healthchek

Patient Registration

Please Print

Name: _____
Last First MI

☐ Male
☐ Female

☐ **Check box if change of address since last visit.**

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____/_____/_____

Email: _____

(I authorize Healthchek to send me a monthly newsletter)

How would you like to get your test results ?

☐ **Mail** ***(Results are usually received in 7-10 days)***

☐ **Fax to Doctor: (Name)** _____

MD Fax #: _____

MD Phone #: _____

Who referred us to you?

_____

☐ **Pick Up / I Authorize (another)** _____ **to Pick Up My Results.**

☐ **Email:** _____

HIPAA COMPLIANCE: Healthchek uses a secure and encrypted email service to send results.

Authorization & Consent

By signing below:

I authorize Healthchek to perform health testing as part of a wellness screening program.
I understand that in no way does Healthchek propose, diagnose, or recommend medical treatment.
I understand that it is my responsibility to contact my personal physician to follow through with these test results.
I relieve Healthchek and its employees from any liabilities relating to the confidentiality of my personal test results.
I authorize Healthchek to release my test results to any named recipients listed above.
I authorize Healthchek to send my test results using any of the methods of delivery I have identified above.
I authorize Healthchek to email me a monthly newsletter.

Signature: _____ **Date:** _____