Patient: Violet Test (01/01/2001 - 25y), Male
Address: Sw Iowa Dr Tualatin, OR 97062
Phone: (309) 551-1333
Seen On: 01/29/2026

Seen At: DoseSpotClinic
Address: N Washington Ave Dune, NJ 57106
Phone: (302) 673-8492
Fax: (332) 241-0212
Provider:

Chief Complaint

10 Panel Rapid Drug Test
Source: Self

Vitals

Vitals:
Air Source: Room Air

Set 1:

History of Present Illness

No history of present illness data entered

PAST MEDICAL HISTORY

Allergies

No allergies entered

Medication

No medications entered

Immunization

No immunizations entered

Surgical History

No surgical history entered

Medical Condition

No past medical history entered

Preventative Med Notes

No preventativeMedNotes entered

Social History

No social history entered

Family History

No family history entered

Review of Systems

No review of systems data entered

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Exam

GU/Rectal (Male) (Abnormal) GU exam abnormal.

Musculoskeletal (Abnormal) Musculoskeletal exam abnormal.

Orders & Procedures

No procedures entered
No lab requests found
No lab reports found

Assessment/Plan

Diagnosis Name: Deficiency of other specified B group vitamins
Explanation: {{testing}}
Treatment: {{testing}}

Prescription

Written Date: 01/29/2026 06:00 PM
Name: IBUPROFEN (PROVIL) Tablet 200MG
Quantity: 2 - Refills: N/A
Route: - Dose Form: Tablet
Days Supply: 4
Directions: test

Written Date: 01/29/2026 06:00 PM
Name: GABAPENTIN (GABAPENTIN) Powder 100 %
Quantity: 11 - Refills: N/A
Route: - Dose Form: Powder
Days Supply: 1
Directions: HI

Written Date: 01/29/2026 06:00 PM
Name: GABAPENTIN (GABAPENTIN) Powder 100 %
Quantity: 10 - Refills: N/A
Route: - Dose Form: Powder
Days Supply: 1
Directions: HI

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Fax: (332) 241-0212
Provider:

Written Date: 01/29/2026 06:00 PM
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Quantity: 1 - Refills: N/A
Route: - Dose Form: Tablet
Days Supply: 5
Directions: jk

Written Date: 01/29/2026 06:00 PM
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Quantity: 11 - Refills: N/A
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Days Supply: 1
Directions: HI

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Signature

Addendums

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Explanation: {{testing}}
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Route: - Dose Form: Tablet
Days Supply: 5
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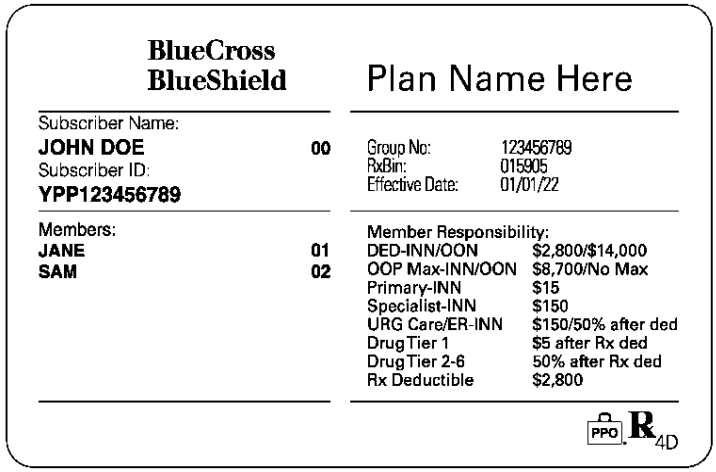
Days Supply: 1
Directions: HI

Signature

Addendums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BlueShield
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Subscriber ID:
YPP123456789
Members:
JANE
01
SAM
02
Group No:
123456789
RxBin:
015905
Effective Date:
01/01/22
Member Responsibility:
DED-INN/OON
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OOP Max-INN/OON
$8,700/No Max
Primary-INN
$15
Specialist-INN
$150
URG Care/ER-INN
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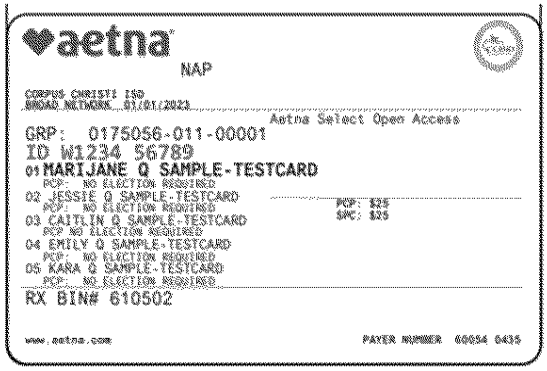
Drug Tier 1
$5 after Rx ded
Drug Tier 2-6
50% after Rx ded
Rx Deductible
$2,800
PPO
R
4D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NAP
CORPUS CHRISTI ISD
BROAD NETWORK 01/01/2023
Aetna Select Open Access
GRP: 0175056-011-00001
ID W1234 56789
01 MARIJANE Q SAMPLE-TESTCARD
PCP: NO ELECTION REQUIRED
02 JESSIE Q SAMPLE-TESTCARD
PCP: NO ELECTION REQUIRED
03 CAITLIN Q SAMPLE-TESTCARD
PCP NO ELECTION REQUIRED
04 EMILY Q SAMPLE-TESTCARD
PCP: NO ELECTION REQUIRED
05 KARA Q SAMPLE-TESTCARD
PCP: NO ELECTION REQUIRED
PCP: $25
SPC: $25
RX BIN# 610502
www.aetna.com
PAYER NUMBER 60054 0435

Recipient Information

To: TEST
Fax #: 12394230143

faxZERO.com
send a fax for free

Sender Information

From: m
Company: m
Email address: meghan.bowar@gmail.com (from 184.83.163.82)
Phone #: 6055553333
Sent on: Wednesday, October 11 2023 at 10:40 AM EDT

Patient Informed Consent, Notice of Disclaimer for Treatment, HIPAA

Informed Consent:

I authorize medical treatment as deemed necessary and appropriate by the physicians/nurse practitioners/ and or Physician Assistants of BreezeMed Urgent Care Centers, LLC and their employees participating in my care. I will provide all necessary information related to my healthcare needs that may affect the treatment I may receive, including but not limited to; past medical history, past and current medications, and current medical issues. I understand that if I do not provide all necessary information pertaining to my current health, that I will not hold the providers or other employees of BreezeMed Urgent Care Center, LLC, liable for any adverse reactions.

I acknowledge that no guarantees have been made regarding the affect of any treatments received any any medical condition.

With my consent, BreezeMed Urgent Care Centers, LLC, may use and disclose Protected Health Information (PHI), about me to carry out treatment, payment, and healthcare operations. Please refer to the BreezeMed Urgent Care Centers, LLC, Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, BreezeMed Urgent Care Centers, LLC may communicate with me via a secured electronic portalfor clinical items and via a secured electronic portal for financial matters. Additionally, I consent for BreezeMed Urgent Care Center(s), LLC to call my home or other designated location that I have provided access to and leave a message on voice mail or a text message in reference to any items that assist the practice in carrying out treatment, payment or healthcare operations, such as appointment reminders, insurance items or other such communications.

With my consent, BreezeMed Urgent Care Centers, LLC may contact me via Email and/or SMS for patient satisfaction/experience purposes.

Notice of Disclaimer:

This shall serve as notice that not all medical services are available or performed at BreezeMed Facilities. Services that are deemed necessary for the treatment or diagnosis of the patient and determined by our Providers as necessary or in the best interest of the management of the patient's condition and any services that may be required at other specialized facilities outside of any BreezeMed Urgent Care Center(s) location are not part of or billed from BreezeMed Urgent Care Centers, LLC.

Any emergency care that the attending physician or mid-level provider believes should, in the best interest of the patient, be provided by another Facility, will not be the financial responsibility of BreezeMed Urgent Care Centers, LLC. A referral to another specialty service or facility will be done in the best interest of the patient and BreezeMed Urgent Care Centers, LLC, has no financial interest in referral facilities or specialist referrals. Patients are expected to follow up with their primary care physician for continued medical management unless otherwise noted by the BreezeMed Urgent Care Center provider. BreezeMed Urgent Care Centers, LLC in no way acts or represents itself as a primary care provider.

The Patient understands that the list below is provided as an example of services outside the scope of practice for BreezeMed Urgent Care Centers, LLC, and does not include all of the services that may be considered to require specialized care beyond the treatment that is provided at the BreezeMed Facilities:

Life threatening events such as gunshot wounds, heart attacks, chest pain, headaches, strokes, pulmonary embolism, DVT, most shortness of breath, and serious infections, hospitalizations and treatment with other doctors, subspecialists, or providers at another healthcare organization.

Patients must agree to see a specialist physician when a medical problem is outside the scope of general medical care or for pre-existing conditions requiring a specialist as determined by our practitioners. Patients with complicated medical conditions (i.e. diabetes, heart failure, seizure disorder, cancer, etc.) will be required to continue to follow up with their specialist based on the recommendations from the specialist. The physicians at BreezeMed Urgent Care Centers will work in conjunction with the specialist to ensure quality care, follow up care and medicine refills when appropriate.

My signature below indicates that I have read and understand the above informed consent and disclaimer and I am consenting to treatment at BreezeMed Urgent Care Centers, LLC.

Patient Signature :

Date :

AUTHORIZATION AND CONSENT TO TREAT A MINOR:

I do hereby solemnly swear that I have legal custody of the aforementioned minor child.

Childs Name: Date of Birth:

I grant my authorization and consent for BreezeMed Urgent Center and its staff to administer treatment for any injuries or illnesses experienced by the minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize any and all professional emergency personnel to attend, transport, and treat the participant and to issue consent for any X-ray, anesthetic, medication, or other medical diagnosis, treatment, or care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, physician assistant, advanced registered nurse practitioner, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur.

It is understood that this authorization is given in advance of any such medical treatment. .

Parent or Legal Guardian's Signature

Date

Verification of Non-Pregnancy and Waiver Form

As a routing part of our practice, all women of childbearing age are asked about their pregnancy status and last menstrual period. We ask that you be truthful in answering these questions as our goal is to provide the safest and highest quality of medical care. If you are unsure whether you are pregnant, a urine pregnancy test will be made available to you.

[____] I certify that I am not pregnant. If a change of pregnancy is in question, I have been offered the opportunity to take a pregnancy test. I hereby assume any risk of harm and release BreezeMed Urgent Care, LLC from any and all liability if I am pregnant at the time of examination and treatment.

UIQ team – if possible can this pop up only when we have a female being registered over 9 years old?

HIPAA

I designate only specific persons to receive communication regarding my medical information.

Yes or No

UIQ Team - [if they mark yes here need a pop-up where they provide the name/info of the person along with the expiration of this authorization]

I authorize BreezeMed Urgent Care, LLC to file a claim with my insurance carrier for services rendered as well as release relevant medical records to the insurance carrier necessary to secure payment on my behalf from my payor.

I authorize my payor to directly pay BreezeMed Urgent Care, LLC for services provided to my dependent or myself. I understand that I am responsible for any part of the charges that are not covered / paid by my insurance company and that I will be billed directly for those services. I further understand that if I do not provide accurate and up to date information regarding my insurance coverage and my claim fails to be paid by my insurance carrier, I will be responsible for the denied claim.

I agree that if payment is not received by my insurance carrier or my personal funds for services provided by BreezeMed Urgent Care, LLC that my outstanding debt may be subject to additional Collection actions including but not limited to Collection Agency placement and/or legal action. I understand and agree that all costs of collection will be my responsibility.

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