PATIENT INFORMATION

Name: _____ **Age**: _____ **Date of Birth**: _____

Social Security Number: _____

Male ____ Female ____ Non-binary____
Single ____ Married ____ Divorced ____ Widowed ____

Address: _____ City _____ State _____ Zip _____

Phone: Home [] _____ Cell [] _____ Work [] _____
Please indicate which number(s) you prefer us to call you on.

Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____
.
Pharmacy Information: Name _____ Phone _____

Address: _____ City _____ State _____ Zip _____

Occupation: _____ Employer: _____ Phone: _____

Address: _____ City _____ State _____ Zip _____

Primary Insurance: _____ Identification #: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____ Relationship: _____

Secondary Insurance: _____ Identification #: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____ Relationship: _____

Referring Physician: Full Name: _____

Phone: _____ Fax**:** _____

Address: _____ City _____ State _____ Zip _____

Primary Care Physician: Full Name: _____

Phone: _____ Fax**:** _____

Address: _____ City _____ State _____ Zip _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balances. I also authorize the physician to release any information to my insurance company that is required to process my claim.

_____ _____
Patient/Guardian Signature Date

HIPAA NOTICE

THE DOCTOR AND STAFF
WANT YOU TO KNOW HOW WE WILL PROTECT YOUR PRIVATE HEALTH INFORMATION.

When you visit our office it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. However, on April 14, 2003, new regulations became effective under a federal law called the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA regulations cover physicians and all other health care providers, health insurance companies and their claims processing staff. In general, HIPAA was enacted to establish national standards to:

1. Give patients more control over their health information
2. Set boundaries for the use and release of health records
3. Establish safeguards that physicians, health plans and other healthcare providers must have in place to protect the privacy of health information.
4. Hold violators accountable, with civil and criminal penalties
5. Try to balance need for individual privacy with requirements for public responsibility that required disclosures to protect the public health.

The HIPAA rules require that our practice provide all of our patients that we see after April 14, 2003 with our Notice of Privacy Practices. The Notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to your access to this information. A copy of this Notice is posted by the waiting room, and a copy is available for you, if desired, at the check-in window.

Please sign below that we have made available a copy of the Notice to review. You are entitled to a personal copy of the Notice at any time to review and keep for your records. If you have any questions about our Privacy Practices, please feel free to contact our office manager.

Additionally, by signing below I allow anyone who comes into the examination and/or consultation room with me to participate in examination(s) and or discussion regarding my health care while in my presence.

Thank you for your cooperation.

I acknowledge that I have received a copy of the Notice of Privacy Practices and have been given an opportunity to ask questions.

Patient Name: _____
Please Print

_____ _____
Signature of Patient or Personal Representative Date

If Personal Representative, give relationship to patient: _____