CORECARE

Patient Information and Consent for Treatment

Patient information				
Last Name	First Name	Date of Birth	Social Security #	Sex ☐ Male ☐ Female
Permanent Mailing Address		City, State ZIP		
Email Address		Primary Phone		Phone Type ☐ Home ☐ Cell
Preferred Language		Race ☐ Black or African American ☐ Asian ☐ White ☐ Native Hawaiian or Pacific Islander ☐ American Indian ☐ Other ☐ Prefer not to answer		
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino				
Emergency Contact Name		Relationship to Patient	Emergency Contact Phone	

Guarantor/Responsible Party (person responsible for payment)	
Legal Name of Responsible Party (First, Middle, Last)	Social Security #
Email Address (if different from the patient email above)	Date of Birth

Authorization for Release of Information

May we leave testing results or referral information in email? ☐ Yes ☐ No

May we leave testing results or referral information in voicemail? ☐ Yes ☐ No

Name of person who may receive information on your behalf regarding testing or referrals

Patient Consent for Treatment

1. I voluntarily consent to any and all health care treatment, diagnostic procedures and obtaining all of my medication/ prescription history when using an electronic system provided by Core Care PLLC and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Core Care.
2. I agree to be contacted via email or SMS with information related to my visit, like: a patient portal invitation, post-visit satisfaction survey, appointment or checkup reminders, health tips, or new services that relate to me or my family.
3. I authorize payment of medical benefits to Core Care, PLLC.

I have received a copy of the Notice of Privacy Practice and Financial Policy Notice. ☐ Yes ☐ No Initials: _____

Patient or authorized person's signature	Date