□ 6199 Transit Road, Depew, NY 14043 Tel: 716.206.0390 Fax: 716.206.0394
□ 1900 Ridge Road, West Seneca, NY 14224 Tel: 716.712.0670 Fax: 716.712.0674
□ 2075 Sheridan Drive, Kenmore, NY 14223 Tel: 716.447.6474 Fax: 716.447.6433

HealthWorks-WNY-LLP: Consent for Physical Examination, Screening Procedures, & Surveillance Testing

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____ SS#: _____

Local Address: _____ City: _____ State: _____ Zip Code: _____

Local Phone: _____ Date of Birth: _____ Gender: _____

Emergency Contact: _____ Phone No.: _____ Primary Physician: _____

Employer Information:

Employer: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____ Occupation: _____

I authorize HealthWorks0WNY, LLP, through its physicians and other health providers, to examine, test, screen, diagnose and offer treatment according to the services requested by my employer or by myself if self-paying.

I assign all rights to payments for these services from employers and/or insurance carriers, if any, to HealthWorks-WNY, LLP.

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ _____

Signature of patient or legal representative Signature of witness

Date: _____ Time: _____ Date: _____ Time: _____

Parent/Guardian Signature
(If patient is a minor): _____ Relationship: _____

REFUSAL OF CARE WAIVER -Do not complete unless requested.

I understand that I am leaving HealthWorks-WNY, LLP against the advice of the physician. I am refusing the recommended treatment for the condition diagnosed today.

Patient Signature: _____ Date: _____ Time: _____

Witnessed by: _____ Date: _____ Time: _____

Rev. 02/01/2015