

PLEASE PRINT

P A T I E N T I N F O R M A T I O N		TODAY'S DATE _____		P A T I E N T R E G I S T R A T I O N		
P A T I E N T I N F O R M A T I O N	The person seeing the doctor.		PLEASE COMPLETE ALL WHITE AREAS			
	PATIENT NUMBER					
	LAST NAME		FIRST NAME & INITIAL			
	ADDRESS LINE 1					
	ADDRESS LINE 2					
	CITY		STATE		ZIP	
	HOME PHONE					
	SEX	MARITAL STATUS (M/S)	DATE OF BIRTH	M.D. REQUESTING YOUR APPOINTMENT		
	PATIENT'S S.S. NO.	IF NOT REFERRED BY PHYSICIAN, PLEASE CHECK ONE BOX BELOW Q PATIENT Q YELLOW PAGES Q PROVIDER BOOK Q OTHER				
	PATIENT'S EMPLOYER					
	EMPLOYER ADDRESS					
	CITY		STATE		ZIP	
EMPLOYER PHONE		EXT.				
G U A R A N T O R	Person responsible for all unpaid balances on the account.		RESP. PARTY LAST NAME		FIRST NAME & INITIAL	RELATIONSHIP
	ADDRESS					
	CITY		STATE	ZIP	E-MAIL ADDRESS	
	HOME PHONE	CELL PHONE	PAGER NUMBER			
	RESP. PARTY DATE OF BIRTH		RESPONSIBLE PARTY S.S. NO.			
	RESP. PARTY EMPLOYER		EMPLOYER PHONE	EXT.		
	EMPLOYER ADDRESS		EMPLOYER FAX #			
I N S U R A N C E	List all insurance for which you have a current card. List Medicare or Medicaid first.		MEDICARE/MEDICAID OR INS. #1 NAME		INS. #1 CODE	
	INSURANCE #1 ADDRESS				INS. #1 PHONE	
	POLICY HOLDER LAST NAME		FIRST NAME	RELATIONSHIP		
	CERTIFICATE #		GROUP NO.	MEMBER NO.		
	INSURANCE #2 NAME		INS. #2 CODE			
	INSURANCE #2 ADDRESS		INS. #2 PHONE			
	POLICY HOLDER LAST NAME		FIRST NAME	RELATIONSHIP		
	CERTIFICATE #		GROUP NO.	MEMBER NO.		
	INSURANCE #3		INS. #3 CODE			
	INSURANCE #3 ADDRESS		INS. #3 PHONE			
	POLICY HOLDER LAST NAME		FIRST NAME	RELATIONSHIP		
	CERTIFICATE #		GROUP NO.	MEMBER NO.		
S p o u s e , s t e p - p a r e n t , s i g n i f i c a n t o t h e r .	NAME					
	DATE OF BIRTH		S.S. NO.			
	EMPLOYER		WORK PHONE			
	NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU		RELATIVE/FRIEND PHONE			

YOU MUST READ AND SIGN THE OTHER SIDE OF THIS FORM

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INS BENEFITS: I authorize my physician to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

INITIAL _____

MEDICARE CERTIFICATION: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician who treats me, to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries or carriers. I request that payment of authorization benefits be made directly to my physician treating me, on my behalf.

INITIAL _____

FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

INITIAL _____

PATIENT'S SIGNATURE _____ **DATE** _____

Parent/Guardian _____ **DATE** _____

Do you have a Living Will? Yes _____ **No** _____

A Copy may be needed for your chart.

A Copy Was Received By This Office. Date _____

H.H.S. Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have received a copy of **NOTICE OF PRIVACY PRACTICES:**

INITIAL _____ **DATE** _____

I give permission for protected Health Care information regarding myself to be shared with the following individuals:

Release of Protected Health Care Information Via Telephone To Answering Machine, Or Voice Mail: I give my consent and authorization for the Medical, or Billing Staff of my Physician's Office to leave protected Health Care information about me or for me on my answering machine or voice mail via the telephone at the number I have listed below. I understand I may revoke this privilege at any time by submitting my request in writing to this office,

NUMBER _____ **INITIAL** _____

PATIENT HISTORY
Columbus Medical

Name: _____

Date: _____

CHIEF COMPLAINT: What symptom, problem, or concern leads you to see medical advice at this time?

PAST HISTORY: Have you had any of the following diseases? Circle if answer is yes.

Rheumatic Fever?	High Blood Pressure?	Ulcers?
Asthma or Hay Fever?	Nervous Breakdown?	Heart Disease?
Syphilis or Gonorrhea?	Jaundice or hepatitis?	Pneumonia?
Thyroid Disease?	Seizures or Epilepsy?	Diabetes?
Tuberculosis?	Anemia?	Serious Injury or Fracture?

OTHER: _____

SURGERY: WHAT? WHERE DONE? SURGEON? DATE? AGE THEN?

- 1.
- 2.
- 3.

HOSPITALIZATIONS: HAVE YOU EVER BEEN A PATIENT IN A HOSPITAL OTHER THAN FOR
CHILDBIRTH OR SURGERY?

ILLNESS (WHAT FOR)	HOSPITAL?	DATE?	AGE THEN?
1.			
2.			
3.			

ALLERGIES:

Are you allergic (sensitive to any food, materials, or drugs (medicines)?)

What reaction?

HABITS:

Do you or did you smoke? Packs per day? For how long?

Do you use alcoholic beverages or drugs? What kinds? How much?

Continued next page

MEDICATIONS: Please list any medicines you take regularly, and bring them to the office on the next visit.

Name of Medicine? What is it for? How long have you been taking it?

- 1.
- 2.
- 3.

Others:

FAMILY HISTORY: **Age** **If Living: Illnesses** **Age at Death** **If Deceased, Cause?**

FAMILY HISTORY	Age	If Living: Illnesses	Age at Death	If Deceased, Cause?
Father				
Mother				
Sibling #1				
Sibling #2				
Sibling #3				
Sibling #4				
Husband or Wife				
Son or Daughter #1				
Son or Daughter #2				
Others:				

Has any blood relative ever had: (Circle if yes and specify who)

Cancer
High Blood Pressure
Diabetes
Heart Trouble

Tuberculosis
Nervous Breakdown
Suicide
Sickle Cell Anemia

Epilepsy
Stroke
Other:

Patient Signature: _____ M.D. Signature: _____

Notice of Privacy Practices



PHYSICIAN'S PRACTICE
ORGANIZATION, INC.

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

The Privacy Officer or Office Manager for assistance.

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

- 1. Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

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2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you with your authorization

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

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4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

7. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

8. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

9. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

10. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the **Privacy Officer** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to the **Privacy Officer**. Your request must describe in a clear and concise fashion:

- (a) the information you wish restricted;
- (b) whether you are requesting to limit our practice's use, disclosure or both; and
- (c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the **Privacy Officer** in order to inspect and/or obtain a copy of your IIHI. Our

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practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the **Privacy Officer**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to the **Privacy Officer**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the **Privacy Officer**.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the **Privacy Officer**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact the **Privacy Officer**.