PATIENT INFORMATION

Personal Man ☐ Woman ☐ Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Widowed ☐ Separated ☐

Asian ☐ Black ☐ Hispanic ☐ Native American ☐ White ☐ Multiethnic ☐ Preferred Language _____

Patient Name _____ Birth date _____

Street _____

City _____ State _____ Zip code _____

Social Security Number _____ Pharmacy Phone ( ) _____

Phone ( ) _____ Cell Phone ( ) _____

Responsible for bills: Self ☐ or name and relationship _____

Address (if different from above) _____

In an EMERGENCY notify _____ Phone ( ) _____

Employment Are you employed? YES ☐ NO ☐ RETIRED ☐ Toxic exposures? **YES NO**

Type of work you do or did _____

Current Employer _____

Address _____ Work Number ( ) _____

Insurance Medicare ☐ HMO ☐ PPO ☐ Traditional ☐ Public Aid ☐ None ☐

	Primary Insurance	**Secondary Insurance**
Company		
Address Phone		
Group Number		
Policy Number		

Treatment and payment agreement

I authorize examination and treatment for this and all following physician visits.
I authorize to release any medical information necessary to process insurance billings.
I authorize payment and assignment of insurance benefits to this office.
I have received a "Welcome to our Practice" packet.
I understand I am personally responsible for all charges copays and deductibles not covered by my insurance and/or for providing correct Patient Information. I authorize a photocopy of this statement to serve as an original.

Signature: _____ Date: _____

FAMILY PRACTICE & MIDWIFERY CARE

Consent for Release of Medical Information

Patient:_____ **DOB:**_____ **Address:**_____

Release From:_____ Release To:_____

Phone:_____ Fax:_____ Phone:_____ Fax:_____

Address:_____ Address:_____

_____ _____

Records Requested: **X-ray Report(s)** ☐ **Copy of Films/Imaging Study** ☐

Laboratory Reports ☐ **Diagnostic Studies** ☐

Progress Notes ☐ **Consultation(s)** ☐

All ☐ **Other** ☐ _____

Dates of records requested: From _____ to _____

Records shall be used for: Acute care ☐ Continuation of care ☐ Second opinion ☐

Please deliver records by: Fax ☐ U.S. Mail ☐ Other ☐ _____

This consent is valid for 30 days from the date signed.

I hereby authorize "Release From" as stated above, to deliver to "Release To" as stated above the medical records as defined above by my _____ (1-9) check marks. I, the patient or patient's representative have the legal right to inspect, copy and request delivery as specified of this Protected Health Information within the next 30 days in accordance with Public Law 104-191 (HIPAA-1996). I accept the responsibility for any fees that may be associated with this request.

Patient Signature:_____ Date:_____

Patient's Legal Representative:_____ Date:_____

Printed name of Legal Representative:_____

Notice of Privacy Practices

Your medical record is called Protected Health Information (PHI) under Federal Law 104-191 - The Health Insurance & Patient Accountability Act of 1996 (HIPAA-1996) . As of March 1, 2003 all medical practices are required by law to notify you of your privacy rights, and we will post any changes to these rights on the examination room bulletin board.

Use of Protected Health Information with your authorization.

By signing the authorization to be treated on our "Patient Registration" you agree that your PHI may be used or disclosed by our office staff for the purpose of Treatment, Payment, health care Operations (TPO), or judicial proceedings and that we call you by name in our waiting room. You also may have authorized a release of your PHI by a written statement from your employer, attorney, or insurance carrier. Your PHI may be required for our business records, our computer/billing system, pharmacies, other physicians, laboratories, your employer, or therapists before they will process our request for TPO. You may revoke any authorization , provided we receive it in writing.

What we mean by:

Treatment - other treating personnel, pharmacists, testing facilities.

Payment - for billing and electronic records your diagnosis and treatment dates are disclosed.

Health care operations - compliance audits, public health, office administration or contractual requests.

Judicial proceedings - any court orders, subpoenas, legal audits, or lawful demand.

Use of Your Protected Health Information without your authorization.

Your PHI may be disclosed as required by law, for public health activities, victims of abuse, health and oversight proceedings, law enforcement, judicial and administrative proceedings, funeral homes, research purposes, or specialized governmental functions. In such cases we will release information only if we have received a written request with documentation that the PHI disclosed is expressly authorized by the order.

What we mean by:

Law - if the law requires we will notify you of such disclosure.

Public health activities - FDA, communicable disease, work related injury, instances of abuse or neglect.

Health and oversight - a legal oversight agency for any investigation in which you are not involved.

Law enforcement - properly issued subpoena, warrant, court order, or legal summons.

Disclosure of Protected Health Information requiring your authorization.

Our office does not E-mail or fax information, unless you request it in writing.
We will not disclose your PHI to family members, personal representatives or guardians unless you request it.
In an emergency we may disclose only relevant information if in our professional judgment it is in your best interest.
You may request that we modify or do not use or disclose any or part of your PHI in order to carry out treatment, payment or heath care operations. This right to restrict does not extend to disclosures as required by law. You may inspect or request a copy of your PHI (in writing) to be sent to you or an alternative location or by alternative means. Our office has the right to charge a fee to cover supplies, labor costs, and postage. There may be an additional charge to prepare a summary or explanation of the records. The records shall be sent within 30 days from receipt of the written request and payment. If these copies can not be sent within 30 days we will notify you.

I authorize the following people to have unlimited access to my PHI (any and all of my medical information):

Print Name	Relationship	Date
Print Name	Relationship	Date

I have reviewed this notice of Privacy Practices and understand the address location and contact information for: the complete HIPAA-1996, and the Privacy Officer for this office is available upon my request, and also that compliance complaints can be made to the Department of Heath and Human Services.

Print Name	Signature	Date