

Patient Information	Insurance			
Date:	Who is responsible for this account?			
Patient Name:	Relationship to Patient:			
Address:	Insurance Co.			
City State Zip	Subscriber Name:			
Sex: M F Age: Birthdate:	Birthdate:SS#:			
Patient SS#:	Insurance Co.			
Occupation:	ID #:			
Employer:				
Employer Phone:	ASSIGNMENT AND RELEASE			
Spouse's Name:	I the undersigned certify that I (or my dependent) have insur-	ance o Dr		
	coverage wtih and assign directly to all insurance benefits, if any, other payable to me for services rendered. I understand that	wise		
Birthdate:	financially responsible for all charges whether or not pa	id by		
Occupation:	insurance. I hereby authorize the doctor to release all inforn necessary to secure the payment of benefits. I authorize t			
Spouse's Employer:	this signature on all insurance admissions.			
	Responsible Party Signature Da	ate		
Whom may we thank for referring you?	MEDICARE AUTHORIZATION			
Diama Nami	I request that payment of authorized Medicare benefits be either to me or on my behalf to Dr. for a			
Phone Numbers	furnished me by that physician. I authorize any holder of n information about me to release to the Health Care Finance			
Home:	Administration and its agents any information needed to d these benefits or the benefits payable for related servi	letermine		
Work: Ext:	understand my signature requests that payment be made	de and		
Cell:	authorizes release of medical information necessary to pa If "other health insurance" is indicated in item 9 of the HCF	•		
	form, or elsewhere on other approved claim forms or elect submitted claims, my signature authorizes releasing of the			
Pharmacy	to the insurer or agency shown. In Medicare assigned carphysician or supplier agrees to accept the charge determina	ses, the		
Email	Medicare carrier as the full charge, and the patient is resp	onsible only		
	for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge			
	determination of the Medicare carrier.			
	, ,	Date		
	cal History			
Surgeries you have had:				
Family Physician:	Last Visit Date:			
Madiagtions	Allancias			
Medications	Allergies	d d		
Include prescriptions, over-the-counter medications and vitamins:	Adhesive/Tape Local Anes Anti-Inflammatories Penicillin	tnetics		
and vitaminio.	Codeine Sulfa			
	lodine Other:			
	onsent			
I certify that the above information is true and correct to the besadminister and perform such procedures as may be deemed				

Patient's Signature __

Date _____

Medical History

Place a mark on "Yes' or "No	" to indicat	e if y	ou have had any of the fo	ollowing: Yes	No	Psychiatric Care	Yes	No
Albo/iiiv	Yes	No	Diabetes	103		1 Sychiatric Care	103	110
Allergies to Anesthetics	Yes	No	Ear Problems	Yes	No	Radiation Treatment	Yes	No
Allergies to Medicine			Epilepsy	Yes	No	Rash	Yes	No
or Drugs	Yes	No	Eye Problems	Yes	No	Respiratory Disease	Yes	No
Anemia	Yes	No	Fainting	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Foot or Leg Cramps	Yes	No	Shortness of Breath	Yes	No
Arthritis	Yes	No	Gout	Yes	No	Sinus Problems	Yes	No
Artificial Heart Valves			Headaches	Yes	No	Special Diet	Yes	No
or Joints	Yes	No	Heart Disease	Yes	No	Stroke	Yes	No
Asthma	Yes	No	Hemophilia	Yes	No	Swelling in Ankles, Feet	Yes	No
Back Problems	Yes	No	Hepatitis or Jaundice	Yes	No	Swollen Neck Glands	Yes	No
Bleeding Disorders	Yes	No	High Blood Pressure	Yes	No	Tired Feet	Yes	No
Cancer	Yes	No	Kidney Problems	Yes	No	Tuberculosis	Yes	No
Chemical Dependency	Yes	No	Liver Disease	Yes	No	Ulcers	Yes	No
Chest Pain	Yes	No	Low Blood Pressure	Yes	No	Varicose Veins	Yes	No
Chronic Diarrhea	Yes	No	Nervous Problems	Yes	No	Venereal Disease	Yes	No
Circulatory Problems	Yes	No	Phlebitis	Yes	No	Weight Loss, unexplained	Yes	No
Advanced Directive: Do	•		? Poor Vision Poor Hearing	Langu -	ıage	Barrier		
			Religious Cultural	l Barrie	er	<u> </u>		
			None of the above	<u></u>				
Reason for consultation								
I certify that the above infor administer and perform suc				•				
Signature	gnatureDate							

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 many use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are 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.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, out 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 uses 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, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and i ndicate 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, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, 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: Und er 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 or the 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

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 of treatment, payment or healthcare operations. You may also request that any part of your protected health info rmation 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 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 may have the right to have your physician amend your protect ed health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

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.

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Detional Circumsture	Date
Patient's Signature	Date