VIGILANT HEALTH®
DIABETES CARE

PATIENT CONSENT AND AUTHORIZATION FOR TREATMENT

I, the undersigned am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize medical care and treatment by Vigilant Health through its individual physicians employees, and/or agents. Such care may include, but not be limited to, diagnostic procedures, other treatments and medications, and procedures considered advisable in my diagnosis, treatment, and course of care. I acknowledge that no guarantees can be made or have been made as to results of treatments or examinations at Vigilant Health.

Unless I tell you otherwise, I authorize Vigilant Health to send results from any diagnostic test to my Primary Care Physician (PCP) or regular professional health care provider or any other health care provider, practice, or facility. Any other specific medical questions I have about my or the patient's medical condition, treatment, care, or diagnosis should be presented to my PCP or regular professional health care provider. I acknowledge and agree that results from any diagnostic test will be sent to the address on my account.

In consideration of services provided by Vigilant Health, I hereby assign and transfer to Vigilant Health any and all rights, entitlement and interest in all benefits and payments now due and payable, or that become due and payable, under any insurance policies, any replacement policies, any self-insurance program, employers and state welfare funds, or under any other benefit or entitlement plan. I authorize the release of any medical information deemed necessary by Vigilant Health or its agents or divisions to my insurance carrier or any entitlement program provider in order to determine the benefits applicable to this date of service. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that I am financially responsible for all charges, whether or not they are covered by my insurance carrier or entitlement plan, including Medicare. I understand that I am responsible for paying any co-payment or deductible amounts at each clinic visit.

I acknowledge that I have received Vigilant Health's Notice of Privacy Practices and the Patient Bill of Rights and Responsibilities. The Notice of Privacy Practices for Vigilant Health is also available in the clinic reception area. I recognize the information gathered by Vigilant Health may need to be disclosed to a third party for purposes of administration, treatment, payment, and other healthcare operations. I consent to such release.

I confirm that I have read, or have had this form read to me, and all questions related to this form have been answered by Vigilant Health providers.

PATIENT NAME (PLEASE PRINT)	**PATIENT DATE OF BIRTH**
SIGNATURE	**TODAY'S DATE**
RELATIONSHIP TO PATIENT, IF CONSENT NOT SIGNED BY PATIENT	**TELEPHONE NUMBER**

PATIENT CONSENT FORM

PLEASE PRINT

Name:_____ Date of Birth: _____

Check one:
☐ Employee ☐ Spouse ☐ Dependent ☐ Other: _____

Social Security #_____ Home #_____ Work # _____

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

Email address:_____ Primary Physician: _____

Insurance Information: Company Insurance ID #: _____

Please complete the following information:

Emergency Contact: fjdjdyj Phone Number: _____

- **I understand that the Employee Clinic is not a substitute for a Primary Physician. I am aware that the responsibility of initiating a yearly examination with a Primary Physician is my responsibility and is encouraged by the clinical staff.**

Consent for treatment

As the patient/employee, I give Vigilant Health permission for any needed treatment. This consent will remain until revoked in writing.

Yes___ No ___

Signature:_____ Date: _____

PRIVACY PATIENT QUESTIONNAIRE

1. Please list the family member or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment and health care). **Please note, if patient is a minor and parents are divorced or separated, both parents have a legal right to minor child's health information unless otherwise permitted by a court of law. Documentation will need to be provided in the case.

   Name:_____Phone:_____

   Name:_____Phone:_____

   Name:_____Phone: _____

2. Please list the family members or other persons, if any, whom we may inform about your medical condition, ONLY IF AN EMERGENCY.

   Name:_____Phone:_____

   Name:_____Phone:_____

   Name:_____Phone: _____

3. Please list the telephone numbers where you want to receive calls about your appointments, lab or imaging results, or other health care information if other than your home phone:

4. May messages regarding appointment reminders be left on your telephone answering machine, voicemail or at your place of employment? YES___NO___

5. May confidential messages regarding medical treatment, x-ray results, or prescriptions be left on your telephone answering machine or voicemail? YES___NO___

PATIENT NAME: _____

SSN:_____ DOB:_____

PATIENT SIGNATURE: _____

(OR GUARDIAN IF UNDER 18 YEARS OF AGE)