no longer in my possession.**

I want to receive information for the purpose of health information and appointment reminders by – check all that apply

- ○ Text
- ○ Voicemail
- ○ Email

- ○ I DO NOT want to receive text messages, voicemails or e-mails for the purpose of health information and appointment reminders

Cell Phone: ________________________________

Email: ____

Patient: ____

Patient Signature: ____Date:_____________

(Parent/Legal Guardian if under 18)

RELEASE OF INFORMATION TO OTHERS (HIPAA)

I authorize HealthFast Medical and its staff to use and disclose the protected health information described below, to the individuals named. These individuals may also pick up prescriptions, medical records and other health related items on my behalf.

What level of information can we release?

▫ All information including specific medications and dosages, lab results and information related to sensitive issues such as sexually transmitted diseases (including but not limited to AIDS and Hepatitis C).

To whom can we release information (please list names):

Name Phone # Relation to patient

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing that the revocation will not apply to any information already release in response to the authorization.

Signature of Patient/Guardian

Date

Patient Check in Survey

1. Are you experiencing a cough, shortness of breath or fever?
   - ○ Yes (If yes, go to question 2.)
   - ○ No (If no, stop questionnaire and return to front desk.)

2. Have you traveled out of the country in the last 14 days?

   - ○ Yes, what country? ________________________
   - ○ No

3. Have you been in contact with anyone who has traveled outside the country OR that has been exposed to OR tested positive for the Coronavirus Disease 2019 (COVID-19)?

   - ○ Yes
   - ○ No

PATIENT INFORMATION

Name: ____ Date of Birth: ______________________

Address: ____

Street or PO Box City State Zip

Cell Phone: ____________________________ Home Phone: ________________________

Emergency Contact:

____ _____________________________

Name DOB

____ ____________________________

Phone # Relationship

Today's Visit

Reason for Visit:

____

Preferred Pharmacy: ____

Location: _____________________________

Self Pay: Y / N

Insurance Company: ____