



1. Medical History / Patient Health Information Form

Patient Information

- Name: _____
- Address: _____
- Social Security #: _____
- Race: _____
- Preferred Pharmacy: _____
- DOB: _____
- Phone: _____
- Preferred Language: _____
- Ethnicity: _____
- Release of Information Text / Call: _____

Medical History

- Current illnesses / diagnoses: _____
- Past surgeries / hospitalizations: _____
- Allergies (medication, food, environmental): _____
- Family medical history: _____
- Social history (smoking, alcohol, occupation, exercise): _____

Consent Statement

I authorize NP PulseOnTheGo HC to collect, store, and use my medical history for treatment purposes.

- Patient Signature: _____ Date: _____
- Provider/Staff Witness: _____ Date: _____

2. Medication Consent / Medication Management Form

Current Medications

Medication Dose Frequency Start Date Notes

Consent Statement

I authorize NP PulseOnTheGo to **prescribe, adjust, and manage my medications**. I understand the importance of **reporting any side effects or changes** in my medications promptly.

- Patient Signature: _____ Date: _____
- Provider/Staff Witness: _____ Date: _____

3. Consent to Treatment Form

Consent to Medical Treatment I hereby authorize NP PulseOnTheGo and staff at NP PulseOnTheGo to perform **medical examinations, diagnostic tests, procedures, and treatments** deemed necessary for my care.

I understand that:

- Risks and benefits of treatments will be explained to me.
- I may refuse or withdraw consent at any time.
- Alternative treatments may be available.

- Patient Signature: _____ Date: _____
- Provider/Staff Witness: _____ Date: _____

4. Financial Responsibility / Billing Consent Form

Acknowledgment of Financial Responsibility

I understand that:

- I am responsible for any **copayments, deductibles, or charges not covered by insurance**.
- NP PulseOnTheGo may **bill my insurance directly**.
- Payment is expected for **services rendered at the time of visit** unless prior arrangements are made.

Consent Statement

I authorize NP PulseOnTheGo to **submit claims and collect payment on my behalf**, and I agree to be responsible for any amounts not covered by insurance.

- Patient Signature: _____ Date: _____
- Provider/Staff Witness: _____ Date: _____