ExpressMED
OF KING OF PRUSSIA

Patient Registration Form

Last Name	First Name		Middle Name	
Address	City		State	Zip code
Home Phone #	Cell Phone #		Work Phone #	
Sex ☐ Male ☐ Female	Date of Birth	Age	Social Security #	
Email Address				
Marital Status (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Emergency Contact (Name and Phone Number)			
Employer Name	Employer Address			
Primary Care Physician (PCP) Name	PCP Address and Phone #			
How did you hear about ExpressMed? ☐ Friend ☐ Mailer ☐ Relative ☐ Signage ☐ Facebook ☐ Website ☐ Work ☐ Google ☐ Yelp ☐ Insurance ☐ CVS ☐ Doctor Referral ☐ Existing Patient ☐ Other				

** By providing your email address you consent to receiving periodic emails from Express Med. Remember, you can unsubscribe at any time, and we will never sell your email address.*

Insurance Information

Insurance Company	
Subscriber Name (policy holder)	Subscriber Date of Birth
Subscriber Address (If different from patient address)	
Subscriber Relationship to Patient	

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Consent to Treat

I hereby authorize employees and agents of ExpressMed of King of Prussia (including physicians, physician assistants, and other employees and staff members) to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

Acknowledgement of Notice of Privacy Policy

ExpressMed of King of Prussia is committed to maintaining the integrity of your protected health information and complies with all applicable state and federal regulations.

While NOT required to receive treatment, we are obligated under federal regulations to ask that you sign an acknowledgement of the HIPAA Privacy Notice being made available to you.

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how ExpressMed of King of Prussia may use and disclose my protected health information. I understand that ExpressMed reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

☐ I give permission for ExpressMed to leave a message with my health information (check all that apply):

☐ Phone List Preferred Number:

_____

☐ Family Member Name(s):

_____

_____

☐ I DO NOT give my permission for ExpressMed to leave a message with my health information

_____

Printed Patient Name

_____ _____

Signature of Patient, Parent or Legal Guardian Date

REFUSAL TO SIGN DOES NOT PREVENT PATIENT FROM BEING TREATED