

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information in the recruitment and/or conduction of clinical research studies in which you may qualify as a subject and subsequently benefit thereof. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

We may use or disclose your protected health information in the following situations without your authorization. Those situations include: as Required By Law, Public Health Issues as required by law, Communicable Diseases; Health Oversight Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization, or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information.

This means you may ask us not to use or disclose any part of your protected health information for the purposes to treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name: _____

Signature: _____ Date: _____

DEMOGRAPHIC INFORMATION

Patient Name: _____ Date of Birth: _____ Sex: _____

Mailing Address: _____

City/State/ Zip Code: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email Address: _____

Marital Status: _____

Social Security Number: _____

Race: White ___ Black ___ Hispanic ___ Other: _____ Ethnicity: _____

Occupation: _____

Employer Name _____

Language: English ___ Spanish ___ Bosnian ___ Other _____ ↑

<p align="center">OK to enable Web Patient Portal? (Get labs, records, Visit Summaries; send messages to nurses/staff) <i>Email address required</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Appointment Reminder preference: (select one) <input type="checkbox"/> Phone call <input type="checkbox"/> Morning (9am) <input type="checkbox"/> Afternoon (3pm) <input type="checkbox"/> Evening (6pm) <input type="checkbox"/> SMS Text message <input type="checkbox"/> Email</p>

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____

Phone Number: _____

Relationship to Patient: _____

<p align="center">OK to discuss Medical Info with Emergency Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Primary Care Physician (PCP): _____

Phone: _____

GUARANTOR/RESPONSIBLE PARTY

Name _____

Guarantor Address: _____

PRIMARY INSURANCE INFORMATION

Insurance: _____

Insured's Name: _____

Insured's Date of Birth: _____

Subscriber Number: _____

Group Number: _____

Insured's relationship to patient: _____

Copay: _____

SECONDARY INSURANCE INFORMATION

Insurance: _____

Insured's Name: _____

Insured's Date of Birth: _____

Subscriber Number: _____

Group Number: _____

Insured's relationship to patient: _____

PHARMACY INFORMATION

Pharmacy Name/Location: _____

Pharmacy Number: _____

I attest that the above information is correct and have read and understand the policies of Endocrinology, Diabetes & Metabolism, Consultants, P.C., and accept my responsibility as stated in those policies

Patient Signature (18 and under requires signature of Parent/Guardian)

DATE

Patient History Form

Patient Name: _____

Date of Birth: ____/____/____

Referring Physician: _____

Date of Visit: ____/____/____

Patient Medical History		
Diabetes.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
High blood pressure...	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Stroke	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Heart disease.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Arthritis/Gout	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Kidney stones	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Thyroid problems.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Convulsions.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Bleeding tendency....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Venereal disease.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Hereditary defects.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Acute infections.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Medications	
1.	_____
2.	_____
3.	_____
4.	_____
5.	_____
6.	_____
7.	_____
8.	_____
9.	_____
10.	_____

Previous Hospitalizations/Surgeries/ Serious Injuries	When
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History			
Disorder	Yes	No	Family Members
Diabetes	_____	_____	_____
Heart Disease	_____	_____	_____
Cancer	_____	_____	_____
Stroke	_____	_____	_____
Thyroid Disease	_____	_____	_____
High Blood Pressure	_____	_____	_____

Patient Social History					
Occupation: _____					
Marital Status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
Use of alcohol	<input type="checkbox"/> Never	<input type="checkbox"/> Rarely	<input type="checkbox"/> Moderate	<input type="checkbox"/> Daily	
Use of tobacco	<input type="checkbox"/> Never	<input type="checkbox"/> Previously, but quit		<input type="checkbox"/> Current packs/day _____	
Use of drugs	<input type="checkbox"/> Never	<input type="checkbox"/> Yes, type/frequency _____			

Patient Name: _____

Date of Birth: ____/____/____

Constitutional Symptoms		
Good general health lately.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Recent change in weight.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Fever.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Fatigue.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Headaches.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Eyes		
Eye disease or injury.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Blurred or double vision.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Glaucoma.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Ear/Nose/Throat/Mouth		
Hearing loss or ringing.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Earaches or drainage.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Chronic sinus problems.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Nose bleeds.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Mouth sores.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Bleeding gums.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Bad breath or bad taste.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Sore throat or voice change.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Swollen glands in neck.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Cardiovascular		
Heart trouble.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Chest pain.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Palpitation.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Shortness of breath with exertion.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Swelling of feet/ankles.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Respiratory		
Chronic or frequent coughs.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Spitting up blood.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Shortness of breath.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Asthma or wheezing.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Gastrointestinal		
Loss of appetite.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Change in bowel movements.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Nausea or vomiting.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Frequent diarrhea.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Constipation.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Rectal bleeding or blood in stool.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Abdominal pain or heartburn.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Peptic ulcer.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Reflux disease.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Musculoskeletal		
Joint pain.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Joint stiffness or swelling.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Weakness of muscles or joints.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Muscle cramps/pain.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Backpain.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Cold extremities.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Genitourinary		
Frequent urination.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Burning or painful urination.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Blood in urine.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Kidney stones.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Sexual difficulty.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Male-testicle pain or mass.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Genitourinary (Female)		
Female-pain with periods.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Female-irregular periods.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Female-vaginal discharge.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Female-# of pregnancies_____ # of miscarriages_____		
Female-date of last pap smear_____/_____/_____		
Female-age of menarche_____		
Female-age of first pregnancy_____/_____/_____		
Female-last menstrual period_____/_____/_____		
Integumentary (Skin, Breast)		
Rash or itching.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Change in skin color.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Change in hair or nails.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Varicose veins.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Breast pain.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Breast lump.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Breast discharge.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Neurological		
Frequent or recurring headaches.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Light headed or dizzy.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Convulsions or seizures.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Numbness or tingling sensation.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Tremors.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Paralysis.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Stroke.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Head injury.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Psychiatric		
Depression.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Insomnia.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Nervousness.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Memory loss or confusion.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Endocrine		
Glandular or hormone problem.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Thyroid disease.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Diabetes.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Excessive thirst or urination.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Heat or cold intolerance.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Skin becoming drier.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Change in ring, hat or glove size.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Hematologic/Lymphatic		
Slow to heal after cuts.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Bleeding or bruising tendency.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Anemia.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Swollen glands.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Allergic/Immunologic		
History of skin reaction or adverse reaction to:		
Penicillin or other antibiotics.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Morphine, Demerol or other narcotics.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Aspirin or other pain medications.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Tetanus antitoxin or other serums.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Allergy to other medications:_____		
Known food allergy:_____		

Additional Comments: _____