

PATIENT INFORMATION FORM

(PLEASE PRINT)

PATIENT'S NAME: _____
(Last) (First) (MI)

SEX: Female _____ Male _____ BIRTHDAY: _____ SOCIAL SECURITY #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE :(____) _____ WORK :(____) _____ CELL:(____) _____

EMAIL ADDRESS: _____ [] Decline

LANGUAGE: _____ RACE: _____ or Decline to answer ETHNICITY _____ or Decline to answer

MARITAL STATUS: _____ NAME OF SPOUSE/PARTNER: _____

How would you like us to contact you? Home Phone Work Phone Cell Phone Mail or Patient Portal

Would you like to be contacted by someone with our offices regarding the customer service you received at your visit?
(no information regarding your visit will be asked, strictly your customer service experience) ____ YES ____ NO

Who referred you to our practice? (circle one) Family/Friend Primary Care Physician Specialty Physician Insurance Plan TV
Newspaper Billboard Radio Internet Yellow Pages Healthy Woman Event Senior Circle Event Hospital Employer

Do you have an Advance Health Care Directive (living will)? ____ YES ____ NO

Are you a member of the following? Healthy Woman? ____ YES ____ NO Senior Circle? ____ YES ____ NO

PRIMARY INSURED INFORMATION (If different from above)

NAME: _____ RELATIONSHIP: _____ BIRTHDATE: _____ SOCIAL SECURITY #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____ PHONE :(____) _____

GUARANTOR INFORMATION

This portion is for whoever is legally responsible for the patient and any medical issues or expenses that may arrive.

NAME: _____ BIRTHDAY: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____ PHONE :(____) _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____ PHONE(____) _____ CELL (____) _____

NAME: _____ RELATIONSHIP: _____ PHONE(____) _____ CELL (____) _____

PATIENT SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE (If under 18): _____

1. ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:

I hereby assign and authorize payment directly to the Physician Clinic all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for this Physician Clinic, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for any charges not covered by my insurance company.

I understand that I am obligated to pay the account of the Physician Clinic in accordance with the regular rates and terms of the Physician Clinic. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Physician Clinic visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent for the Physician Clinic to work with my insurance company/companies on my behalf on authorization, appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.

2. PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

I have been provided the Electronic Prescribing Notice.

3. NOTICE OF PRIVACY PRACTICES:

Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Physician Clinic's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Physician Clinic, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

4. GENERAL CONSENT FOR TESTS, TREATMENT, AND SERVICES:

I have been informed of the treatment procedures considered necessary for me and that the treatments/ procedures will be directed by a physician or independent Advanced Practitioner, in accordance with state laws, scope of practice, and licensure of medical staff.

I hereby consent to engaging in virtual health/telemedicine services, where available, as part of my treatment. I understand that "virtual health" or telemedicine services includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications.

11. VIDEOTAPING/RECORDING:

I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

12. TRANSLATION SERVICES:

This provider complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-660-263-8400 (TTY: 1-800-735-2966).

Este proveedor cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-660-263-8400 (TTY: 1-800-735-2966).

該供應商遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-660-263-8400 (TTY：1-800-735-2966)。

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above and understand that any sections of this consent that I do not consent to, I have struck through and initialed the section that does not have my consent or permission.

Patient's Signature or Legal Representative			Date	Time	
Relationship to Patient		Interpreter, if Utilized		Date	Time
Witness Signature	Date	Time	If Telephone Consent, Second Witness Signature	Date	Time

Notice of Communication Accessibility Services

Our staff wants to communicate effectively with you and your family members. Please fill out this paper and return it to Registration Clerk or your Nurse.

All of the communication accessibility aids and/or services that you need are free of charge to you.

Do you think you need any of the following aids and/or services?*

	YES	NO
American Sign Language interpreter		
Oral interpreter		
TTY/TDD		
Hearing-aid compatible telephone receiver with volume control		
Television closed captioning		
Written/printed materials in other formats (i.e. large print, audio, accessible electronic or other formats as available)		
Written/printed materials in Braille (if available). Other alternatives will be made available to accommodate individuals who are blind or have limited vision.		

Additional aids and/or services may be available. Please list any other ways we may better communicate with you:

*Please note that some aids or services will only be necessary in certain situations.

Patient/Family Member/Companion Signature	Date/Time <input type="checkbox"/> AM <input type="checkbox"/> PM
Signature of person, <i>if any</i> , who filled out this form on behalf of the patient, family member, or companion:	Date/Time <input type="checkbox"/> AM <input type="checkbox"/> PM

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注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-660-263-8400 (TTY: 1-800-735-2966)。

Signature	Date/Time <input type="checkbox"/> AM <input type="checkbox"/> PM
Witness	Date/Time <input type="checkbox"/> AM <input type="checkbox"/> PM

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 CAREFULLY.**

If you have any questions about this notice, please contact the Facility Privacy Officer.

Who Will Follow This Notice: This notice describes the facility's practices and how the facility shares your information with others for treatment, payment and health care operations purposes.

- Any health care professional authorized to enter information into your facility chart.
- All departments and units of the facility.
- Any member of a volunteer group allowed to help you while you are in the facility.
- All employees, staff, agents and other facility personnel.
- Health care providers and their authorized representatives who are members of the facility's organized health care arrangement, or "OHCA." These health care providers and their authorized representatives will be operationally and/or clinically integrated with the facility, or will otherwise be permitted by law to receive your information. For example, to the extent permitted by law and in accordance with our policies, the facility will share your medical information with physicians who are members of the facility's medical staff, even if the physician is not employed by the facility.
- All entities, sites and locations within this facility's system will follow the terms of this notice. They also may share medical information with each other for treatment, payment and health care operations purposes.

Our Pledge Regarding Medical Information: We understand that medical information about you and your healthcare is personal. We are committed to protecting medical information about you. A record is created of the care and services you receive at this facility. This record is needed to provide the necessary care and to comply with legal requirements. This notice applies to all of the records of your care generated by the facility. Your personal physician may have different policies or notices regarding the physicians use and disclosure of your medical information in the physician's office or clinic.

This notice will tell about the ways in which the facility may use and disclose medical information about you. Also described are your rights and certain obligations we have regarding the use and disclosure of medical information.

The law requires the facility to:

- Make sure that medical information that identifies you is kept private;
- Inform you of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect. This notice is effective as of September 23, 2013.

HOW THE FACILITY MAY USE and DISCLOSE YOUR MEDICAL INFORMATION:

Except with respect to Highly Confidential Information (described below), we are permitted to use your health information for the following purposes:

- **Treatment.** Your medical information may be used to provide you with medical treatment or services. This medical information may be disclosed to physicians, nurses, technicians, and others involved in your care at the facility, including employees, volunteers, students and interns at the facility. This includes using and disclosing your information to treat your illness or injury, to contact you to provide appointment reminders or to give you information about treatment options or other health related benefits and services that may interest you.

For example: A physician treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. The physician may need to tell the dietitian about the diabetes so appropriate meals can be arranged. Different departments of the facility may also share medical information about you in order to coordinate your different needs, such as prescriptions, lab work and X-Rays. The facility also may disclose medical information about you to people outside the facility who may be involved in your medical care after you leave the facility, such as family members, home health agencies, and others who provide services that are part of your care.

- **Payment.** Your medical information may be used and disclosed so that the treatment and services received at the facility may be billed and payment may be collected from you, your insurance company and/or a third party. Please note, we will comply with your request not to disclose your health information to your insurance company if the information relates solely to a healthcare item or service for which you have paid out of pocket and in full to us. This restriction does not apply to the use or disclosure of your health information for your medical treatment.

For example: To the extent insurance will be responsible for reimbursing the facility for your care, the health plan or insurance company may need information about surgery you received at the facility so they can provide payment for the surgery. Information may also be given to someone who helps pay for your care. Your health plan or insurance company may also need information about a treatment you are going to receive to obtain prior approval or to determine whether they will cover the treatment.

- **Health Care Operations.** Your medical information may be used and disclosed for purposes of furthering day-to-day facility operations. These uses and disclosures are necessary to run the facility and to monitor the quality of care our patients receive.

For example: Subject to any limitations described in this notice, your medical information may be:

1. Reviewed to evaluate the treatment and services performed by our staff in caring for you.
2. Combined with that of other facility patients to decide what additional services the facility should offer, what services are not needed, and whether certain new treatments are effective.
3. Disclosed to physicians, nurses, technicians, and other agents of the facility for review and learning purposes.
4. Disclosed to healthcare students, interns and residents.
5. Combined with information from other facilities to compare how we are doing and see where we can improve the care and services offered. Information that identifies you in this set of medical information may be removed so others may use it to study health care and health care delivery without knowing who the specific patients are.

- **Individuals Involved in Your Care.** With your permission, your medical information may be released to a family member, guardian or other individuals involved in your care. They may also be told about your condition unless you have requested additional restrictions. In addition, your medical information may be disclosed to an entity assisting in a disaster relief effort so your family can be notified about your condition, status, and location.

- **Research.** Under certain circumstances, your medical information may be used and disclosed for research purposes.

For example: A research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same conditions. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, balancing the research needs with the patients' need for privacy of their medical information. Your medical information may be disclosed to people preparing to conduct a research project; for example, helping them look for patients with specific medical needs, so long as the medical information they review does not leave the facility. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the facility.

- **Marketing Activities.** We may, without obtaining your authorization and so long as we do not receive payment from a third party for doing so, 1) provide you with marketing materials in a face-to-face encounter, 2) give you a promotional gift of nominal value, or 3) tell you about our own health care products and services. We will ask your permission to use your health information for any other marketing activities.
- **Appointment Reminders.** Your medical information may be used to contact you as a reminder of an appointment you have for treatment or medical care at the facility.
- **Treatment Alternatives.** Your medical information may be used to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services.** Your medical information may be used to tell you about health-related benefits or services that may be of interest to you.
- **Participation in Health Information Exchanges.** We may participate in one or more health information exchanges (HIEs) and may electronically share your health information for treatment, payment and permitted healthcare operations purposes with other participants in the HIE – including entities that may not be listed under “**Who Will Follow This Notice**” on the first page of this notice. Depending on State law requirements, you may be asked to “opt-in” in order to share your information with HIEs, or you may be provided the opportunity to “opt-out” of HIE participation. HIEs allow your health care providers to efficiently access and use your pertinent medical information necessary for treatment and other lawful purposes. We will not share your information with an HIE unless both the HIE and its participants are subject to HIPAA’s privacy and security requirements.
- **As Required by Law.** Your medical information will be disclosed when required to do so by federal, state, or local authorities, laws, rules and/or regulations.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, your medical information will be disclosed in response to a court or administration order, subpoena, discovery request, or other lawful process by someone else involved in the dispute when we are legally required to respond.
- **Law Enforcement.** Your medical information will be released if requested by a law enforcement official:
 1. In response to a court order, subpoena, warrant, summons or similar process;
 2. To identify or locate a suspect, fugitive, material witness, or missing person;
 3. About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person’s agreement;
 4. About a death we believe may be the result of criminal conduct;
 5. In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
- **National Security and Intelligence Activities.** Your medical information will be released to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Protective Services for the President and Others.** Your medical information may be disclosed to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
- **To Alert a Serious Threat to Health or Safety.** Your medical information may be used and disclosed when necessary to prevent a serious threat to your health and safety and that of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

- **Health Oversight Activities.** Your medical information may be disclosed to a health oversight facility for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

SPECIAL SITUATIONS:

- **Organ and Tissue Donation.** If you are an organ or tissue donor, your medical information may be released to organizations that handle organ procurement or organ, eye and tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, your medical information may be released as required by military command authorities. If you are a member of the foreign military personnel, your medical information may be released to the appropriate foreign military authority.
- **Workers' Compensation.** If you seek treatment for a work-related illness or injury, we must provide full information in accordance with state-specific laws regarding workers' compensation claims. Once state-specific requirements are met and an appropriate written request is received, only the records pertaining to the work-related illness or injury may be disclosed.
- **Public Health Risk.** Your medical information may be used and disclosed for public health activities. These activities generally include the following:
 1. To prevent or control disease, injury or disability;
 2. To report births and deaths;
 3. To report child abuse or neglect;
 4. To report reactions to medications or problems with products;
 5. To notify people of recalls of products they may be using;
 6. To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
 7. To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- **Coroners, Medical Examiners, and Funeral Directors.** Your medical information may be released to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the facility to funeral directors as necessary to carry out their duties.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the following reasons:
 1. For the institution to provide you with health care;
 2. To protect the health and safety of you and others;
 3. For the safety and security of the correctional institution.

HIGHLY CONFIDENTIAL INFORMATION:

Federal and/or State law require special privacy protections for certain highly confidential information about you, including your health information that is maintained in psychotherapy notes. Similarly, Federal and/or State law may provide greater protections for the following types of information than HIPAA, in which case we will comply with the law that provides your information with the greatest protection and you with the greatest privacy rights: (1) mental health and developmental disabilities; (2) alcohol and drug abuse prevention, treatment and referral; (3) HIV/AIDS testing, diagnosis or treatment; (4) communicable diseases; (5) genetic testing; (6) child abuse and neglect; (7) domestic or elder abuse; and/or (8) sexual assault. In order for your highly confidential information to be disclosed for a purpose other than those permitted by law, your written authorization is required.

YOUR WRITTEN AUTHORIZATION

We will first obtain your written authorization before using or disclosing your protected health information for any purpose not described above, including disclosures that constitute the sale of protected health information or for marketing communications paid for by a third party (excluding refill reminders, which the law permits without your authorization). If you provide the facility permission to use or disclose your medical information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your medical information for the reasons covered in your written authorization. You understand that we are unable to take back any disclosures already made with your permission, and that we are required to retain our records of the care that the facility provided to you.

ADDITIONAL INFORMATION CONCERNING THIS NOTICE:

- **Changes To This Notice.** We reserve the right to change this notice and make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. The facility will post a current copy of the notice with the effective date. In addition, each time you register at, or are admitted to, the facility for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.
- **Complaints.** You will not be penalized for filing a complaint. If you believe your privacy rights have been violated, you may file a complaint with the facility or with the Secretary of the Department of Health and Human Services. Some States may allow you to file a complaint with State's Attorney General, Office of Consumer Affairs or other State agency as specified by applicable State law. To file a complaint with the facility, submit your complaint to the facility's Privacy Officer in writing. The facility's Privacy Officer can provide you with contact information for the Secretary of the Department of Health and Human Services as well as the State agency or agencies authorized to accept your complaints.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding medical information the facility maintains about you:

**** NOTE: All Requests Must Be Submitted in Writing to the Facility****

- **Right to Request Access to Your Health Information.** You have the right to timely inspect and copy medical information that may be used to make decisions about your care. Such access will be granted by the facility in accordance with applicable law.

To inspect and copy medical information or to receive an electronic copy of the medical information that may be used to make decisions about you, you must submit a written request. If you request a paper copy of your information, we may charge a fee for the cost of copying, mailing or other supplies associated with your request.

If the facility uses or maintains an electronic health record with respect to your medical information, you have the right to obtain an electronic copy of the information if you so choose.

1. You may direct the facility to transmit the copy to another entity or person that you designate provided the choice is clear, conspicuous, and specific.
2. The facility may charge a fee equal to its labor cost in providing the electronic copy (e.g., costs may include the cost of a flash drive, if that is how you request a copy of your information be produced). If you request an electronic copy of your information, we will provide the information in the format requested if it is feasible to do so.

We may deny your request to inspect and copy in some limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional, other than the person who denied your request, will be chosen by the facility to review your request and the denial. The facility will comply with the outcome of the review.

1. A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person.
2. The protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person.
3. The request for access is made by the individual's personal representative, and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment to information kept by or for the facility. Except where individual state laws are more stringent, this facility has a minimum of 60 days to act on your request.

To request an amendment, you must submit a written request. You must also provide a reason that supports your request.

Your request for an amendment may be denied if:

1. Your request is not in writing or does not include a reason to support the request;
2. The medical information was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
3. The medical information is not part of the medical information kept by or for the facility;
4. The medical information is not part of the information you would be permitted to inspect and copy; or
5. The medical information is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of your medical information for purposes other than treatment, payment and health care operations. Except where individual state laws are more stringent, this facility has a minimum of 60 days to act on your request.

To request this list or accounting of disclosures:

1. You must submit your request in writing.
2. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003.
3. Your request should indicate in what form you want the list (for example, on paper, electronically).

The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have a right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member.

To request restrictions, you must make your request in writing. In your request, you must tell us:


1. What information you want to limit;
2. Whether you want to limit our use, disclosure or both;
3. To whom you want the limits to apply, for example, disclosures to your spouse.

You also have a right to request that a health care item or service not be disclosed to your health plan for payment purposes or health care operations. We are required to honor your request if the health care item or service is paid out of pocket and in full. This restriction does not apply to use or disclosure of your health information related to your medical treatment.

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
For example: You can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to Be Notified of Breach.** We will notify you if we discover a breach of your unsecured protected health information.
- **Right to a Paper Copy of This Notice.** You have the right to a copy of this notice. You may ask us to give you a copy at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

NOTICE OF PRIVACY PRACTICES:

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I was provided a copy of the Facility's Notice of Privacy Practices.

Patient's Signature or Legal Representative			Date	Time	
Relationship to Patient		Interpreter, if Utilized		Date	Time
Witness Signature	Date	Time			
Physician Practice Notices of Privacy Practices Acknowledgement Form 100-PPSI-1001 09/13 Page 1 of 1					