PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home/Cell: ______________________

- ☐ OK to leave message with detailed information
  OR
- ☐ Leave Message with call-back number

☐ Work Telephone: ______________________

- ☐ OK to leave message with detailed information
  OR
- ☐ Leave Message with call-back number

☐ Written Communication

- ☐ OK to mail to my home address
- ☐ OK to mail to my work/office address
- ☐ OK to fax to this number: ____________
- ☐ Other: ______________________

Communication with person(s) other than the patient:

Is there a medical power of attorney? Yes No Please provide a copy

If yes, does the patient suffer from Alzheimer's, Dementia, or Cognitive Impairment? Yes No

May we discuss your medical/financial information with anyone else?

Yes No (if yes, please list the names below)

Name: ______________________ Relationship ______________________ Phone ______________________

Name: ______________________ Relationship ______________________ Phone ______________________

Name: ______________________ ____________ Phone ______________________

____
Patient Signature

____
Date

____
Print Name

____
Birth Date

Today's Date ____/____/____

Name ______________________________ DOB ____/____/____
Last First Dr. Mr. Mrs. Ms. (circle one)

Pharmacy Name ______________ Street ______________ City ______________

Reason for visit? ______________________________

Do you suffer from memory loss, Dementia or Alzheimer's? YES NO (please circle)
If yes, please explain ______________________________

Do you have allergies to any medications? YES NO (please circle)
If yes, please explain ______________________________

Have you ever had any surgery? YES NO (please circle)
If yes, please explain ______________________________

Do you take any medications? YES NO (please circle)
If yes, list ______________________________

Have you had any of the following problems? If yes, please explain: (please circle)

Chronic fever, weight loss/gain, fatigue?	YES	NO
Ear/nose/throat problems? (hearing loss, sinus problems, sore throat)	YES	NO
Neurological? (headaches, double vision, confusion, memory problems)	YES	NO
Heart problems: (chest pain, irregular heart beat, hypertension)	YES	NO
Respiratory problems? (shortness of breath, asthma, bronchitis)	YES	NO
Gastrointestinal problems? (heartburn, abdominal pain, diarrhea)	YES	NO
Urinary Problems? (pain, bladder problems, blood in urine)	YES	NO
Musculoskeletal problems? (aches, arthritis, swollen joints)	YES	NO
Psychiatric problems? (depression, anxiety)	YES	NO
Do any medical or eye diseases run in the family?	YES	NO
Do you smoke or consume alcohol? If yes, how much?	YES	NO

Women, are you pregnant: YES NO
If yes, how many months? ________

Medical Insurance Information

Patient________________________________ DOB ____/____/____ Age____ Sex____
Last First

Social Security # ______-______-______ Phone (____) __________ Marital Status_____

Home Address____
Street City State Zip

Employer ____
Street City State Zip

Parent, Spouse, or Responsible Party______________________________
Name Relationship

Contact Information______________________________________
Address Phone

Emergency Contact____
Name Address Phone

Referred by____
Name Address Phone

Are you presently a member of an HMO health plan? YES NO (please circle)

Are you currently enrolled in Hospice? YES NO (please circle)

Primary Insurance:

Insurance Company______________________________ Group Policy # ______________

Policy Holder ______________________________ Member/ID # ______________

Date of Birth ____/____/____ Sex____ Patient Relationship to Policy Holder______________

Primary Care Physician______________________________ Referring Medical Group____________

Secondary Insurance:

Insurance Company______________________________ Group Policy # ______________

Policy Holder ______________________________ Member/ID # ______________

Date of Birth ____/____/____ Sex____ Patient Relationship to Policy Holder______________

Primary Care Physician______________________________ Referring Medical Group____________

Consent for use and disclosure of protected health information

By signing below, you consent to the use and disclosure of your protected health information by our office for treatment, payment, and health care operations. For a more detailed explanation, please review our Notice of Information Practices posted at the front desk.

Patient or Guardian's Signature________________________________ Date______________

Form # 12, 10/09

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INSURANCE NON-COVERED SERVICE AGREEMENT

NOTICE TO BENEFICIARY

Insurance companies will only pay for services that it determines to be "reasonable and necessary". If your insurance company determines that a particular service is not "reasonable and necessary" under their set policy they will deny payment for that service. If your insurance denies your service you will be responsible for payment.

BENEFICIARY AGREEMENT

I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR ANY UNPAID BALANCE THAT MY INSURANCE CARRIER DENIES.

Print Name__________________________ Insurance Co.____________________

Signed_________________________________ Date_____________________

2024