

**BAPTIST PHYSICIAN NETWORK
PATIENT REGISTRATION**

Patient Name _____
Last First Initial
Address _____ City _____ State _____ Zip _____
Home Phone # _____ Cell Phone# _____ Social Security _____ - _____ - _____
Birth Date _____ - _____ - _____ Age _____ Gender _____ Preferred Language _____ Marital Status ___ S ___ M ___ D ___ W
Race _____ Ethnicity _____ Email Address _____
Occupation _____ Employer _____ Work # _____
Pharmacy: _____

PRIMARY INSURANCE

Insured Name _____ Birth Date _____ - _____ - _____
Last First Initial
Relation to Insured: ___ Self ___ Spouse ___ Other Primary Care Physician _____
Insurance _____ Policy/ID# _____ Group # _____
Billing Address _____ City _____ State _____ Zip _____
Insurance Phone # _____ Employer _____ Work # _____

SECONDARY INSURANCE

Insured Name _____ Birth Date _____ - _____ - _____
Last First Initial
Relation to Insured: ___ Self ___ Spouse ___ Other Primary Care Physician _____
Insurance _____ Policy/ID# _____ Group # _____
Billing Address _____ City _____ State _____ Zip _____
Insurance Phone # _____ Employer _____ Work # _____

RESPONSIBLE PARTY

Name _____ Social Security # _____
Address _____ City _____ State _____ Zip _____
Relation to Patient ___ Self ___ Spouse ___ Other Phone # _____

EMERGENCY CONTACT

Name _____ Relationship _____ Phone # _____

I hereby authorize payment of Medicare, ALL other insurance benefits to be made directly to Baptist Physician Network for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I hereby authorize to release all information necessary to secure the payment of benefits.

X _____ Date _____
Signature of Patient (or parent if Minor)

Patient History Form

Date of first appointment: ____ / ____ / ____
Month Day Year

Birthplace: _____

Name: _____ Birthdate: ____ / ____ / ____
last first middle initial maiden Month Day Year

Address: _____ Age _____ Sex: F ☐ M ☐
Street apt#
City State Zip Telephone: Home: (____) _____
Work: (____) _____

MARITAL STATUS: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse/Significant Other: ☐ Alive/Age _____ ☐ Deceased/Age _____ Major Illnesses: _____

EDUCATION (circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of hours worked/Average per work: _____

Referred here by: (check one) ☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Describe briefly your present symptoms: _____

Date symptoms began (approximate): _____

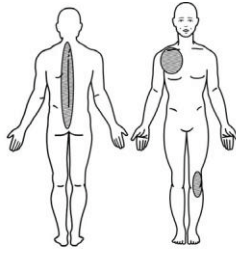
Diagnosis: _____

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later):

Please list the names of other practitioners you have seen for this problem:

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.

Example:



LEFT RIGHT LEFT

LEFT RIGHT

Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9): 1797-808. Used by permission.

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (Check if “yes”)

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or “SLE”	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood Arthritis			Osteoporosis	
	Scleroderma			Psoriasis/ Psoriatic Arthritis	
	Vasculitis			Polymyositis/ Dermatomyositis	
	Fibromyalgia			Sjogren’s Syndrome	
				Raynauds	

Other arthritis conditions: _____

SOCIAL HISTORY

Do you drink caffeinated beverages?
Cups/glasses per day: _____

Do you smoke? ☐ Yes ☐ No ☐ Past – How long ago? _____

Do you drink alcohol? ☐ Yes ☐ No Number per week _____

Has anyone ever told you to cut down on your drinking?
☐ Yes ☐ No

Do you use drugs for reasons that are not medical? ☐ Yes ☐ No
If yes, please list: _____

Do you exercise regularly? ☐ Yes ☐ No
Type _____
Amount per week _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ☐ Yes ☐ No

Do you wake up feeling rested? ☐ Yes ☐ No

Are you receiving disability? ☐ Yes ☐ No

Are you applying for disability? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Do you now have or have you ever had: (check if “yes”)

<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Depression	<input type="checkbox"/> Stomach ulcers	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Bad headaches	<input type="checkbox"/> Hepatitis/ Liver Disease	<input type="checkbox"/> Crohn’s/ Ulcerative Colitis
<input type="checkbox"/> Kidney disease/ Stones	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Anemia	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Tuberculosis

Other significant illness (please list) _____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.) _____

SYSTEMS REVIEW

As you review the following list, please check any problems, which have significantly affected you:

Date of last mammogram: ____/____/____ Date of last eye exam: ____/____/____ Date of last chest x-ray: ____/____/____

Date of last Tuberculosis Test ____/____/____ Date of last bone densitometry ____/____/____

Constitutional

- ☐ Recent weight gain amount _____
- ☐ Recent weight loss amount _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever

Eyes

- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye
- ☐ Itching eyes

Ears-Nose-Mouth-Throat

- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Dryness in nose
- ☐ Runny nose
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness of mouth
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty swallowing

Cardiovascular

- ☐ Chest Pain
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat
- ☐ High blood pressure
- ☐ Heart murmurs

Respiratory

- ☐ Shortness of breath
- ☐ Difficulty breathing at night
- ☐ Swollen legs or feet
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing (asthma)

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting of blood or coffee ground material
- ☐ Stomach pain relieved by food or milk
- ☐ Jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools
- ☐ Heartburn

Genitourinary

- ☐ Difficult urination
- ☐ Pain or burning on urination
- ☐ Blood in urine
- ☐ Cloudy, "smoky" urine
- ☐ Pus in urine
- ☐ Discharge from penis/vagina
- ☐ Getting up at night to pass urine
- ☐ Vaginal dryness
- ☐ Rash/ulcers
- ☐ Sexual difficulties
- ☐ Prostate trouble

For Women Only:

Age when periods began: _____

Periods regular? ☐ Yes ☐ No

How many days apart? _____

Date of last period? ____/____/____

Date of last pap? ____/____/____

Bleeding after menopause? ☐ Yes ☐ No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal

☐ Morning stiffness
Lasting how long?
____ Minutes ____ Hours

- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint swelling

List joints affected in the last 6 mos.

Integumentary (skin and/or breast)

- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive (sun allergy)
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet in The cold

Neurological System

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle spasm
- ☐ Loss of consciousness
- ☐ Sensitivity or pain of hands and/or feet
- ☐ Memory loss
- ☐ Night sweats

Psychiatric

- ☐ Excessive worries
- ☐ Anxiety
- ☐ Easily losing temper
- ☐ Depression
- ☐ Agitation
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

Endocrine

- ☐ Excessive thirst

Hematologic/Lymphatic

- ☐ Swollen glands
- ☐ Tender glands
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Transfusion/when _____

Allergic/Immunologic

- ☐ Frequent sneezing
- ☐ Increased susceptibility to infection

PREVIOUS SURGERIES

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ☐ No ☐ Yes *Describe:* _____

Any other serious injuries? ☐ No ☐ Yes *Describe:* _____

FAMILY HISTORY

IF LIVING		IF DECEASED	
Age	Health	Age at Death	Cause
Father			
Mother			

Number of siblings _____ Number living _____ Number decreased _____

Number of children _____ Number living _____ Number decreased _____ List ages of each _____

Health of children _____

MEDICATIONS

Drug allergies: ☐ No ☐ Yes If yes, please list: _____

Type of reaction: _____

PRESENT MEDICATIONS *(List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)*

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Helped?		
			A Lot	Some	Not At All
1.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PAST MEDICATIONS: Please review this list of “arthritis” medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the results of taking the medication and list any reactions you may have had. *Record your comments in the spaces provided.*

Drug names/Dose	Length of time	Please check: <i>Helped?</i>			Reactions
		A Lot	Some	Not At All	
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Circle any you have taken in the past</i>					
Arthrotec/ Diclofenac + misoprostil					
Celebrex/ Celecoxib					
Sulindac/ Clinoril					
Oxaprozin/ Daypro					
Diflunisal/ Dolobid					
Piroxicam/ Feldene					
Indomethacin /Indocin					
Etodolac /Lodine					
Ibuprofen/ Mortin/ Advil					
Relafen/ Nabumetone					
Naproxen/ Aleve/ Naprosyn					
Ketoprofen/ Orvdis					
Tolmetin/ Tolectin					
Meloxicam/ Mobic					
Diclofenac/ Voltaren					
Pain Relievers					
Acetaminophen		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Codeine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydrocodone/ Vicodin/ Norco		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ultram/ Tramadol		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Disease Modifying Antirheumatic Drugs (DMARDs)					
Certolizumab/ Cimzia		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Golimumab/ Simponi		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydroxychloroquine/ Plaquenil		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Leflunomide/ Arava		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methotrexate		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Azathioprine/ Imuran		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfasalazine/ Azulfidine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Abatacept/ Orencia		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclophosphamide/ Cytoxan		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclosporine A/ Neoral		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etanercept/ Enbrel		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infliximab/ Remicade		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tocilizumab/ Actemra		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sarilumab/ Kevzara		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Adalimumab/ Humira		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mycophenolate Mofetil/ Cellcept		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Belimumab/ Benlysta		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rituximab/ Rituxan		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Secukinumab/ Cosentyx		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ixekizumab/ Taltz		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vedolizumab/ Entyvio		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ustekinumab/ Stelara		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tofacitinib/ Zeljan		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Baricitinib/ Olumiant		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Apremilast/ Otezla		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

PAST MEDICATIONS *Continued*

Drug names/Dose	Length of time	Please check: <i>Helped?</i>			Reactions
		A Lot	Some	Not At All	
Osteoporosis Medications					
Estrogen		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alendronate/ Fosamax		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ibandronate/ Boniva		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Raloxifene/ Evista		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Zoledronic acid/ Reclast		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Denosumab/ Prolia		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Risedronate/ Actonel/ Atelvia		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Teriparatide/ Forteo		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gout Medications					
Probenecid/ Benemid		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colchicine/ Colcrys		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allopurinol/ Zyloprim		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Febuxostat/ Uloric		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pegloticase/ Kyrstexxa		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lesinurad/ Zurampic		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Others					
Cortisone/ Prednisone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Viscosupplement Injections/ Supartz/ Synvisc/ Hyalgan/ Euflexxa		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fibromyalgia Medications					
Duloxetine/ Cymbalta		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pregabalin/ Lyrica		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Milnacipran/ Savella		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclobenzaprine/ Flexeril		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Amitriptyline/ Elavil		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fluoxetine/ Prozac		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Please list supplements:

Have you had a pneumonia shot? ☐ Yes ☐ No If so, list date _____

Have you had a flu shot? ☐ Yes ☐ No If so, list date _____

Have you had a shingles shot? ☐ Yes ☐ No If so, list date _____

Patient's Name: _____ Date: _____ Physician Initial: _____



**REQUEST FOR LIMITATIONS AND RESTRICTIONS OF
PROTECTED HEALTH INFORMATION (PHI)**

**PATIENT PLEASE NOTE: THE PRACTICE IS NOT REQUIRED TO AGREE TO
YOUR REQUEST. PLEASE SEE OUR NOTICE OF
PRIVACY PRACTICES FOR MORE INFORMATION
REGARDING SUCH REQUESTS.**

Patient Name: _____ Date of Birth: _____

Patient Address: _____
Street

Apartment #

City, State and Zip Code

Type of PHI to be restricted or limited: (Please check all that apply. Note: should you
need to be referred to another physician, anything
checked will **NOT** be shared.)

<input type="checkbox"/> Home phone #	<input type="checkbox"/> Patient History
<input type="checkbox"/> Home address	<input type="checkbox"/> Office address
<input type="checkbox"/> Occupation	<input type="checkbox"/> Office phone #
<input type="checkbox"/> Name of employer	<input type="checkbox"/> Spouse's name
<input type="checkbox"/> Visit notes	<input type="checkbox"/> Spouse's office phone #
<input type="checkbox"/> Hospital notes	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Prescription information	

How may we use and/or disclose of your PHI restricted information?

Signature of Patient or Legal Guardian

Date



***PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED
HEALTH INFORMATION***

By signing this authorization, I authorize, Baptist Physician Network, to use and/or disclose certain Protected Health Information (PHI) about me to the following family members:

This authorization permits Baptist Physician Network to use and/or disclose medical and/or billing information directly related to my diagnosis and/or treatment. This information will be used or disclosed at the request of myself or the person(s) designated above. This authorization will not expire unless specifically revoked by either myself or the person(s) designated above.

I do not have to sign this authorization in order to receive treatment from Baptist Physician. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

Signed by:

Signature of Patient or Legal Guardian

Relationship to Patient

Print Name of Patient or Legal Guardian

Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION



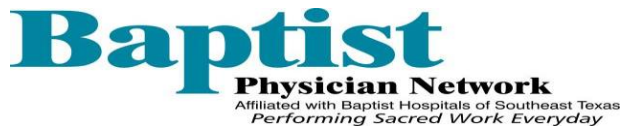
***RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM***

I, _____, have received a copy of Baptist Physician Network
Patient's Name

Notice of Privacy Practices.

Signature of Patient

Date



Medical Record Request Form

Patient Identification – Please Print

Full Name: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone #: (____) _____ - _____ Cell Phone #: (____) _____ - _____

Information To Be Released – Covering the Periods of Healthcare

From (date): _____ To (date): _____

Type of Information To Be Released – Please Check Only Those That Apply

<input type="checkbox"/> Complete Health Record	<input type="checkbox"/> Photographs, videotapes	<input type="checkbox"/> X-ray reports
<input type="checkbox"/> History and Physical exam	<input type="checkbox"/> X-ray films / images	<input type="checkbox"/> Complete billing record
<input type="checkbox"/> Laboratory test results	<input type="checkbox"/> Consultation reports	<input type="checkbox"/> Discharge summary
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Other, (please be specific): _____	

Purpose of Request

<input type="checkbox"/> Treatment or Consultation	<input type="checkbox"/> At the request of the Patient	<input type="checkbox"/> Billing or Claims Payment
<input type="checkbox"/> Other, (please be specific): _____		

Where to Send Information

Practice Name: **Baptist Physician Network Rheumatology Center**

Address: **740 Hospital Drive, Suite 150**

City: **Beaumont** State: **Texas** Zip: **77701**

Telephone #: **(409) 212-5115** Fax #: **(409) 212-5112**

What Practice are We Requesting Records

Practice Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: () _____ - _____ Fax #: () _____ - _____

Signature of Patient or Personal Representative

I authorize the release of this information to Baptist Physician Network

I authorize Baptist Physician Network to request the protected health information specified above

Signature: _____ Date: _____

Signing Authority: _____ Relationship: _____



Cancellation/No Show Policies:

A 24-hour notice is required if you are unable to keep a scheduled appointment. Missed appointments will incur a \$25.00 fee. This fee must be paid prior to scheduling another appointment. Failure to appear for scheduled appointments will result in discharge from the clinic.

Signature: _____ Date: _____

Witness: _____



Dear valued patient:

The most valuable information that I need to properly take care of you is an accurate medication list. Therefore, I strongly urge you to bring **all your MEDICATION BOTTLES** with you each time you come for an office visit so we can compare it to our current list and make sure it is accurate. I must have a correct list of your medications, dosage, and the frequency in which you are taking these medications to care for you properly. I also need to be aware of any over-the-counter medications you are taking. As many patients see multiple physicians it is often possible you may be taking medications or had dosage changes that I am not aware of. In addition I request that you **call** us immediately with any change in your medications or medication dosages. Failure to comply with the above request could lead to serious errors in your treatment with the potential for significant morbidity and mortality. By signing below you attest that you have read and understand the potential seriousness of your noncompliance with this request.

Signature: _____ Date: _____

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 takes effect on _____ January 1, 2017 _____ and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

NOTICE OF PRIVACY PRACTICES

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operation, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, to others who contact us and ask for information about you by name.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established to protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also,

when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

NOTICE OF PRIVACY PRACTICES

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary; to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you \$_____ for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the time we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer at your office.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.