OCOTILLO PRIMARY CARE

NEW PATIENT INFORMATION

PLEASE PRINT

Today's Date: _____

Patient Information:

LAST NAME _____ FIRST NAME _____ MI _____

Date of Birth __ __ / ____ / _____ (mm/dd/yyyy) Social Security No. _____ Sex: ☐ Male ☐ Female

Marital Status (check one): ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner ☐ Unknown

Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Cell Phone No. _____

Work Phone No. _____ Ext. _____

Billing Address (if different from mailing):

Address _____

City _____ State _____ Zip _____

☐ **OK to leave message at home** ☐ **OK to leave message on cell phone**

Previous PCP: _____ Tel. #: _____ Fax #: _____

E-mail _____ Language _____ Race (optional) _____

Responsible Party Information: (statements will be addressed to the responsible party)

Name _____

Address _____

City, State, Zip _____

Home Phone No. _____ Work Phone No. _____

Date of Birth: _ _ /_ _ / _ _ _ _ Social Security No.: _____

Sex: ☐ Male ☐ Female ☐ OK to leave message

Advance Directive (Living Will):

☐ HAS – has one will bring it at next office visit
☐ INP – in the process of making one
☐ WM – will make one

OCOTILLO PRIMARY CARE

Insurance Information: (**Primary Insurance)**

Insurance Name: _____

Address: _____

Phone No.: _____

Subscriber's Name: _____

Subscriber ID No.: _____ Group No.: _____

Patient relationship to Subscriber (check one): ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Subscriber's Date of Birth : _ _ / _ _ / _ _ _ _ Co-Payment Amount: _____

Insurance Information: **(Secondary Insurance)**

Insurance Name: _____

Address: _____

Phone No.: _____

Subscriber's Name : _____

Subscriber ID No.: _____ Group No. _____

Patient relationship to Subscriber (check one): ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Subscriber's Date of Birth: _ _ / _ _ / _ _ _ _ Co-Payment Amount : _____

Responsible Party's Employer Information:

Company: _____

Address _____ City _____

State _____ Zip _____ Phone No. _____

Emergency Contact #1

Name: _____
Phone: _____
Address: _____

Relationship: _____

Emergency Contact #2

Name: _____
Phone: _____
Address: _____

Relationship: _____

Pharmacies: **(Retail)**

Name: _____
Cross Streets: _____
Phone No.: _____
Fax No.: _____
Plan Type: _____

(Mail Order)

Name: _____
Address: _____
Phone No.:
Fax No.:
Plan Type: _____

OCOTILLO PRIMARY CARE

HEALTH HISTORY QUESTIONNAIRE

Name (Last, First, M.I) o Male o Female DOB:

Date of last physical :

Your Medical History

o Hay fever (allergies)
o Hearing loss
o Cataracts
o Other eye diseases _____

LUNGS
o Asthma
o COPD
o Lung nodule
o Other lung diseases _____

HEART
o HTN (high BP pressure)
o Heart attack (MI)
o Heart Failure
o Heart arrythmias
o Atrial Fibrillation
o High cholesterol or triglycerides
o Other heart disease _____

GASTRIC
Acid Reflux
o Crohn's disease
o Ulcerative Colitis
o IBS
o Hepatitis

BONE/MUSCULAR
o Osteoarthritis
o Rheumatoid arthritis
o Fibromyalgia
o Lupus
o Osteoporosis
o Osteopenia
o Other rheumatoid disorders _____

ENDOCRINE
o Diabetes
o Prediabetes
o Menopause
o Polycystic Ovarian Disorder
o Hypothyroidism (low thyroid)
o Other Endocrine disorders _____

KIDNEYS
o Kidney disease
o Kidney stones
o Enlarged Prostate
o Frequent Urinary infections
o Other Kidney diseases _____

NEUROLOGICAL
o Stroke/TIA (mini stroke)
o Migraine Headaches
o Other headaches
o Seizures o
o Dementia
o Parkinson's
o Other Neurological issues _____

SKIN
o Skin cancer
o Eczema
o Other skin issues

BLOOD
o Anemia
o Leukemia
o Lymphoma
o Blood clot
o Other blood disorders _____

OCOTILLO PRIMARY CARE

HEALTH HISTORY QUESTIONNAIRE

Name (Last, First, M.I)

ANY CANCER

_____

_____

PSYCHIATRIC

- o Depression
- o Anxiety
- o ADD
- o Bipolar
- o Eating disorders
- o Other Psych issues

_____

_____

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? o Yes o No

OCOTILLO PRIMARY CARE

HEALTH HISTORY QUESTIONNAIRE

Name (Last, First, M.I)

Immunizations

Immunization	**Date**	**Immunization**	**Date**
o Influenza		o Pneumovax	
o Shingles (Zostavax)		o Gardasil	
o Hepatitis B		o Tetanus	
o Hepatitis A		o dTap	
o MMR		o Any other Vaccines	

Screening Male and Female	**Date**		
o Stool Cards		o Normal	o Abnormal
o Colonoscopy		o Normal	o Abnormal
o Bone Density		o Normal	o Abnormal
Which imaging center: _____			

Screening Male	**Date**		
o PSA		o Normal	o Abnormal
o Testicular Exam		o Normal	o Abnormal

Screening Female	**Date**		
o Pap Smear		o Normal	o Abnormal
o Mammogram		o Normal	o Abnormal
Which imaging center: _____			

OCOTILLO PRIMARY CARE

HEALTH HISTORY QUESTIONNAIRE

Name (Last, First, M.I)

List all your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name of the Drug	Strength	Frequency Taken

Allergies to medications

Name of the Drug	Reaction you had

Allergies to all other agents including food

Name of agent or food	Reaction you had

OCOTILLO PRIMARY CARE

HEALTH HISTORY QUESTIONNAIRE

Name (Last, First, M.I)

Health Habits and Personal Safety

Exercise

- o Sedentary (No Exercise)
- o Mild exercise (climbing stairs, walk, golf)
- o Occasional vigorous (i.e. work or recreation, less than 4x/week for 30 mins.)
- o Regular vigorous (i.e. work or recreation, 4x/week for 30 mins)

Diet

Are you dieting?			o Yes	o No
If yes, are you on a physician prescribed medical diet?			o Yes	o No
Number of meals you eat in an average day? _____				
Rank salt intake	o High	o Medium	o Low	
Rank fat intake	o High	o Medium	o Low	

Caffeine

o None o Coffee o Cola o Tea

Number of cups/cans per day? _____

Alcohol

Do you drink alcohol?	o Yes	o No
If yes, what kind? _____		
How many drinks per week? _____		
Are you concerned about the amount you drink?	o Yes	o No
Have you considered stopping?	o Yes	o No
Have you ever experienced black outs?	o Yes	o No
Are you prone to "binge" drinking?	o Yes	o No
Do you drive after drinking?	o Yes	o No

Tobacco

Do you use tobacco? o Yes o No

- o Cigarettes-pks/day
- o Chew #/day _____
- o Pipe #/day
- o Cigars #/day _____
- o Number of years _____
- o Or year you quit _____

OCOTILLO PRIMARY CARE

HEALTH HISTORY QUESTIONNAIRE

Name (Last, First, M.I)

Drugs	Do you currently use recreational or street drugs?	o Yes	o No
	Have you ever given yourself street drugs with a needle?	o Yes	o No
Sex	Are you sexually active?	o Yes	o No
	If yes, are you trying for a pregnancy?	o Yes	o No
	If not trying for a pregnancy list contraceptive or bar rier method used: _____		
	Any discomfort with intercourse?	o Yes	o No
	Would you like to speak with your provider about y our risks of HIV/AIDS	o Yes	o No
Personal Safety	Do you live alone?	o Yes	o No
	Do you have frequent falls?	o Yes	o No
	Do you have vision or hearing loss?	o Yes	o No
	Do you have an advanced directive or living will?	o Yes	o No
	Would you like information for the preparation of these?	o Yes	o No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	o Yes	o No

Family Health History

	Age	Significant Health Problems		Age	Significant Health Problems
Father			**Children**		
			o Male o Female		
Mother			o Male o Female		
Siblings					
o Male o Female			o Male o Female		
o Male o Female			o Male o Female		
o Male o Female			**Maternal**		
			Grandmother		
o Male o Female			Grandfather		
			Paternal		
o Male o Female			Grandmother		
			Grandfather		

OCOTILLO PRIMARY CARE

HEALTH HISTORY QUESTIONNAIRE

Name (Last, First, M.I)

Mental Health

Is stress a major problem for you?	o Yes	o No
Do you feel depressed?	o Yes	o No
Do you panic when stressed?	o Yes	o No
Do you have problems with eating or your appetite?	o Yes	o No
Do you cry frequently?	o Yes	o No
Have you ever attempted suicide?	o Yes	o No
Have you ever seriously thought about hurting yourself?	o Yes	o No
Do you have trouble sleeping?	o Yes	o No
Have you ever been to a counselor?	o Yes	o No

OCOTILLO PRIMARY CARE

PATIENT CONSENT FORM

I consent to the use or disclosure of my protected health information by Ocotillo Primary Care for the purpose of my diagnosis, treatment, payment, or to conduct health care operations.

I understand the following:

- Diagnosis or treatment of me by Dr. Huma Rashid MD may be conditioned upon my consent as evidenced by my signature on this consent.
- I have the right to request a restriction on the uses of my protected health information, the physician's practice may not agree with the restrictions. However, if they do agree, the restriction is binding.
- I have the right to revoke this Consent, in writing, at any time; all future disclosures will subsequently cease. Any disclosures previously made from my prior consent, will not be affected by this revocation.
- Prior to signing this consent, I have the right to review Ocotillo Primary Care Notice of Privacy Practices & Financial Policy, which have been provided to me.

My "protected health information" means health information, including my demographics information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Ocotillo Primary Care has a Notice of Privacy Practices. The Notice of Privacy Practices describes how we may use and disclose protected health information about you. The Notice of Privacy Practices also describes patient rights under the law.

At any time, Ocotillo Primary Care may change the privacy practices as described in the Notice of Privacy Practices. I may contact the office to receive a revised copy.

This document is provided in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As a courtesy to our patients, we will file up to 2 insurance companies. Because we are Medicare Providers, we must first file to the insurance companies of all Medicare patients.

Medical Information Release-Direct Physician Payment Release

By Signing below, I authorize the release of all medical information necessary for filing my insurance claims. I also authorize my insurance company to make direct payment to my physician. A copy of this release may be used in place of the original. I understand that I am responsible for any balance due on my account after my insurance carriers(s) have paid, including my yearly deductibles, co-payments and coinsurance. I also understand that any overpayment will be refunded if authorized by my insurance company.

OCOTILLO PRIMARY CARE

FINANCIAL POLICY

It is your responsibility to be aware of your benefits. If you are unsure of your insurance benefits, you will need to contact your insurance carrier for clarification of your benefits.

This office will not change or re-code claims once they have been billed. This constitutes fraud and will not be done.

This office bills only for services performed by our providers. The laboratory and radiology will bill you or your insurance company for all labs and imaging studies performed. If you have any questions regarding your lab or radiology bill, please contact the laboratory/radiology directly or your insurance carrier.

All insurance information, including prior authorizations, referrals, and claim forms when necessary, must be provided at the time of service.

All co-pays, deductibles, and payments are due at the time of service, with co-pays being collected prior to you seeing the doctors. We accept cash, Visa, MasterCard, American Express and most debit cards displaying the Visa or MasterCard logo as forms of payments.

Any account left unpaid after 90 days will be turned over to an outside collection agency. Any collection fees necessary to collect this debt will be added to the outstanding balance. Please keep in mind that should your account go to our collection agency, any arrangements/payments will need to be made directly with/to the collection agency. In addition, once an account has been turned over to the collection agency, the patient may receive a letter of discharge from our practice.

We understand that situations arise that you must cancel your appointment. We do request a 24-hour notice of such cancellations.
Although we require you to fill out “update” on your first appointment of each New Year, it is your responsibility to notify our office immediately of any change of name, address, phone number, or insurance coverage.

I have read the above Financial Policy and understand and agree to these terms.

Patient/Guardian Signature _____ Date _____

Relationship to Patient _____

OCOTILLO PRIMARY CARE

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT NAME: _____

DATE OF BIRTH: ____/____/_____ **SOCIAL SECURITY NO:** _____

ADDRESS _____

CITY, STATE, ZIP _____

PHONE (HOME) _____ **(WORK)** _____

I hereby authorize _____

Tel. No._____ Fax No. _____

to send/release photocopies of my medical records to:

Ocotillo Primary Care
Dr Huma Rashid MD
2860 S Alma School Road Ste 33
85286
Phone: (480) 581-1200 Fax : (480) 581-1300

For the purpose of: _____

I authorize the release of photocopies of the following records in the possession or control of _____, its employees and/or agents. FOR THE PURPOSE HEREOF, "MEDICAL RECORDS" AND "X-RAY FILMS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S SECTION 36-611), CONFIDENTIAL ALCHOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2 ET SEQ.) AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

REQUESTED DATE(S): From _____ To _____

___ Complete Medical Records
___ Hospital Records
___ Consultation Reports
___ Laboratory Reports
___ Imaging Studies
___ Other _____

This consent will expire one (1) year after the signed date below. I have given my consent freely and voluntarily. I may revoke this authorization at any time provided I notify my PCP in writing to that effect. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

_____ _____
Patient Signature **Date**

_____ _____
Parent/Legally Authorized Representative **Relationship to Patient**

NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices describes how this practice may use and disclose your medical information, as well as your rights to access your medical information. If you still have questions, after reading this document, please contact our office HIPAA Privacy Officer.

The HIPAA Privacy Rule permits this practice to disclose your protected health information to carry out Treatment, Payment, or other Healthcare Operations. We may also disclose your health information for purposes required by law. HIPAA also grants you rights to access and control your protected health information. We must abide by the information outlined in the Notice of Privacy Practices. As HIPAA evolves, we reserve the right to update our Notice of Privacy Practices at any time. You also have the right to request a copy of our current Notice of Privacy Practices at any time.

USES AND DISCLOSURES

Your protected health information may be used and disclosed by your physician, our office staff and others who are involved in your care and treatment for treatment, payment, or other healthcare operations.

The following are common types of uses and disclosures your physician's office is authorized to make. While not a complete list of allowable disclosures, these examples will provide you with an understanding of acceptable disclosures made by this practice.

Treatment: Our practice will use and disclose your protected health information to provide, coordinate, or manage your health care. This includes the coordination or management of your health care with another provider. We will disclose protected health information to any other physicians who may be treating you. We may also disclose your protected health information to another physician or health care provider, such as a laboratory, who becomes involved in your treatment.

Health Care Operations: Our practice will use and disclose your protected health information in order to support our practice's business activities. Examples of health care operations include, but are not limited to, quality assessment, employee reviews, medical student training, licensing, fundraising, and conducting or arranging for other business activities. We may also provide you with information about treatment alternatives or other services that may be of interest to you. Please contact our Privacy Officer if you would prefer these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, in order to contact you for fundraising activities supported by our practice. Please contact our practice Privacy Officer if you do not wish to receive these materials.

Payment: Our practice will use and disclose your protected health information, to obtain payment for your services performed by us or by another provider. This may include disclosures to health insurance plans, insurance providers, and collection agencies. We strongly encourage you to be in contact with your insurance agency to determine the level of coverage your plan provides, as well as having an understanding of the financial figures you will be responsible for.

Business Associates: We will share your protected health information with third party "business associates" that perform various activities on our behalf. Examples of a Business Associate include, billing services, transcription services, and legal services. Prior to disclosing any protected health information with a business associate, we will establish a written contract that contains the terms that will protect the privacy of your information. Business Associates and their subcontractors must also comply with HIPAA Privacy and Security Regulations. We verify their understanding and responsibility.

HIPAA Permits and Requires Additional Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object. These situations include:

Disclosures Required By Law & Workers Compensation: We are permitted to use or disclose your protected health information to the extent that law requires the use or disclosure. We will maintain compliance with the law and will limit the disclosure to the minimum necessary. If required, you will be notified of any disclosure. We are permitted to disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Abuse or Neglect: We believe abuse or neglect to be a serious issue. We may disclose your protected health information to a public health authority authorized to receive reports of child abuse or neglect. We may also disclose your information if, in our best judgment, we believe you have been a victim of abuse, neglect or domestic violence. When disclosing protected health information in cases of abuse or neglect, we will follow applicable state and federal laws.

Public Health & Communicable Diseases: We are permitted to disclose your protected health information for public health purposes or to a public health authority that is permitted by law to collect or receive the information. Examples may include disclosure to prevent or controlling disease, or injury. We are permitted to disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease. We may disclose your information if said person may be at risk of contracting or spreading the disease or condition.

Research & Health Oversight: We are permitted to disclose your protected health information to researchers when an institutional review board that has reviewed the research proposal, as well as established protocols to ensure the privacy of your information has approved their research. We are permitted to disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Legal Proceedings: We are permitted to disclose protected health information in connection with any judicial or administrative proceeding, subpoena, or in responding to a court order or tribunal.

Law Enforcement: We may also disclose protected health information, under lawful conditions to law enforcement. Permitted law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency associated with a crime.

Organ Donation, Coroners, & Funeral Directors: We are permitted to disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties. Disclose may be made in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Military Activity and National Security: We are permitted to use or disclose protected health information of individuals who are Armed Forces personnel under the following circumstances: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We are also permitted to disclose your information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Written Authorization

Unless required by law, your written authorization will be required for all other uses and disclosures of your protected health information. You may revoke authorization at any time, by written request. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Note: We are unable to undo any disclosures previously made with your authorization.

Opportunity to Agree or Object

The following are examples of instances where we may use and disclose your protected health information; however, you have the opportunity to agree or object to the use or disclosure of all or part of the disclosure. If you are not present or able to agree or object to the use or disclosure, then we may, using professional judgment, determine whether the disclosure is in your best interest.

- Unless you object, we may disclose to a member of your family, a relative, or a close friend, your protected health information that directly relates to that person's involvement in your health care. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your care.

- Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition, and your religious affiliation. This information, except religious affiliation, will be disclosed to individuals who ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

- Should we choose to participate in Marketing or Fundraising Efforts we will first provide you with an opportunity to Opt-Out of such Marketing or Fundraising Materials. You will be made aware if our Marketing or Fundraising Efforts will include our practice receiving financial remuneration. You will have the opportunity to opt-out of our current marketing or fundraising efforts, or to opt-out of all future marketing or fundraising efforts. Because we may receive financial remuneration, you will be provided with a separate form to authorize or opt-out of our efforts.

Patient Rights

You have the right to inspect and copy your protected health information. As long as we are maintaining your protected health information, you may inspect and obtain a copy of your protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician uses for health care decisions. As permitted by federal or state law, we may charge you a "*reasonable copy fee*" for a copy of your records.

However, federal law prohibits you from inspecting or copying psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access. You may have the right to appeal the denial. Please contact our Privacy Officer if you have questions.

You have the right to request a restriction of your protected health information. You may ask us not to use or disclose any part of your protected health information 1) for the purposes of treatment, healthcare operations, or payment 2) to family members or friends who may be involved in your care or

3) for notification purposes as described in this Notice of Privacy Practices. Your written request must state the specific restriction requested and to whom you want the restriction to apply. We are NOT required to agree to a restriction that you may request, unless your account has been paid in full. However, if your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction other than emergency treatment situations.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We strive to accommodate all reasonable requests. As a condition, we may ask for additional information, such as payment, alternative address, or additional contact information. We will not request an explanation for the request. Notify our Privacy Officer in writing for all requests.

You have the right to receive an accounting of certain disclosures made. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You may request an amendment of your protected health information in a designated record set for so long as we maintain this information. We may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement and we may provide you with a copy of any rebuttal. Please contact our Privacy Officer if you have questions.

If we maintain an electronic copy of your Medical Records, then you have the right to receive an electronic copy of your Medical Records.

You have the right to obtain a hard copy of this Notice of Privacy Practices.

Complaints

Should you believe your privacy rights have been violated, and you wish to file a complaint, you may complain to us or to the Secretary of Health and Human Services.

To file a Complaint with us, you may contact our Privacy Officer. Protecting your private health information is essential to us, and we will not retaliate against you should you file a complaint.

Complaints filed with the Secretary of Health and Human Services should be directed to your regional office. A directory of regional offices can be found by visiting the following website: http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html

OCOTILLO PRIMARY CARE

HIPAA Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

Patient Name: _____ **Date of Birth:** _____/____/_____

Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, and/or health insurance payers as is necessary and appropriate for your care. Patient hereby waives his/her confidentiality rights should collection action become necessary. You have the right to request restrictions in the use of your protected health information and to request changes in certain policies used within the office. However, we are not obliged to alter internal policies to conform to your request.

My protected health information can be released to the following people:

Name: _____ **Relationship:** _____ **Phone:** _____

Address: _____

Name: _____ **Relationship:** _____ **Phone:** _____

Address: _____

Name: _____ **Relationship:** _____ **Phone:** _____

Address: _____

HIV/AIDS/STD: This form authorizes release of medical information including HIV related. Confidential HIV-related information is any information indicating that a person has had an HIV related test, or has an HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV. **I DO** ____**DO NOT** _____consent to the release of any positive or negative test result for AIDS/HIV or STD infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** _____ **Date:** _____

With this consent, I give Ocotillo Primary Care permission to call my home or other alternative location provided in the patient information form and leave a detailed message on voice mail or in person with someone listed above in reference to the items that assist the Practice in carrying out treatment, payment, and health care operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care such as lab and test results.

_____ _____

Patient Signature (or parent, guardian or legal representative) **Date (expires in 1 year)**

OCOTILLO PRIMARY CARE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ _____

Patient Signature (or parent, guardian or legal representative) **Date**

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please specify)

_____

_____