OCEANA
COMMUNITY HEALTH, INC.

Empowering health.
Empowering lives.

NEW PATIENT INFORMATION

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Marital Status: _____ **DOB:** _____ **SS#**: _____ - ___ - _____

Height: _____ **Weight**: _____ **Gender**: Male / Female

RACE: Caucasian African American Asian Hispanic American Indian/Alaskan National Multi-Racial

ETHNICITY: Hispanic/Latino Not Hispanic or Latino Refuse to Report

Address: _____ **Apt. #**: _____

City: _____ **State:** _____ **Zip Code:** _____

Cell Phone: _____ **E-mail:** _____

Work Status: _____ **Who Referred You?** _____

EMERGENCY CONTACT / SPOUSE INFORMATION

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Address: _____ **City:** _____ **State:** _____

Phone Number: (_____)-_____ **Relationship:** _____

REQUIRED (WHERE DO YOU WANT MEDICATIONS SENT)

Pharmacy: _____ **Phone Number:** _____

Address: _____ **City:** _____ **State**: _____

INSURANCE COMPANY INFORMATION

Name of Primary Insurance: _____

Name of Secondary Insurance: _____

* If we **DO** participate with your insurance plan, we will ask you to pay any co-payment, deductible or co-insurance amounts at the time of service and we will submit a claim to your insurance company.
* If we **DO NOT** participate with your insurance plan, we will ask you to pay in full at the time of service and as a courtesy submit a claim to your insurance company.
* If you **DO NOT** present any insurance cards, we will presume you **DO NOT** have any insurance coverage and payment in full will be due at the time of service.

****** I understand that I am responsible for all charges to me, including the balance remaining after payment by possible insurance benefits.**

Signature: _____ **Date**: _____

POLICY HOLDER INFORMATION (**THE PERSON WHO PAYS INSURANCE PREMIUM**)

First Name: _____ **Middle Initial:** _____ **Last Name** :_____

Employer:_____

Phone Number: (_____)-_____ **DOB**: _____ **SS#:** _____ - ___ - _____

PLEASE LIST PREVIOUS PCP

Name: _____

Phone Number: _____

Address: _____

_____

ALLERGY LIST

ALLERGEN	**REACTION** (What happened?)

Please circle **YES** or **NO** if you have or have had any of the following conditions:

Heart conditions	**YES** or **NO**	Stroke or TIA	**YES** or **NO**
High Blood Pressure	**YES** or **NO**	Thyroid Problems	**YES** or **NO**
Radiation or Chemotherapy	**YES** or **NO**	Tuberculosis	**YES** or **NO**
Anemia/Blood Problems	**YES** or **NO**	Ulcers / Colitis	**YES** or **NO**
Arthritis	**YES** or **NO**	Neurological Disorders	**YES** or **NO**
Do you wear glasses or contacts?	**YES** or **NO**	Glaucoma or Eye Problems	**YES** or **NO**
Do you smoke?	**YES** or **NO**	Asthma	**YES** or **NO**
Do you drink alcohol?	**YES** or **NO**	Diabetes	**YES** or **NO**
Cancers	**YES** or **NO**	Kidney Problems	**YES** or **NO**
Rheumatic Fever	**YES** or **NO**	Depression	**YES** or **NO**
Sinus Problems / Seasonal Allergies	**YES** or **NO**	Anxiety	**YES** or **NO**
Weight Loss	**YES** or **NO**	Liver Problems / Hepatitis	**YES** or **NO**
Reaction to Anesthesia	**YES** or **NO**	Breathing Problems	**YES** or **NO**
Leg Swelling	**YES** or **NO**	Ever been Baker Acted?	**YES** or **NO**

PLEASE LIST ANY MEDICAL CONDITIONS YOU HAVE THAT ARE NOT LISTED ABOVE:

_____

_____

_____

_____

_____

PREVIOUS SURGERIES

SURGERY	DATE

MEDICATION LIST: PLEASE INCLUDE VITAMINS AND OTC MEDICATIONS

NAME OF MEDICATION	DOSAGE	FREQUENCY	ROUTE

Have you ever had the following tests / procedures?

Procedure	YES	NO	Date	Procedure	YES	NO	Date
Tetanus Shot				Echocardiogram (ECHO)			
Flu Shot				Stress Test			
Shingles Shot				Bone Density Test			
Pneumococcal Shot				Colonoscopy/Endoscopy			
Mammogram				Pap Smear			
Pulmonary Function Test				Other _____			

FAMILY HISTORY

	Living	Deceased	Age of Death	Cause of Death
Mother-	_____	_____	_____	_____
Father-	_____	_____	_____	_____
Child-	_____	_____	_____	_____
Child-	_____	_____	_____	_____
Child-	_____	_____	_____	_____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

[45 CFR 164.520]

Background

The HIPPA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and most of their health care providers, as well as to be informed of their privacy rights with respect to their most personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

How the Rule Works

General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices.

The Privacy Rule does not require the following covered entities to develop a notice:

- Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR 164.500(b)(1).
- A correctional institute that is a covered entity (e.g. , that has a covered health care provider component).
- A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information. See 45 CFR 164.520(a).

Content of the Notice. Covered entities are required to provide a notice in *plain language* that describes:

- How the covered entity may use and disclose protected health information about an individual.
- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.
- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.
- Whom individuals can contact for further information about the covered entity's privacy policies.

The notice must include an effective date. See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice. A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals.

Providing the Notice.

- A covered entity must make its notice available to any person who asks for it.
- A covered entity must prominently post and make available its notice on any web site it maintains that provides information about its customer services or benefits.
- Health Plans must also:
  - Provide the notice to individuals then covered by the plan no later than April 14, 2003 (April 14, 2004, for small health plans) and to new enrollees at the time of enrollment.
  - Provide a revised notice to individuals then covered by the plan within 60 days of a material revision.
  - Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years.
- Covered Direct Treatment Providers must also:
  - Provide the notice to the individual no later than the date of first service delivery (after the April 14, 2003 compliance date of the Privacy Rule) and, except in an emergency treatment situation, make a good faith effort to obtain the individual's written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.
  - When first service delivery to an individual is provided over the Internet, through e-mail, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual's first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice.

- In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgment from individuals.
- Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the provider's office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.

- A covered entity may e-mail the notice to an individual if the individual agrees to receive an electronic notice. See 45 CFR 164.520(c) for the specific requirements for providing the notice.

Organizational Options.

- Any covered entity including a hybrid entity or an affiliated covered entity, may choose to develop more that one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.

Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must described the covered entities and the service delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities. See 45 CFR 164.520(d).

By signing this document, I acknowledge that I have received a copy of **Oceana Community Health's** Notice of Privacy Practices.

Signature: _____ Date: _____

Printed Name: _____

For Office Use Only

Date Acknowledgement Received: _____

OR

Reason Acknowledgement was not obtained: _____

_____

Signature: _____ Date: _____

Printed Name: _____

Please list anyone who you authorize to view or discuss your records:
(If none, please write none on line 1)

_____

_____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize Oceana Community Health, Inc. and its entities, its officers or agents to permit inspection, copying and/or release of health information complied in the ordinary course of business in connection with the following:

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

Address: _____ **SS#**: _____

_____ **Phone #:** _____

I further understand and acknowledge that in complying with my request for release, such disclosure will require

Oceana Community Health, Inc. to disclose, as provided under applicable federal law, Protected Health Information, as defined in *42 C.F.R §160 et seg*.

Information to be disclosed:

_____ Complete Health Record
_____ Discharge Summary
_____ History and Physical Exam
_____ Consultation Reports
_____ Progress Notes
_____ Radiology Reports
_____ Abstract/Pertinent Information
_____ Emergency Department Record
_____ Laboratory Tests
_____ Other (Please Specify) _____

I understand this may include information relating to the following UNLESS EXPRESSLY EXCLUDED BY CHECKIN THE FOLLOWING BELOW:

_____ Acquired Immunodeficiency Syndrome (AIDS)
_____ Human Immunodeficiency Virus (HIV)
_____ Psychiatric Care (Behavioral Health)[1]
_____ Treatment for Alcohol and Drug Abuse[2]
_____ Genetic Testing
_____ Sexually Transmitted Diseases (STDs)

THIS INFORMATION IS TO BE DISCLOSED TO: PHONE # **(855) 479-4404** -- FAX # **(772) 255-3565**
MAILING ADDRESS: 2828 S Seacrest Blvd, Suite 208, Boynton Beach, FL 33435

- I understand there may be a charge for copying my records as provided under federal and state law.
- I understand this authorization may ne revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked in writing, this authorization will expire 60 days from the date of execution. A photocopy or FAX of this document is valid as the original.
- The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosures of the above information to the extent indicated and authorized herein:

Signature of Patient/Legal Representative: _____ Date: _____

Witness: _____ Date: _____

The patient information requested above may not be further disclosed to any party under any circumstances except with the patient's written consent or as otherwise permitted by law. The information may not be used except for the need specified above. [1]Except psychotherapy notes as provided under federal and state laws [2]PROHIBITION ON REDISCLOSURE: This information has been disclosed from records whose Confidentiality id protected by federal and state law, Federal Regulations (42 CPR. Part 2) prohibit the receiver of these records from making any further disclosure of this information except with the specific written consent of the person who it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose.