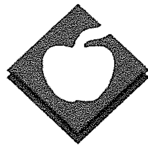
ID IS REQUIRED
Please write as clear as possible:
We **DO NOT** accept **MEDI-CAL**



EVERYDAY HEALTH CARE

www.everydayhc.com

Parking #

Check One:

☐ **RAPID 15 Minute Antigen Covid Test**	☐ **PCR (required for Travel)**
You may use insurance (We **DO NOT** accept any form of **MEDI-CAL**) or pay $165 (Cash or Credit Card)	Cannot bill insurance. $275 (Cash or Credit Card) ***Inform staff this is the test you are requesting***

Date:	Email Address:		How did you hear about us?	
Patients First Name:	Patient Last Name:		Middle Initial:	
	DOB:	Age:	Sex: ☐ Male ☐ Female	
Martial: ☐ Single (Widow, Divorced, Not Married) ☐ Married			Driver License/ ID:	
Address:	Apt:	City:	State:	Zip Code
Home Phone:	Cell Phone:		Message Phone:	

If insurance card not present, please fill out section below and email Virtual card to **Staff@everydayhc.com**

Insurance Name:	Member ID:

I ______________________, understand Everyday Health Care will be billing your medical insurance for the services rendered. I understand if my insurance does not pay, I will be held responsible for the services rendered under contracting price. All results/services will be released to the contracted medical insurance. I give Everyday Health Care consent to proceed with my treatment requirements. Everyday Healthcare does not refuse services; however, we do require payments when due.

By signing this form, you are granting consent to Everyday Health Care to use and disclose your protected health information (PHI) for the purpose of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose these protected practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our facility at (559) 225-4706

You have the right to request us to restrict how we use and disclose your protected health information (PHI) for the purpose of treatment, payment, or health care operations. We are not required by law to grant your request. However, if you refuse to sign this consent, or revoke this consent, Everyday Health Care may refuse to treat you as permitted by section 164.506 of the code of Federal Regulations.

You have the right to revoke this consent in writing, except to the extent we already have used, or disclosed your protected health information (PHI) in reliance on your consent.

Patient/Guardian Signature: ______________________ Date: ______________________