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M-TEE'S MOBILE MEDICAL SERVICES - INTAKE & CONSENT FORM

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PATIENT INFORMATION

Full Name: _____ Date of Birth: ____/____/_____

Phone Number: (____) _____-_____ Email: _____

Home Address: _____

Emergency Contact Name: _____ Phone: (____) _____-_____

INSURANCE & BILLING INFO

Primary Insurance Provider: _____ Policy ID #: _____

Group #: _____ Subscriber Name: _____

[ ] AHCCCS / Medicaid ID: _____ [ ] Medicare ID: _____

[ ] Private Pay (Credit/Debit/Cash)

PHYSICIAN ORDER VERIFICATION (Strictly Required)

Ordering Physician Name: _____ Clinic/Facility: _____

Physician Phone: (____) _____-_____ Physician Fax: (____) _____-____

INFORMED CONSENT FOR MOBILE MEDICAL SERVICES & POC TESTING

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1. ACKNOWLEDGMENT OF ORDER-BASED ONLY SERVICE: I understand that M-Tee's Mobile Medical Services operates strictly as a collection and point-of-care (POC) screening provider. Services are only performed upon the explicit, signed order of a licensed healthcare provider.
2. CONSENT FOR SPECIMEN COLLECTION: I hereby consent to have the staff of M-Tee's Mobile Medical Services perform venipuncture (blood draw), capillary sampling (fingerstick), urine collection, or respiratory/throat swabbing as ordered by my physician.
3. POINT OF CARE TESTING: I consent to the performance of rapid POC screening tests (including but not limited to PT/INR, Lipids/Glucose, Hemoglobin, UA, and Respiratory panels). I understand these results will be sent directly to my ordering physician for formal diagnosis and treatment planning.
4. FINANCIAL RESPONSIBILITY: I authorize M-Tee's Mobile Medical Services to bill my insurance on my behalf. I understand that I am ultimately responsible for any balances, co-pays, or non-covered services determined by my insurance provider.

Patient/Guardian Signature: _____ Date: ____/____/_____

Printed Name: _____ Relationship: _____