OPTUM®

Registration Form

Optum Student Health Services
578 Huntington Ave.
MassArt Tree House Residence Hall, 2nd Fl.
Boston, MA 02115
P 617-879-5220
F 617-879-5221

Thank you for choosing MedExpress! If you have any questions or require help filling out this for, please ask a staff member. Please print clearly to complete the form in its entirety. Return it to the front desk when you are finished.

Please check school you attend: ◯MCPHS ◯Wentworth ◯MassArt

Step:1 Enter Information About the Patient

Name: _____
Last First M.I

_____
Address

_____
City State Zip

_____
Phone Email

_____ Sex: ◯ Male ◯ Female
Date Of Birth

Step 2: Enter the Parent/Guardian (Only if you are under the age of 18)

Name:_____
Last First M.I.

_____ Sex: ◯ Male ◯ Female
Date Of Birth

Step 3: Enter the Policy and Subcriber Information

_____
Primary Insurance Name Member ID Number

_____
Subcriber First Name Last Date Of Birth

Patient Relation to Subcriber ◯ Self ◯Spouse ◯Child

ATHENANETESIGNATURE

MedExpress

Patient's Consent to Treat, Authorization for Payment, Acknowledgement of Unencrypted Email Risks, and Release of Responsibility for Loss of Valuables

Patient First Name: _____ **Date of Birth:** _____

Patient Last Name: _____

Consent to Treat. I consent to all treatments and/or health screenings as deemed appropriate by the treating practitioner and provided by healthcare providers at MedExpress. This may include, but is not limited to, diagnostic procedures such as: X-rays, blood draw and laboratory testing as well as other medical treatments or procedures that a condition may require.

Authorization for Payment. If I am receiving services at my employer's worksite or a MedExpress Center due to a work-related injury or testing, I understand that payment for these services is to be made by my employer or on its behalf through a third-party affording workers' compensation coverage to me. I may be responsible for fees associated with such services if the claim is denied by employer and/or workers' compensation carrier. If I am receiving services at my employer's worksite or a MedExpress Center for other reasons, I am responsible for fees related to the services rendered unless covered by employer.

If I am receiving care at any other MedExpress location, I agree to pay for all such services rendered. Furthermore, unless I have made full payment for services received at the time of service and have expressly informed MedExpress otherwise in writing, I authorize MedExpress and/or related/affiliated entities to apply for benefits on my behalf for services rendered by MedExpress. I request payment from my insurance company be made directly to MedExpress. I certify that the information I have reported with regard to my insurance coverage is correct, and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided.

All professional services rendered are charged to the patient or parent/guardian if the patient is under 18 years of age. The patient may be treated by a provider who is out of network and, as such, out of network costs may be associated with that care. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient (or parent/guardian) is responsible for fees for all services rendered, regardless of insurance coverage. All payments are due when the service is rendered. There may be a significant delay in the patient receiving a statement of additional payments due when insurance carriers are involved. This delay in no way lessens the patient's responsibility for full payment of services rendered. As a service to you, our front office personnel may access information provided by your health insurance carrier. MedExpress shall not be bound by that information nor do we guarantee the accuracy of same. By execution of this document, the individual signing below hereby agrees to be solely responsible for all charges associated with care received, notwithstanding any information/ assertions to the contrary. I understand that any overpayment that I make to MedExpress, which is greater than $10 (ten dollars), will result in a refund check, mailed to me within a reasonable timeframe. Any overpayment on my account that is $10 (ten dollars) or less will be applied as a credit on my MedExpress account, unless I otherwise notify MedExpress to issue payment to me.

The patient and/or the patient's insurance carrier may receive a separate bill for laboratory services. These payments are due to the entity performing these services. MedExpress has no control over the costs or terms of payment associated with these services.

In furtherance of high-quality care, MedExpress may designate certain providers as preferred providers in an effort to expedite and coordinate follow-up care. I acknowledge that in the event a referral to an outside healthcare provider is deemed necessary, I am free to choose any follow-up primary care provider or specialist, whether or not the provider chosen by me is a designated MedExpress preferred provider. MedExpress does not receive any fee, compensation or remuneration from any preferred provider.

Your insurer may require a prior authorization or referral from your primary care physician to receive services at MedExpress. The patient is responsible for obtaining such authorization and is responsible for all charges not paid by the insurer due to failure to obtain a referral/authorization.

Acknowledgement of Unencrypted Email Risks. If I choose to provide MedExpress my insurance information via electronic transmission (email), the email may be sent to MedExpress unencrypted. Unencrypted email is not a secure form of communication. I understand there may be some risk that unencrypted emails may be misdirected, disclosed to, or intercepted by unauthorized third parties.

Release of Responsibility for Loss of Valuables. I relieve MedExpress of any responsibility for loss of money, clothing, valuables or any other items I choose to keep with me while a patient in any MedExpress Center. MedExpress will not be responsible for replacing any personal property I decide to keep with me that becomes lost, stolen or broken, while a patient.

This Consent to Treat does not apply to DOT Drug and/or DOT Alcohol Testing, as no such consent is required.

_____ _____

Patient's Signature **Date**

(Parent/Guardian's Signature if patient is under 18)

MedExpress

Authorization for Disclosure of Protected Health Information for Treatment, Payment and Operation Purposes

Patient First Name: _____ **Date of Birth:** _____

Patient Last Name: _____

I authorize MedExpress and/or related/affiliated entities to release protected health information that is required to carry our treatment and to obtain payment for healthcare services performed on my behalf. I further attest that I have had the opportunity to receive my own copy of MedExpress' Notice of Privacy Practices, to read the Notice, and to ask question in order to understand the Notice of Privacy Practices.

I hereby authorize MedExpress to share medical information including, but not limited to, prescriptions with other MedExpress Centers, physicians, and/or designated representatives or any healthcare provider involved in my care.

I further acknowledge that, in order to provide the best medical care, it is important for the practitioners of MedExpress to be aware of my complete medical history including all conditions, treatments, exams, tests, and medications that have been prescribed for me by all other medical providers including: my Primary Care Provider, providers working at local Emergency Departments, other MedExpress Centers, pain management centers, and any other medical provider who has prescribed medications. Medications include those subject to monitoring according to the Controlled Substance Act of 1970.

I hereby authorize MedExpress to obtain and share any and all information about medications prescribed for me, including, but not limited to, information about Controlled Substance prescribed by MedExpress with other medical providers involved at any time in my care.

I also agree that MedExpress may receive from and share with other medical providers any decisions by any medical providers to limit prescribing of Controlled Substances to me. I understand that if I do not agree to share this information, MedExpress providers may not prescribe medications controlled by the Drug Enforcement Administration to me.

I agree that MedExpress may use my email address for quality assurance and communication purposes and that my email address will not be provided to unaffiliated third parties.

This Authorization does not apply to DOT Drug and/or DOT Alcohol Testing, as no such authorization is required.

_____ _____

Patient's Signature **Date**
(Parent/Guardian's Signature if patient is under 18)

MedExpress

Nondiscrimination Notice & Access to Communication Services

Patient First Name: _____ **Date of Birth:** _____

Patient Last Name: _____

MedExpress does not discriminate on the basis of sex, age, race, color, national origin, or disability.

Free services are available to help you communicate with us. Such as, letters in other languages, or in other formats like large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free number 888-249-6365.

If you think you weren't treated fairly because of your sex, age, race, color, national origin, or disability, you can send a complaint to:

Optum Civil Rights Coordinator
11000 Optum Circle
Eden Prairie, MN 55344
Fax: 855-351-5495
Email: Optum_Civil_Rights@Optum.com

If you need help with your complaint, please call the toll-free number 888-249-6365. You must send the complaint within 60 days of when you found out about the issue.

You can also file a complaint with the U.S. Dept. of Health and Human services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

Language Assistance Services and Alternate Formats

This information is available in other formats like large print. To request another format, please ask us or call the toll-free number: 888-249-6365.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 888-249-6365.

KUJDES: Në rast se flisni **shqip (Albanian)**, juve ju ofrohen falas shërbimet e ndihmës gjuhësore. Ju lutemi merrni në telefon në 888-249-6365.

ማሳሰቢያ: **አማርኛ (Amharic)** የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ያለክፍያ ይቀርብልዎታል። እባክዎትን በ 888-249-6365 ይደውሉ።

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال بالرقم 888-249-6365.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե **հայերեն (Armenian)** եք խոսում, անվճար լեզվական օգնության ծառայություններ են հասնում Ձեզ: Խնդրվում է զանգահարել 888-249-6365 համարով:

ICITONDERWA: Nimba uvuga **Ikirundi (Kirundi)**, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 888-249-6365.

ATENSYON: Kung **Cebuano (Cebuano)** ang imong sinultihan, magamit nimo ang mga serbisyo sa tabang sa lengguwahe, nga walay bayad. Palihug tawag sa 888-249-6365.

ঘোষণা : আপনার ভাষা যদি **বাংলা (Bengali)** হয়, ভাষা সহায়তা পরিষেবা আপনি বিনামূল্যে পেতে পারেন। দয়া করে কল করুন 888-249-6365.

သတိထားပါ- သင် **ဗမာစကား (Burmese)** ပြောဆိုလျှင်၊ ဘာသာစကားအကူအညီ ဝန်ဆောင်မှုများ အခမဲ့ရနိုင်သည်။ ကျေးဇူးပြု၍ 888-249-6365 ကို ခေါ်ပါ။

ចំណាប់អារម្មណ: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** បសវាជំនួយភាសាបោយឥតគិតថ្លៃគឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 888-249-6365 ។

Ꮻ: ᎢᏳᏃ **ᏣᎳᎩ(Cherokee)** ᏧᏬᏂᏍᎩ ᏱᎩ, ᏲᏬᏂᏧᏍᏗ ᎠᏚᏀᏝᏍᏗ ᎠᏢᏍᏚᎸᏧᏁᏧ ᎤᎾᏝᏍᏚᎸᎡᏗᎢ, ᎠᏎᏬ, ᏂᏧᏃ ᏗᏚᏟᏅᏗ. ᏫᏢᏃᏈᏓ 888-249-6365.

睛注意：如果您靓**中文 (Chinese)**，我們免費為您提供語言協助服務請注意。請致電: 888-249-6365。

Anumpa Pa̲ Pisa: **Chahta (Choctaw)** anumpa ish anumpuli hokmvt tohsholi yvt peh pilla ho̲ chi apela hinla. I̲ pa̲ya 888-249-6365.

HUBACHISA: Kan ati dubbattu **Afaan Oromoo (Oromo)** yoo ta'ee, tajaajilliwwan gargaarsa afaanii, kanfalttii malee siif jira. Maaloo karaa 888-249-6365.

OPGELET: Indien u **Nederlands (Dutch)** spreekt zijn taalbijstandsdiensten gratis voor u beschikbaar. Gelieve 888-249-6365 te bellen.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 888-249-6365.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 888-249-6365.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 888-249-6365 an.

ΠΡΟΣΟΧΗ : Αν μιλάτε **Ελληνικά (Greek)**, υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε 888-249-6365.

ધ્યાન આપો: જો તમે **ગુજરાતી (Gujarati)** બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વિના મૂલ્યે પ્રાપ્ય છે. કૃપા કરી 888-249-6365 પર કોલ કરો.

MALIU MAI! Inā ʻōlelo ʻoe i ka **ʻōlelo Hawaiʻi (Hawaiian)**, loaʻa ke kōkua unuhi manuahi no ke kōkua ʻana aku iāʻoe. ʻOluʻolu e kelepona aku i ka helu 888-249-6365.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया 888-249-6365. पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 888-249-6365.

GEE NTI: Ọ bụrụ na ina asụ asụsụ **Igbo (Igbo)**, enyemaka na-ahazi asụsụ, bu n'efu, dịrị gị mgbe niile. Biko kpọọ 888-249-6365.

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 888-249-6365.

PERHATIAN: Jika Anda berbicara **Bahasa Indonesia (Indonesian)**, layanan bantuan bahasa akan tersedia untuk Anda secara gratis. Harap hubungi 888-249-6365.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 888-249-6365.

注意事項：**日本語**(Japanese)を話される場合、無料の言語支援サービスを ご利用いただけます。888-249-6365にお電話ください。

ဟ်သူဉ်ဟ်သးဘဉ်တက့ၢ်–ဖဲနမ့ၢ်ကတိၤ**ကညီကျိာ်(Karen)**န့ဉ်,ကျိာ်တၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖဉ်,လၢတလိဉ်ဟ့ဉ်အပ္ၢ်ဘဉ်နူဉ်အိဉ်ဝဲဒဉ်လၢနဂီၢ်နူဉ်လီၤ.

ဝံသးစူၤကိးဘဉ်ဟ888-249-6365=နူဉ်တက့ၢ်.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 888-249-6365 번으로 전화하십시오.

YI LÈ: I balè u mpòt **Bassa (Bassa)**, bot ba kòbòl mahòp yanga, bayé ha i nyuu hola wè. Sébél nsinga ini: 888-249-6365.

تێبینی :گەر بە **کوردی سۆرانی (Kurdish Sorani)** قسە دەکەیت، بێبەرامبەر خزمەتگوزاری زمانت لەبەردەستە. تکایە پەیوەندی بکە بە ڕەقەم تەلەفۆنی 888-249-6365.

ກະລຸນາຟັງ: ຖ້າຫາກວ່າທ່ານເວົ້າພາສາ **ລາວ (Laotian)**,ການບໍລິການຊ່ວຍເຫຼືອ ຂໍ້ມູນສໍາລັບການພາສາ,ບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ,ມີສໍາລັບທ່ານກະລຸນາໂທ 888-249-6365.

कृपया लक्ष द्या: जर तुम्ही **मराठी (Marathi)** बोलत असल्यास, भाषा सहाय्य सेवा तुम्हाला मोफत उपलब्ध आहेत. 888-249-6365 येथे संपर्क करा.

LALE: Ñe kwōj kōnono **Kajin Ṃajeļ (Marshallese)**, kwomaroñ bōk jerbal in jipañ in kajin ejjeļọk wōṇāān. Kwōn jouj im kalļọk ñan 888-249-6365.

KANSENOH: Ma komw **lokaiahn Pohnpei (Pohnpeian)**, mie sawas en mahsen, soh isepe, ong komwi. Menlau, eker 888-249-6365.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 888-249-6365 hodíilnih.

ध्यान दें: यदि तपाईं **नेपाली (Nepali)** भाषा बोल्नुहुन्छ भने, तपाईंको निम्ति निशुल्क भाषा सेवा उपलब्ध छ। कृपया 888-249-6365 मा कल गर्नुहोस्।

DETTIC: Na yi jam ë **Thuɔŋjäŋ (Dinka)** ke kuɔɔny de wɛë ï de thookyic abac atɔ alëu benë yï kony. Them ba cööt në 888-249-6365.

OBS: Hvis du snakker **norsk (Norwegian)**, kan du få gratis språkhjelp. Ring 888-249-6365.

AADACHT: Wann du **Deitsch Schwetze (Pennsylvanian Dutch)** kann, kannscht du frei Schprooch aushilfe griege. Ruf Nummer 888-249-6365.

توجه :اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره 888-249-6365 تماس بگیرید.

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ **(Punjabi)** ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਬਿਲਕੁਲ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ 888-249-6365 'ਤੇ ਕਾੱਲ ਕਰੋ।

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 888-249-6365.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 888-249-6365.

ATENȚIE: Dacă vorbiți **românește (Romanian)**, vi se pun la dispoziție, în mod gratuit, servicii de traducere. Vă rugăm să sunați la 888-249-6365.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русским (Russian)**. Позвоните по номеру 888-249-6365.

FAAALIGA: Afai e te tautala Faa-**Samoa (Samoan)**, o loo avanoa tautua mo fesoasoani tau gagana mo oe, e le totogia. Faamolemole telefoni le 888-249-6365.

POZOR: Ako govorite **hrvatski (Croatian)**, možete besplatno koristiti usluge prevodioca. Molimo nazovite 888-249-6365.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 888-249-6365.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 888-249-6365.

MAANDOORE: **(Fulani)**, to aɗa haala **Ingilisre**, walliinde wolde, caahu, e woodi ngam maaɗa. Kusu noddu 888-249-6365.

TAHADHARI: Kama unazungumza **Kiswahili (Swahili)**, huduma ya msaada wa lugha, bure, inapatikana. Tafadhali piga 888-249-6365.

ܙܘܗܪܐ: ܐܢ ܟܐ ܡܡܠܠܝܬܘܢ **ܣܘܪܝܬ** (Syriac)، ܒܡܫܟܚܬܐ ܕܚܕܡܬܐ ܕܗܝܪܬܐ ܕܠܫܢܐ، ܡܓܢܐܝܬ، ܐܝܬ ܦܬܝܚܐ ܠܘܬܟܘܢ.
ܩܪܘܢ ܥܠ ܡܢܝܢܐ 888-249-6365

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 888-249-6365.

ముఖ్య గమనిక : మీరు **తెలుగు (Telugu)** మాట్లాడేవారైతే, మీకు సహాయక సర్వీసులు ఉచితంగా లభిస్తాయి. దయచేసి ==== కి

కాల్ చెయ్యండి 888-249-6365

โปรดทราบ: หากคุณพูด**ภาษาไทย (Thai)** มีบริการความช่วยเหลือด้านภาษาให้แก่คุณโดยที่คุณไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด โปรดโทรศัพท์ถึงหมายเลข 888-249-6365.

FAKATOKANGA: Kapau oku ke lea **Fakatonga (Tongan)**, ‘oku iai pe ‘ae sevesi fakatonulea ‘e lava ma’u ta’etotongi atu ma’au. Kataki o tā ki he fika 888-249-6365.

NENENGENI: Ika ke aea kapasen **Chuuk (Chuukese),** ke tongeni angei aninisin eman chon awewe, ese kamo. Kosemochen kori 888-249-6365.

DİKKAT: **Türkçe (Türkçe)** konuşuyorsanız, dil yardım hizmetleri size ücretsiz olarak sunulmaktadır. Lütfen belirtilen numarayı arayınız: 888-249-6365.

УВАГА: Якщо ви розмовляєте **українською мовою (Ukrainian)**, у вас є можливість скористатися безкоштовними послугами перекладача. Зателефонуйте, будь ласка, за номером 888-249-6365.

توجہ درکار ہے :اگر آپ **اردو (Urdu)** زبان بولتے ہیں تو آپ کے لئےزبان معاون خدمات دستیاب ہے۔
برائے مہربانی کال کریں-888-249-6365

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 888-249-6365.

אויפמערקזאם :אויב איר רעדט **אידיש (Yiddish)** , זענען שפראך הילף סערוויסעס אוועילעבל פאר אייך פריי פון אפצאל.
ביטע רופט 888-249-6365.

AKIYESI: Ti o bá nsọ **Yorùbá (Yoruba)**, irànlọwọ lóri èdè, l’ọfẹ, wà fun ọ. Jọwọ pe 888-249-6365.

I attest that I have had the opportunity to receive my own copy of MedExpress’ Nondiscrimination Notice and Access to Communication Services, to read the Notice, and to ask questions in order to understand the Nondiscrimination Notice and Access to Communication Services.

______________________________ ______________________________

Patient’s Signature
(Parent/Guardian’s Signature if patient is under 18)

Date

Submit to AthenaNet

ATHENANETESIGNATURE

MedExpress

Telephone and Text Messaging Communications Consent

Date: _____

Patient First Name: _____

Patient Last Name: _____

DOB: _____

ID#: _____

I hereby consent to, and authorize MedExpress* to contact me via land-based or cellular telephone personal, artificial, or pre-recorded voice calls or short message service (SMS or Text)at the telephone numbers listed by me below for all purposes including, but not limited to, availability of seasonal vaccines or services, medical alerts, promotions, availability of test results, appointment information (where and when applicable), health tips, center closures due to unforeseen circumstances such as weather, and business matters including those relating to billing, collections and insurance.

This consent may be withdrawn by the patient at any time by any reasonable means, including but not limited to the following:

A) text message in response to text message received from MedExpress
B) via telephone by calling MedExpress at 888-249-6365 or
C) via "Contact Us" at www.medexpress.com

I certify that I am at least eighteen (18) years of age and may be contacted via any method set forth above at any of the following telephone numbers which have been assigned to me by the utility carrier providing communication services:

Cell Number _____

Land-line Telephone Number _____

_____ _____

Patient's Signature **Date**
(Parent/Guardian's Signature if patient is under 18)

Submit to AthenaNet

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