INTERMED
Care without compromise.

Adult Patient Information

Patient's Legal Name: _____ Date of Birth: _____
First Last Preferred Name *mm/dd/yyyy*

Mailing Address: _____ _____ _____ _____
Street *City* *State* *Zip*

Email Address: _____ **Relationship to patient:** _____

Phone Preferences:

Home phone: (_____) _____ - _____

Cell phone: (_____) _____ - _____

Work phone: (_____) _____ - _____

Emergency Contact: _____ **Relationship to patient:** _____
First Last

Home phone: (_____) _____ - _____

Cell phone: (_____) _____ - _____

Work phone: (_____) _____ - _____

This information and communication authorization will remain active for 12 months, at which time I will be given an opportunity to confirm or update. I understand I have the right to revoke these preferences in writing at any time.

_____ _____
Patient / Legal Guardian Signature *Date: mm/dd/yyyy*

UPON INSTRUCTION ONLY:

Confirmation that above authorization remains in place for the next 12 months:

Patient / Legal Guardian Signature:	**Year:**

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Adult Communication Authorization

Patient's Legal Name: _____ Date of Birth: _____
First Last Preferred Name *mm/dd/yyyy*

You may specify up to three individuals authorized to receive routine verbal communication about your healthcare (prescription requests, referral requests, requesting a new appointment, requesting changes to an appointment, and medical inquiries/status updates). Please provide the first and last names of the individuals you authorize us to communicate with.

*This authorization does not include communication about mental health treatment.

1. **Name:** _____ **Relationship to Patient:** _____
2. **Name:** _____ **Relationship to Patient:** _____
3. **Name:** _____ **Relationship to Patient:** _____

This authorization should be confirmed every 12 months. I understand that I will need to complete InterMed's Authorization to Release Health Care Information form or provide an equivalent HIPAA compliant authorization if I wish to allow my provider to discuss health information not covered by the categories listed above. Disclosure of mental health treatment status requires execution of InterMed's Release of Information.

_____ _____
Patient / Legal Guardian Signature *Date: mm/dd/yyyy*

UPON INSTRUCTION ONLY:

Confirmation that above authorization remains in place for the next 12 months:

Patient / Legal Guardian Signature:	**Year:**

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InterMed Consent to Treat

Patient's Legal Name: _____ Date of Birth: _____
First *Last* *mm/dd/yyyy*

I consent to routine medical treatment and/or evaluation including but not limited to surgery, laboratory, pharmacy and x-ray examinations. I understand that separate consents will be requested for certain special procedures. I also understand I have the right to refuse any proposed procedure or treatment. Treatment may be face-to-face, or I may choose to receive telehealth services via a secure, web-based platform.

This authorization will remain current until an updated version is received, or this version is revoked in writing. I understand I have the right to revoke this authorization in writing at any time.

_____ _____
Patient / Legal Guardian Signature *Date: mm/dd/yyyy*

Version: 05/07/2024