ProActive
WORK HEALTH SERVICES

REGISTRATION

First Name: De'onte Middle Name: Raishawn Last Name: Jackson

DOB: 2-8-1995 SS# 631-46-3724

Address: 321 CR 488B

City: Sweeny State: TX Zip: 77480

Telephone: 979-417-1036 Email: deonte.jackson90@icloud.com

Company: PSC Group Reason for Visit: drug screen

I acknowledge that the occupational services performed at ProActive are done at my request or at the request of my employer through blood, urine, saliva, hair testing or other occupational services. I also acknowledge that ProActive is a collection facility and the actual testing will be done by a third-party laboratory. I acknowledge and agree that ProActive will report the results of the testing directly to me, my employer, my physician or a government agency. I consent and authorize that such disclosure may be fax, email, direct courier, mail or any other electronic means. I acknowledge and agree that the services provided and the test results from ProActive will be maintained as confidential, protected health information by ProActive as required by federal and state law.

I acknowledge the results of the testing or examination will become part of my medical record. I also acknowledge that an insurance company may discover the results of this testing by obtaining a copy of my medical record in accordance with the terms of a company's insurance policy.

This authorization in effect for the visit date (today's date) listed on this authorization form. Each visit requires completion and authorization of a new form.

I have read and agree to all the terms above.

[signature] 11-3-22

Signature Date

CC08633665 Z GEN
2nd I.D. ___

CC08633664 Z GEN
2nd I.D. ___

Office Use Only

______ Sign in Time

______ Completed Paperwork Time

______ Pulled Back Time

______ Completed (MA, DR, NP)

Deer Park	1803 Center St, Suite A	Deer Park, TX 77536	P 281.680.2007	F 281-930-8856
Brazosport	1100 N Brazosport Blvd # 3	Freeport, TX 77541	P 979.705.7565	F 979.358.3010
Freeport	1002 ABC Ave, Suite 400	Freeport, TX 77541	P 979.239.3000	F 979.239.3003

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PATIENT CONSENT FOR TREATMENT, ACKNOWLEDGEMENT OF PRIVACY PRACTICES & AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO EMPLOYER

My employer or potential employer, PSC Group **, has sent me to Proactive Work Health Services ("PWHS") for testing, evaluation or treatment.** By signing below, I authorize PWHS to disclose my protected health information in accordance with the following terms & conditions:

1. PWHS may disclose my protected health information to my employer, prospective employer, or to an entity designated to evaluate my suitability for (1) initial or continued employment or (2) other activity required by my employer, or any other disclosure required by law.
2. **If I have been sent to PWHS for only a drug screen and/or breath alcohol test**, my protected health information only includes the results of that testing. Otherwise, my protected health information can include the results of tests, evaluations, including diagnoses and medical history relevant to the tests and evaluations performed that my employer or prospective employer has ordered or requires.
3. I understand that my health information may not be protected from further disclosure by some entities receiving my information under this authorization, and that PWHS has no control over subsequent disclosures by other entities.

CONSENT FOR MEDICAL TREATMENT

I consent to medical evaluation and treatment from PWHS, its affiliates, physicians, chiropractors, physical therapists, physical therapy assistants and employees. Treatment may include examination, diagnostic tests, (e.g. including but not limited to x-rays, EKG, blood draws and other laboratory tests), administration of medications, injections, and immunizations and any medical procedures ordered by the physician(s) to be performed by PWHS' staff. I give permission to PWHS to perform breath alcohol testing, urine drug screen, hair collection or other specimens to determine the presence of drugs and alcohol. I give permission to PWHS to perform a physical examination and/or wellness health screening. I understand that I am solely responsible for following up with my personal physician other healthcare provider about the results of my physical examination. In performing the physical examination and/or wellness health screen, PWHS does not assume any responsibility for ongoing treatment or management of care.

NOTICE OF PRIVACY PRACTICES

I have been provided the Notice of Privacy Practices (NPP) to review and have had the opportunity to ask any questions I have about it. I understand the NPP is posted in the center and a copy shall be provided to me at my request.

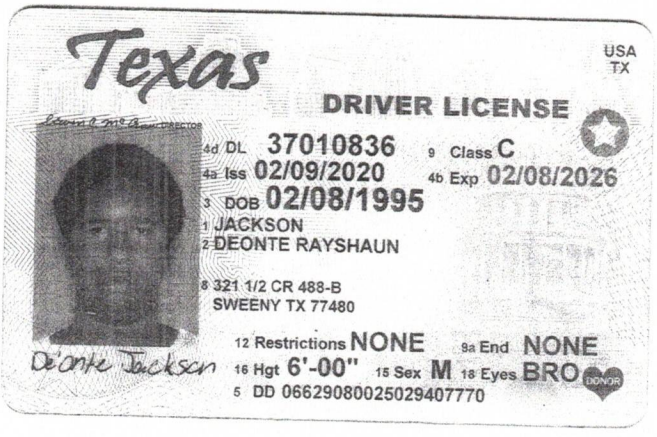
FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

- If I am being treated for a worker's compensation injury or illness, PWHS will seek payment from the responsible payer or the employer's workers' compensation insurance carrier.
- If I am receiving employer-directed services (e.g. physical examination, medical surveillance, drug testing, alcohol testing, mask fit testing, TB screening, vaccinations, and/or pulmonary function testing), PWHS will seek payment from the employer.

SIGNATURE

Patient or Guardian Signature: De'Onte Jackson **Date:** 11-3-22

Patient Name: De'Onte Jackson **Date of Birth:** 2-8-1995


Texas

USA
TX

DRIVER LICENSE

4d DL 37010836 9 Class C
4a Iss 02/09/2020 4b Exp 02/08/2026
3 DOB 02/08/1995
1 JACKSON
2 DEONTE RAYSHAUN

8 321 1/2 CR 488-B
SWEENY TX 77480

12 Restrictions NONE 9a End NONE
16 Hgt 6'-00" 15 Sex M 18 Eyes BRO
5 DD 06629080025029407770

DONOR

De'onte Jackson