New Patient Packet

Mission

"Serving Others with Humility"

Vision

"Improve Physical and Spiritual Quality of Life for Those Around Us"

Core Values

H^3

Honor God

- We care about people

Honor People

- Treat others like we would want to be treated

Honor Communities

- Be passionate about our communities

Patient Demographic Form

Name _____ DOB _____

Address_____

City _____ Zip _____ KY _____

Sex ____M _____F SSN _____

Phone Number _____

PRIMARY INSURANCE

Company _____

ID # _____

Policy Holder _____

GROUP # _____

SECONDARY INSURANCE

Company _____

ID # _____

Policy Holder _____

GROUP # _____

Emergency Contact #1

Name _____

Relationship to Patient _____

Address_____

City_____ Zip _____ State _____

Phone Number _____ Cell _____

Emergency Contact #2

Name _____

Relationship to Patient _____

Address_____

City_____ Zip _____ State _____

Phone Number _____ Cell _____

CONSENT FOR TREATMENT & START OF CARE

I, _____, do voluntarily give consent to start treatment with Care2U and medical providers associated with them. The provider will assume treatment for general medical and to use his/her professional judgment in order to render care to me.

In the event of an emergency, I give permission for treatment by the medical provider using their medical judgment to assist in my care.

***Please be advised that Care2U uses Faith Healthcare as a billing partner. This will show up on your insurance billing statement.**

Patient Name _____

Patient Signature _____
Date _____

Consent Witness _____
Date _____
……...

Care2U Name _____

Care2U Signature _____
Date _____

Authorization for Release of Protected Health Information

Name _____ DOB _____

I, _____, give authorization for Care2U to obtain medical records, including medical chart, medication records, chart notes, and any notes from consulting providers.

Name:	DOB:	Last 4 of SSN:
Address:	City:	State/Zip

This information will be released for continuity of care and is to be released to
Care2U
255 Overlook Lane
Smiths Grove, KY 42171
Fax: 270-278-1380

Information to be included in medical records include:

☐ Summary Abstract Only (clinic notes, H&P, consultations, pathology, procedure reports, test results)

☐ Emergency Reports	☐ Discharge Summary	☐ Laboratory
☐ Complete Chart	☐ History & Physical	☐ Progress Notes
☐ Consultations	☐ Immunizations	☐ Operative Records
☐ Provider Orders	☐ Radiology Reports	☐ Other: _____

_____ _____
Signature of Patient/Representative Date

_____ _____
Print Name of Representative Relationship

_____ _____
Witness (if Verbal Consent) Date

Designated Pharmacy

ServRx is a pharmacy packaging service that delivers straight to your door. Their service provides monthly medication delivery in a convenient, easy to use package. They are teamed up with Care2U as total partners in healthcare.

Would you like to sign up and use our partnered & preferred pharmacy ServRx to package and deliver your maintenance medications? _____ Yes _____No

Please list your current/previous pharmacy:

Name: _____

City: _____

Phone: _____

By signing, I authorize ServRx to bill my prescription drug insurance and fill any prescriptions monthly and deliver them to my residence.

_____ _____

Signature Patient/Representative Date

_____

Printed Name of Patient/Representative

_____ _____

Witness (if Verbal Consent) Date