PATIENT INFORMATION

Patient Name: (LAST) _____ (FIRST) _____ (MIDDLE) _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: (HOME) _____ (CELL) _____ (WORK) _____

Emergency Contact: (NAME) _____ (PHONE) _____ (RELATION) _____

If Minor, Mother's Name: _____ Father's Name: _____

Birth Sex: ☐ Male ☐ Female Date of Birth: _____ Social Security #: _____

Sexual Orientation:

☐ Straight, Heterosexual ☐ Lesbian, Gay, Homosexual ☐ Bisexual ☐ Do Not Know ☐ Choose not to disclose

☐ Other: _____

Gender Identity:

☐ Male ☐ Female ☐ Female to Male (Transgender Male) ☐ Male to Female (Transgender Female)

☐ Genderqueer (Neither exclusively male nor female) ☐ Choose not to disclose

☐ Other: _____

Race: ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ ASIAN ☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER

☐ BLACK/AFRICAN AMERICAN ☐ WHITE ☐ HISPANIC ☐ OTHER RACE ☐ OTHER PACIFIC ISLANDER

Ethnicity: ☐ HISPANIC/LATINO ☐ NOT HISPANIC/LATINO

Language: ☐ ENGLISH ☐ SPANISH ☐ OTHER: _____

PATIENT INSURANCE

Primary Insurance: ☐ Medicare ☐ Medi-Cal ☐ Health Net/Medi-Cal ☐ Health Plan of San Joaquin/Medi-Cal
(PROVIDE INSURANCE CARD) ☐ Other: _____

Secondary Insurance: ☐ Medicare ☐ Medi-Cal ☐ Health Net/Medi-Cal ☐ Health Plan of San Joaquin/Medi-Cal
(PROVIDE INSURANCE CARD) ☐ Other: _____

I, the undersigned certify that I (or my dependent) have insurance coverage with the above Insurance Companies and assign directly to Pathway Healthcare, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Pathway Healthcare to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party: (NAME) _____ (RELATIONSHIP) _____

Responsible Party Signature: _____ Date: _____

ADDITIONAL INFORMATION

Street Address (if different from mailing address): _____

City: _____ State: _____ Zip: _____

Email Address: _____ *(Required for appointment reminders and online access)*

Employer Name: _____ Employer Phone: _____

Employer Address _____ Employer City: _____ State: _____ Zip:

PHARMACY

Pharmacy Name: _____ Address: _____

Phone: _____ City: _____ State: _____

Female Patients Only

Are you currently pregnant?	☐ Yes	☐ No
Age at first pregnancy:		
Number of pregnancies:		
Number of deliveries:		
Number of miscarriages or abortions:		
Have you ever nursed?	☐ Yes	☐ No

Are you using birth control?	☐ Yes	☐ No
Age at first period:		
Do you have regular periods?		
Date of last period:		
Do you have abnormal periods?	☐ Yes	☐ No

Childhood Diseases – Please check Yes or No

Measles	☐ Yes	☐ No
Mumps	☐ Yes	☐ No
Other:		

Chickenpox (Varicella)	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No

MEDICATIONS AND ALLERGIES

List all medications you are taking – prescription and over the counter (Attach separate list in necessary)

Medication Name	Dosage	Frequency

Medication Name	Dosage	Frequency

List all allergies to medications, food or environmental and your reaction (Attach separate list in necessary)

Allergy	Reaction

Allergy	Reaction

CURRENT AND PAST MEDICAL CONDITIONS – Please check Yes or No

Asthma	☐ Yes	☐ No
COPD (emphysema)	☐ Yes	☐ No
Diabetes Mellitus	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Coronary artery disease	☐ Yes	☐ No
Acute MI (heart attack)	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Alzheimer's (dementia)	☐ Yes	☐ No
Anxiety disorder	☐ Yes	☐ No
Pancreatitis	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Cirrhosis	☐ Yes	☐ No
Breast cancer	☐ Yes	☐ No
Ovarian cancer	☐ Yes	☐ No
Colon cancer	☐ Yes	☐ No
Cancer, other	☐ Yes	☐ No
Hyperlipidemia (high cholesterol)	☐ Yes	☐ No
Irritable bowel syndrome	☐ Yes	☐ No
GERD (gastroesophageal reflux)	☐ Yes	☐ No
Peptic ulcer disease	☐ Yes	☐ No
Osteoarthritis	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Epilepsy (seizures)	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No

HIV infection	☐ Yes	☐ No
Renal (kidney) disorders	☐ Yes	☐ No
Hepatic (liver) disorders	☐ Yes	☐ No
Respiratory (lung) disorders	☐ Yes	☐ No
Psychiatric disorders	☐ Yes	☐ No
Sleep apnea	☐ Yes	☐ No
Migraine headache	☐ Yes	☐ No
Sickle cell anemia	☐ Yes	☐ No
Thyroid disorders	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Hepatitis, unknown type	☐ Yes	☐ No
Hepatitis A, B (circle)	☐ Yes	☐ No
Hepatitis C	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No
Prolapsing mitral valve	☐ Yes	☐ No
Other:	☐ Yes	☐ No
	☐ Yes	☐ No
Pulmonary embolism	☐ Yes	☐ No
Bleeding problems	☐ Yes	☐ No
Thrombosis (blood clot)	☐ Yes	☐ No
MRSA (staph infection)	☐ Yes	☐ No
Thrombophlebitis (blood clots with inflammation) in the deep vessels of the legs	☐ Yes	☐ No

SOCIAL HISTORY – Please check any of the following items that apply

Smoking status for all patients over 13:	Are you:	Are you Currently:	Marital Status:
☐ Current every day smoker	☐ Living with Spouse	☐ Employed	☐ Married
☐ Current some day smoker	☐ Living with Parent(s)	☐ Retired	☐ Single
☐ Former smoker	☐ Living Alone	☐ Unemployed	☐ Widowed
☐ Never smoker	☐ Living with Caregiver	☐ Student	☐ Divorced
☐ Smoker, current status unknown	☐ In Assisted Living Facility	☐ Military	☐ Partner
☐ Unknown if ever smoked			
☐ Smokeless tobacco user			

Do you use Medical Marijuana	☐ *Yes*	☐ *No*	If Yes, Do you have a MM Card	☐ *Yes*	☐ *No*

Occupation:

Are you currently on disability?	☐ Yes	☐ No	Date disability started:
Type of Disability (State, Social Security, Etc.):			

SOCIAL HISTORY – Please check any of the following items that apply (Continued)

			How Often/Much	Caffeine Use			How Often/Much
Alcohol	☐ Yes	☐ No		Coffee	☐ Yes	☐ No	
Recreational Drug Use	☐ Yes	☐ No		Tea	☐ Yes	☐ No	
				Soda	☐ Yes	☐ No	

Surgical History – Please check Yes or No

Blood transfusion	☐ *Yes*	☐ *No*
If yes, what complications?		
Any adverse reactions to anesthesia?	☐ *Yes*	☐ *No*
If yes, what?		
Gallbladder removal, open surgery	☐ *Yes*	☐ *No*
Gallbladder removal, laparoscopic	☐ *Yes*	☐ *No*
Appendectomy	☐ *Yes*	☐ *No*
Tonsillectomy	☐ *Yes*	☐ *No*
Thyroid surgery	☐ *Yes*	☐ *No*
Diagnostic laparoscopy	☐ *Yes*	☐ *No*
Ulcer surgery	☐ Yes	☐ No
Coronary artery bypass grafting	☐ Yes	☐ No
Lung surgery	☐ Yes	☐ No
Kidney surgery	☐ Yes	☐ No
Bladder surgery	☐ Yes	☐ No
Orthopedic surgery	☐ Yes	☐ No
Location/limb:		

Repair of abdominal wall	☐ Yes	☐ No
Hernia repair	☐ Yes	☐ No
Lumpectomy	☐ Yes	☐ No
Mastectomy	☐ Yes	☐ No
Dilation and curettage (D&C)	☐ Yes	☐ No
Abdominal aortic aneurysm repair	☐ Yes	☐ No
Small bowel resection	☐ Yes	☐ No
Colon (large intestine) surgery	☐ Yes	☐ No
Hemorrhoidectomy	☐ Yes	☐ No
Anal sphincterotomy	☐ Yes	☐ No
Splenectomy (spleen removal)	☐ Yes	☐ No
Tubal ligation	☐ Yes	☐ No
Hysterectomy	☐ Yes	☐ No
Cesarean section delivery	☐ Yes	☐ No
Other:	☐ Yes	☐ No
	☐ Yes	☐ No
	☐ Yes	☐ No

REVIEW OF SYSTEMS – Check all that apply

General

Recent weight gain?	☐ Yes	☐ No
How much? Over what time period?		
Recent weight loss?	☐ Yes	☐ No
How much? Over what time period?		
Chills	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
Feeling tired	☐ Yes	☐ No

Eyes

Vision problems	☐ Yes	☐ No
Sensitivity to light (photophobia)	☐ Yes	☐ No
Eye pain	☐ Yes	☐ No
Itching	☐ Yes	☐ No

Neck

Neck pain	☐ Yes	☐ No
Neck stiffness	☐ Yes	☐ No
Lump or swelling in neck	☐ Yes	☐ No

Breasts

Breast pain	☐ Yes	☐ No
Nipple discharge	☐ Yes	☐ No
Breast lump	☐ Yes	☐ No

Cardiovascular

Chest pain or discomfort	☐ Yes	☐ No
Fast heart rate	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No

Head

Headache	☐ Yes	☐ No
Facial pain	☐ Yes	☐ No
Sinus pain	☐ Yes	☐ No

Ears, Nose, Throat

Earache	☐ Yes	☐ No
Hearing loss	☐ Yes	☐ No
Ringing in ears	☐ Yes	☐ No
Nosebleeds	☐ Yes	☐ No
Nasal discharge	☐ Yes	☐ No
Mouth sores	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Hoarseness	☐ Yes	☐ No
Throat pain	☐ Yes	☐ No

Genitourinary

Painful urination (dysuria)	☐ Yes	☐ No
Increased urinary frequency	☐ Yes	☐ No
Blood in urine (hematuria)	☐ Yes	☐ No
Change in appearance of urine	☐ Yes	☐ No

Skin

Itching (pruritus)	☐ Yes	☐ No
Lesions	☐ Yes	☐ No
Rash	☐ Yes	☐ No

Endocrine

Excessive sweating	☐ Yes	☐ No
Excessive thirst	☐ Yes	☐ No
Change in libido (sex drive)	☐ Yes	☐ No

Pulmonary

Shortness of breath	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Coughing up blood	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No

Gastrointestinal

Changes in appetite	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No
Nausea	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Black or bloody stools	☐ Yes	☐ No
Yellow skin or eyes (jaundice)	☐ Yes	☐ No

Musculoskeletal

Joint pain, localized	☐ Yes	☐ No
Joint stiffness, localized	☐ Yes	☐ No
Muscle aches	☐ Yes	☐ No

Neurological

Dizziness	☐ Yes	☐ No
Spinning dizziness (vertigo)	☐ Yes	☐ No
Fainting (syncope)	☐ Yes	☐ No
Motor disturbances	☐ Yes	☐ No
Sensory disturbances	☐ Yes	☐ No

Psychological

Sleep disturbances	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Depression	☐ Yes	☐ No

FAMILY HISTORY

	Living	*Deceased*	*Age*	*Major Illness / Cause of Death*
Father	☐	☐		
Mother	☐	☐		

Has anyone in your family had any of these conditions – Circle Yes or No, if Yes, check who in the family had the condition

Condition	Circle	Mother	Father	Maternal		Paternal	
				Grandmother	Grandfather	Grandmother	Grandfather
Diabetes mellitus	Y or N	☐	☐	☐	☐	☐	☐
Hypertension	Y or N	☐	☐	☐	☐	☐	☐
Heart disease	Y or N	☐	☐	☐	☐	☐	☐
Heart attack	Y or N	☐	☐	☐	☐	☐	☐
Stroke	Y or N	☐	☐	☐	☐	☐	☐
Kidney disease	Y or N	☐	☐	☐	☐	☐	☐
Liver disease	Y or N	☐	☐	☐	☐	☐	☐
Lung disease	Y or N	☐	☐	☐	☐	☐	☐
Pulmonary embolism (clot in lung)	Y or N	☐	☐	☐	☐	☐	☐
Thyroid disorder	Y or N	☐	☐	☐	☐	☐	☐
Bleeding problems	Y or N	☐	☐	☐	☐	☐	☐
Blood clot (thrombosis)	Y or N	☐	☐	☐	☐	☐	☐
Phlebitis (inflammation of a vein)	Y or N	☐	☐	☐	☐	☐	☐
Asthma	Y or N	☐	☐	☐	☐	☐	☐
Allergies	Y or N	☐	☐	☐	☐	☐	☐
Adverse reaction to anesthesia	Y or N	☐	☐	☐	☐	☐	☐
Arthritis	Y or N	☐	☐	☐	☐	☐	☐
Alcoholism	Y or N	☐	☐	☐	☐	☐	☐
Migraine headache	Y or N	☐	☐	☐	☐	☐	☐
Anxiety disorder	Y or N	☐	☐	☐	☐	☐	☐
Depression	Y or N	☐	☐	☐	☐	☐	☐
Mental disorder	Y or N	☐	☐	☐	☐	☐	☐
Alzheimer's dementia	Y or N	☐	☐	☐	☐	☐	☐
Epilepsy (seizures)	Y or N	☐	☐	☐	☐	☐	☐
Glaucoma	Y or N	☐	☐	☐	☐	☐	☐
HIV infection, AIDS	Y or N	☐	☐	☐	☐	☐	☐
Sickle Cell Anemia	Y or N	☐	☐	☐	☐	☐	☐
Brest Cancer	Y or N	☐	☐	☐	☐	☐	☐
Ovarian Cancer	Y or N	☐	☐	☐	☐	☐	☐
Colon Cancer	Y or N	☐	☐	☐	☐	☐	☐
Other Cancer	Y or N	☐	☐	☐	☐	☐	☐

INSURANCE ASSIGNMENT

I, the undersigned certify that I (or my dependent) have insurance coverage with the above Insurance Companies and assign directly to Pathway Healthcare, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Pathway Healthcare to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

CONSENT FOR TREATMENT AUTHORIZATION, ASSIGNMENT & RESPONSIBILITY STATEMENT

By signing below, I, (or my authorized representative on my behalf) authorize Pathways Nursing Practitioners, Inc. dba Pathway Healthcare and their staff to conduct any diagnostic examinations, tests and procedures, minor surgery and to provide any local anesthesia (if necessary), medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

I authorize payment of medical benefits for myself to Marc Stoner, FNP, Dr. Michael Schorr, MD and/or Pathways Nursing Practitioners, Inc. dba Pathway Healthcare, the release of any medical information necessary to process this claim.

If I am a Medicare patient, I authorize Medicare payments to be paid to Marc Stoner, FNP, Dr. Michael Schorr, MD and/or Pathways Nursing Practitioners, Inc. dba Pathway Healthcare.

I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on any outstanding balance on my account.

RIGHT TO REFUSE TREATMENT

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating healthcare providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

Patient / Legal Guardian Signature: _____ Date: _____

If Guardian, Relationship: _____

OFFICE POLICIES

Appointments/Follow Up:

When you make an appointment, be sure to let our staff know the reason for the visit to properly allow for adequate time.

- Patients must make a follow up appointment with the provider to discuss any test results. We do not give results over the phone. YOU MUST make an appointment to discuss the results. In the worst case scenario, if you do not hear from the provider about these results it is your responsibility to make an appointment with the provider to discuss results. If you wish to discuss test results that were ordered by another provider, you must either bring a copy of the test results or have it faxed to us.

Appointment time:

Patients arriving more than 20 minutes late will be asked to reschedule or seen as a walk in patient if time allows.

Same day appointments:

We understand you or your family member is sick, so you worry. You want to be seen right away to make sure it is not serious; you can come in as a walk in patient. If it is a true emergency, we ask that you go to the nearest emergency room. We cannot guarantee or predict the wait time.

Missed appointment fee:

Patients, who fail to cancel with less than 24-hour notice, will incur a $50 fee. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will not be allowed to schedule an appointment, you must walk in and we will fit you into the schedule as available. If you continue to miss appointments after you walk-in and are seen, we may discharge you from the practice.

Phone calls:

For truly life threatening emergencies call 911.

Our phones are generally busiest early in the morning when we first open and right when we return from lunch. Our business hours are from Monday thru Thursday, 8:00am to 5:00pm and Friday 8:00am to 12:00pm, closed on Saturday and Sunday.

If we are busy we do prioritize phone calls according to nature of the call, if you are asked to wait on hold please be patient.

Prescription refills:

All patients must return every two months for prescription refills or sooner as determined by your provider. No refills will be issued to your pharmacy without a scheduled appointment. You are expected to time your office visits with your prescriptions.

Please plan ahead so that you do not run out of important medications. We cannot refill mediation we did not prescribe or to patients that have never been seen in our office. We will not prescribe or refill medication on weekends or holidays.

Controlled and Narcotic medications will require patients to be seen monthly for observation.

Form Fee

There is a $25.00 fee for all forms that we are required to complete including but not limited to, Disability, Gas & Electric Discounts, Insurance Physicals or DMV Forms, etc. There is a $20.00 fee for Disability extension forms.

Violence/Abuse:

Disrespect towards the staff, including but not limited to verbal abuse or physical violence or threats, will not be tolerated. If this is not met we have the right to refuse service and/or discharge the patient from the practice.

Waiting Room and Examination Rooms:

Please no cell phone, food: drinks or pets allowed, except for service animals.

In the examination rooms we ask that only the patient with the appointment be in the room, except for caregivers for patient who require assistance. If the patient is a minor, parents and guardians are welcome.

Statements:

If you have a balance on your account, statements are sent once a quarter (4 times a year). It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account. We will only issue four statements for unpaid balances. After that we will forward the balance to a collection agency and asses a $50.00 fee.

Payments:

Unless other arrangements are approved by us in writing, the balance on your statement is due when the statement is issued, and is past due if not paid within 30 days. If your balance is less than $50.00, we will accept a minimum of $10.00 per month. If balance/payment has not been paid, we have the right to refuse service.

Required Payments:

Any copayments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these. If you are unable to pay your co-payment at the time of service, we will ask you to reschedule for another time.

Deductibles:

All deductible amounts are to be paid upon check in. Any additional services rendered not covered by your insurance will be added to your account.

Payment Options:

If you do not have insurance, we accept payment by cash or credit card (Visa, MasterCard, American Express, and Discover). At this time, we do not accept personal checks. All payments must be paid at the time services are rendered.

Non-contracted Insurance:

Insurance is a contract between you and your insurance company. We are not a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. However, we will require you to pay our current cash rate at the time of check-in. If your receive payment from your insurance company and the amount is greater than the rate you paid, the additional sum must be paid to us to provide the full payment we billed to your insurance company. You agree to pay any portion of the charges not covered by your insurance.

OFFICE POLICIES *(continued)*

Divorce:

In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for the child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Finance Charge:

A finance charge will be imposed on each item of your account (30) days of the time the item was added to the account. The Finance Charge will be computed at the rate of one and a half percent (1.5%) per month or an Annual Percentage Rate of eighteen (18%). The finance charge on your account is computed by applying the periodic rate (1.5%) to the “overdue balance” of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payment or credits applied to the account during that time. The minimum Finance Charge is $.50.

Past-due Account:

If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection cost which is incurred. If we have to refer collection of the balance to an attorney, you agree to pay all legal fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Stanislaus County, California.

Bankruptcy:

If you should include your past due debt in your case, we have the right to discharge you from care. Unless the past due debt is reaffirmed and payment is made in full.

Returned checks:

If we accept payment via Personal Check, there is a fee (Currently $25) for any checks returned by your bank in addition to the check amount. For checks written fraudulently or under a closed account we will assess $100.00 in addition to the check amount.

Transferring/Copying of Medical Records:

All records requests require a records release authorization signed by the patient or legal guardian. If you request a copy of your records, you will be charged a copying fee of $0.35 per page. If a records request comes from another provider or organization, we will provide one (1) copy to them at no charge as required by law. All copies of records over 30 pages total will be provided in PDF file format on CD. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Waiver of confidentiality:

You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you're past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Workers Compensation:

Pathway Healthcare does not provide services for Workers Compensation insurance.

Personal injury:

We do not bill third party claims. These cases will be treated as self-insured and ask that payment be made at the time of service unless other arrangements are made in advance.

Referral request:

We are pleased to obtain the necessary authorization from your insurance company and refer you. This can sometimes take up to 30 days to complete. Urgent/STAT referrals require 72 hours to the process the request per all major insurances.

Hospital Relief:

In an effort to relieve our local hospital of seeing patients on an emergency basis, we have made arrangements with Doctors Medical Center in Modesto to see Pathway Healthcare patients in the event of a medical emergency.

We ask you to use Doctors Medical Center as your source of ER care. You understand that if your life is at risk, you will go to THE NEAREST MEDICAL FACILITY to seek immediate medical attention.

Effective Date:

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient / Legal Guardian Signature: _____ Date: _____

ACKNOWLEDGEMENT OF 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.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse Protected Health Information (PHI).

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 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, your protected health information may be provided to a physician to whom you have been referred to ensure that the health care professional has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for 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, and conducting or arranging for other business activities. We may use or disclose, as needed, your protected health information to support the business activities of this practice. 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, as necessary, to contact you to remind you of your appointment. We may call your home and leave a message (either on an answering machine or with the person answering the phone) or send you an email to remind you of an upcoming appointment, the need to schedule a new appointment or to call our office. We may also mail a postcard reminder to your home address. If you would prefer that we call or contact you at another telephone number or location, please let us know.

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 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 HIPAA.

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: The 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 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 information not be disclosed to family members or friends who may be involved in you care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction you may request. If your 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 protected 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 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 officer of your complaint at our office and main telephone number. We will not retaliate against you for filing a complaint.

This Notice was published and becomes effective on/or before 8/1/2011.

Patient / Legal Guardian Signature: _____ Date: _____