**KARI HALLORAN, MEd, RD, LDN**

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**PATIENT DEMOGRAPHIC SHEET**

**PATIENT INFORMATION**: DATE: \_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you referred by a doctor? Yes No

If yes, doctor’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, where did you hear about my services? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would you like to discuss today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH INSURANCE INFORMATION:**

**Primary Insurance Carrier**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Insurance ID#/Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Insurance Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Copayment Amount:$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is patient subscriber to this insurance?: Yes No

If NO, name of the person who subscribes to the insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s relationship to subscriber:\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance Carrier**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Insurance ID#/Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient’s Insurance Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is patient subscriber to this insurance?: Yes No

If NO, name of the person who subscribes to the insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s relationship to subscriber:\_\_\_\_\_\_\_\_\_\_\_\_

**2 Locations to serve you:**

**Inside Fritz Physical Therapy Inside Erb Physical Therapy**

**918 Washington Avenue 153 E. Pike Street**

**Carnegie PA 15106 Canonsburg PA 15317**

**Kari Halloran MEd, RD, LDN**

**Notice of Privacy Practices**

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

By law, Kari Halloran MEd, RD, LDN is required to protect the privacy of your protected health information. Kari Halloran MEd, RD, LDN is also required to give you this notice to tell you how Kari Halloran MEd, RD, LDN may use and give out ("disclose") your protected health information held by Kari Halloran MEd, RD, LDN.

Kari Halloran MEd, RD, LDN **must** use and give out your protected health information to provide information:

• To you or someone who has the legal right to act for you (your personal representative),

• To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected, and

• Where required by law.

Kari Halloran MEd, RD, LDN may use or give out your protected health information for the following purposes under limited circumstances:

To State and other Federal agencies that have the legal right to receive Kari Halloran MEd, RD, LDN, data (such as to make sure Kari Halloran MEd, RD, LDN is making proper payments and to assist Federal/State Medicaid programs),

• For public health activities (such as reporting disease outbreaks),

• For government health care oversight activities (such as fraud and abuse investigations),

• For judicial and administrative proceedings (such as in response to a court order),

• For law enforcement purposes (such as providing limited information to locate a missing person),

• For research studies that meet all privacy law requirements (such as research related to the prevention of disease or disability),

• To avoid a serious and imminent threat to your or another’s health or safety,

• To contact you about new or changed benefits under Kari Halloran MEd, RD, LDN, and

• To create a collection of information that can no longer be traced back to you.

• To doctors, nurses and other professionals involved in your care to inform them of relevant response(s) to medical nutrition therapy.

• To insurance company(s) or other parties identified by you for purposes of payment of services. Information will be used to prepare invoices, bills, statements, etc.

• To individuals identified by you as being approved to view, hear, discuss private health information regarding billing, care given, etc.

• We may use your information to contact you in an effort to schedule appointments, discuss billing issues and inform you of relevant services which may be of interest to you. You may request a specific avenue of contact (i.e. email, etc.)

By law, Kari Halloran MEd, RD, LDN must have your written permission (an "authorization") to use or give out your protected health information for any purpose that isn't set out in this notice. You may take back ("revoke") your written permission at any time, except if Kari Halloran MEd, RD, LDN has already acted based on your permission.

By law, you have the right to:

• See and get a copy of your protected health information held by Kari Halloran MEd, RD, LDN.

• Have your protected health information amended if you believe that it is wrong or if information is missing, and Kari Halloran MEd, RD, LDN agrees. If Kari Halloran MEd, RD, LDN disagrees, you may have a statement of your disagreement added to your protected health information.

• Get a listing of those getting your protected health information from Kari Halloran MEd, RD, LDN. The listing won't cover your protected health information that was given to you or your personal representative, that was given out to pay for your health care or for Kari Halloran MEd, RD, LDN operations, or that was given out for law enforcement purposes.

• Ask Kari Halloran MEd, RD, LDN to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).

• Ask Kari Halloran MEd, RD, LDN to limit how your protected health information is used and given out to pay your claims and run the Kari Halloran MEd, RD, LDN program. Please note that Kari Halloran MEd, RD, LDN may not be able to agree to your request.

• Get a separate paper copy of this notice.

You may file a complaint with the Secretary of the Department of Health and Human Services. Visit www.hhs.gov/ocr/hipaa or contact the Office for Civil Rights at 1-866-627-7748. TTY users should call 1-800-537-7697.

By law, Kari Halloran MEd, RD, LDN is required to follow the terms in this privacy notice. Kari Halloran MEd, RD, LDN has the right to change the way your protected health information is used and given out. If Kari Halloran MEd, RD, LDN makes any changes to the way your protected health information is used and given out, you will get a new notice by mail within 60 days of the change.

Patient (Guardian) Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Kari Halloran, MEd, RD, LDN**

**Consent to Bill/Treat**

**Financial Responsibility**

I must have your authorization to submit a claim for payment for services covered under your insurance policy to your insurance carrier. Please initial and sign below.

I, \_\_\_\_\_\_\_\_\_\_\_, authorize Kari Halloran, MEd, RD, LDN to submit a claim(s) to my insurance carrier or its intermediaries for all services rendered and authorized and direct my insurance carrier or its intermediaries to issue payment(s) directly to Kari Halloran, MEd, RD, LDN.

I, \_\_\_\_\_\_\_\_\_\_, understand that I am financially responsible for, and will be billed for, all balances remaining on my account which are unpaid by my insurance carrier (i.e. co-pays, co-insurance, deductibles, etc.). I am aware that I am solely responsible for knowing and understanding my insurance plan coverage for medical nutrition therapy.

Patient (guardian) Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_

**Kari Halloran MEd, RD, LDN**

**Late Cancellation/Missed Appointment Policy**

I would like to advise you of my office policy regarding appointment cancellations and missed appointments:

* Any missed appointment or appointment cancelled with less than 24 hours notice will be subject to a $20.00 fee. This fee will **not** be covered by your insurance.
* If you have a special circumstance regarding a missed appointment, please contact me immediately at 412-278-4288.
* As a courtesy, I will do my best to contact you prior to your appointment as a reminder. **It is your responsibility, however, to remember your scheduled appointments.**

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Print patient name Signature patient/guardian Date