Visitation Form

Patient Information

First Name	Last Name	DOB

Phone Number	Email Address	Social Security #

Physical Address

City	State	Zip Code	Parish/County

Reason for Visit

Illness / Injury (Select One) ☐ Work Related ☐ Personal

Work Location	**Lease Operator**

Complaint

Testing ☐ Drug Screen ☐ Physical ☐ Occupational ☐ COVID

Company Representative

Name

Title	Company

Phone Number	Email

Company Billing Information

Name of Billing Contact	Billing Telephone

Company Billing Address

Billing Email

I understand that by signing this form, I authorize XstremeMD to treat the above employee and the company above will be held responsible for payment of all fees incurred. If the visit is deemed personal after it has begun, the company is still liable for the charges.

I understand that XstremeMD Does Not bill Workers Compensation, Medicaid, or private insurance. You are expected to pay XstremeMD for the invoice by the due date. If you have not set up a customer account with XstremeMD, payment is due in 14 days. Failure to pay will result in your company no longer being seen in our clinics.

Signature of Company Representative

Request For and Authorization To Release Medical Records or Health Information

Privacy Act

This form authorizes release of information requested in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164 in addition to those routine uses disclosures of the information authorized by HIPAA and in accordance with the Notice of Privacy Practice.

Patient Name:			
Date of Birth:		Telephone Number:	
Information may be released to: Purpose for Release of Information:	To: The person or entity responsible for payment for healthcare services, and/or involved in my treatment, including but not limited to My Employer, and any entity working with my Employer, such as an insurer, case manager or Third-Party Administrator for treatment or payment purposes. Treatment and payment purposes include, but are not limited to employment related functions, such as fitness for duty, drug screening, and worker's compensation or similar programs established by law that provide benefits for work related injuries or illnesses without regard to fault.		
Name of health care provider or entity to release this information:	XstremeMD		
Address of above entity:	1028 Forum Drive	Broussard, LA	70518

Information to be released:

Expiration Date: This Authorization expires 2 years from date of signature below, unless otherwise revoked in writing.

_____ I hereby authorize the release of All MEDICAL RECORDS AND INFORMATION pertaining to my care and treatment for my Injury or Illness on the visit of _____ (DATE), and any subsequent visits or other encounters for such Injury or Illness, including but not limited to visit notes (history, physical examination and assessment), test results of any kind, radiology reports, referrals, consultant notes, billing records, insurance records, and ALL records created or received by XstremeMD for the care and treatment provided on all dates relative to my Injury or Illness.

_____ I hereby authorize the release of my Medical Records and Information through the XstremeMD portal, which allows the recipient access to my medical records, including return to work forms and work-related case management reports.

_____ Limitation on release of information:

Acknowledgement

I request that health information regarding my care and treatment be released as set forth on this form and understand: 1) This authorization may include disclosure of information relating to alcohol and drug abuse, mental health treatment, and confidential HIV related information only if I sign my name on the line below. 2) I have the right to revoke this authorization at any time by writing to XstremeMD at: 1028 Forum Drive Broussard, LA 70518. 3) I understand that signing this authorization is voluntary. I understand that information released pursuant to this authorization maybe subject to re-disclosure by the recipient and may no longer be protected by HIPAA. 4). My treatment will not be conditioned upon my authorization of this disclosure except as allowed by HIPAA for health care services that are solely for the purpose of creating protected health information for disclosure to a third party, like my Employer for purposes such as pre-placement physicals, drug tests, and fitness-for-duty examinations, and failure to provide authorization may result in termination of the patient relationship.

Additional Authorization for release of information:

I understand that this information may be used to adjust, describe, or report matters about my care and treatment to persons entitled to receive this information and I expressly authorize XstremeMD to engage in ORAL COMMUNICATIONS regarding my medical records and information as set forth above.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction. A photocopy of this authorization shall have the same validity as the original.

_____ Patient Signature

_____ Date

_____ Witness Signature

_____ Date

Telemedicine Consent Form with XstremeMD

Patient Information

First Name	Last Name	Location of Patient

Employer

By signing this Authorization and Informed Consent form, I understand the following:

1. I understand that my employer wishes me to engage in a telemedicine consultation with an emergency room physician employed by XstremeMD.

2. My employer and/or designee of XstremeMD have explained to me how the video conferencing technology will be used to affect such a consultation. I understand that this consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my employer or I can discontinue the telemedicine consult /visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I understand I will provide this withdrawal in writing.

5. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my employer and the XstremeMD physician in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following (1) ask non-medical personnel to leave the telemedicine examination room; (2) terminate the consultation at any time.

6. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation; I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

7. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me as to the result of care, treatment, and the provision of medical services

8. I understand that my history and physical examination will be video recorded, saved on a secure network, and become a part of my legal medical record.

9. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise the onsite personnel that his/her responsibility will conclude upon the termination of the videoconference connection.

10. I authorize XstremeMD to release any and all information, including medical records, social security number if required, and any and all other pertinent information pertaining to my treatment by the XstremeMD physician as may be requested by Workman's Compensation, my employer, or any other agency which may have a concern or involvement with payment of charges or other genuine interest relating to the professional services rendered to me.

11. I authorize XstremeMD to release my reason for visit and return to work status to my employer, or any other agency which may have a concern or involvement with payment of charges or other genuine interest relating to the professional services rendered to me.

12. I authorize XstremeMD to use data from this visit; regarding treatment, disposition, and diagnoses rendered to me, including potential publication for educational or promotional reasons. I understand that my identity and all identifying information will be kept confidential.

13. I have read this document carefully, and understand the risks and benefits of the teleconferencing consultation. I have had my questions regarding the procedure explained to me, and I hereby consent to participate in a telemedicine visit under the terms described herein.

14. I understand that the physicians who are treating me are located in Lafayette, Louisiana and are licensed to practice medicine in the states of Louisiana, Texas, New Mexico, North Dakota, and Oklahoma. I agree that any dispute arising from the telemedicine consult with the XstremeMD physician who is treating me will be resolved in the courts of Louisiana. I also agree that the laws of Louisiana shall be applied to all disputes, including any medical malpractice claim.

I have read and understand the information provided above regarding telemedicine, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

Signature of Patient	Date / Time
Signature of Witness	Date / Time

Acknowledgment of Notice of Privacy Practice Consent to Release of Protected Health Information for Treatment, Payment and Healthcare Operations.

XstremeMD (XMD) is committed to maintaining the privacy of your health information. During your treatment with us, physicians, nurses, and other personnel may collect information about your health history and your current health status. Our Notice of Privacy Practices explains how that information, called "Protected Health Information" may be used and disclosed to others. This Notice in its entirety is available to you at this time, if you request a paper copy.

By virtue of this document, I am also giving my consent to XstremeMD to use and/or disclose my protected health information for the purposes of treatment, payment, and healthcare operations as allowed by HIPAA. I understand that XstremeMD may, in the course of rendering care to me, disclose personal health information about me to any person that I identify as long as the information disclosed is relevant to their involvement in my care or the payment for my care. I understand that I may opt-out or otherwise restrict the disclosure of my information to such persons or revoke this general privacy consent by providing written notice, signed and dated by the patient or the patient's personal representative. In the event that such consent to disclose my protected health information for the purposes of treatment, payment, and operations is revoked, I understand that XstremeMD may terminate the patient relationship.

I have read and understand the above statement.

Signature of Patient	Date / Time