Robert Stephenson, MD
320 Santa Fe Dr. Suite 303
Encinitas, CA 92024
Phone: (760) 943-6730 - Fax: (760) 943-6735

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND PATIENT CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and/or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have received, read and understand your *Notice of Privacy Practice* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____
Relationship to Patient: _____ (Self/Spouse/Parent/Guardian)

Signature: _____ Date: _____

Office Use ONLY

I attempted to obtain the patients signature in acknowledgement on this *Notice of Privacy Practices* Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

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ELIGIBILITY GUARANTEE FORM

(Please Select one of the Following):

☐ I, _____ *(Last Name, First Name)* herby certify that I am eligible for _____ *(Insurance Company Name)* health plan coverage as of _____ *(Month/Day/Year)* through _____ *(Employer/Self/Spouse/Etc.).*

☐ I currently **(do not have/do not wish to use)** *(please circle one)* insurance. As such, I agree to pay cash/credit/check for my visits on the day of my appointment prior to seeing the Doctor. Additionally I acknowledge that any additional care/treatment/procedures rendered will be an additional charge and must be collected prior to leaving the office on the day of my appointment.
(Any questions about insurance/cash visits can be answered by the office staff)

I have chosen Dr. Robert Stephenson, M.D. to be my Primary Care Physician.

I understand that if the above is not true or if I am not eligible under the terms of my Medical and Hospital Subscriber Health Insurance Agreement, I am liable for all chargers for services rendered. Also, if the above is not true, I agree to pay in full for all services received within 30 days of receiving a bill form the above-noted medical provider.

Patient Name: _____
Relationship to Patient: _____ (Self/Spouse/Parent/Guardian)

Signature: _____ Date: _____

Office Use ONLY

Office Representative - Date: _____ Name: _____ Title: _____

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Patient Information

Patient Name: _____
Address:: _____ City/State: _____
Zip:_____ Gender: Male/Female Phone#:_____
DOB: _____ SSN: _____ Race/Ethnicity: _____
Marital Status: _____ Email Address: _____
Primary Next of Kin: _____ Phone#:_____

Employment Information

Employment Status: F/T - P/T - Retired - Student - Unemployed
Employer Name: _____ Work#: _____
Address:: _____ City/State: _____
Zip:_____ Type of Business: _____ Job Title: _____

Emergency Contact *(If different than Primary Next of Kin)*

Contact Name: _____ Phone#:_____
Relationship: _____

Authorization to Release Information and Assignment of Benefits

I authorize the release of any information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.
Signature: _____ Date: _____

I authorize Dr. Stephenson to apply for benefits on my behalf for covered services rendered by him, I am also aware that I am responsible for any charges that may not be covered by my insurance company, and if my insurance may change, I am aware of my responsibility for notifying the office of the change.
Signature: _____ Date: _____

**I hereby allow Dr. Stephenson to discuss my medical records with family members and/or consulting physicians.*
Signature: _____ Date: _____

**Authorizing this discussion of medical records (last signature) is optional, however, by law, a signature will be needed in order for Dr. Stephenson to discuss any information regarding your medical records to anyone besides the patient.*

REFERRED BY: _____

Robert Stephenson, MD

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HEALTH QUESTIONNAIRE

Name: _____ Date of Birth: _____

***PERSONAL MEDICAL HISTORY:** *Place "X" if you have or have HAD any of the following:*

__ Tuberculosis	__ Stroke	__ Kidney Disease	__ Glaucoma
__ Migraine	__ High Blood Pressure	__ Hypertension	__ Mental Illness
__ Menstrual Pain	__ Epilepsy	__ Heart Issues	__ Diabetes
__ Cancer	__ Prostate Issues	__ Ear Issues	__ Allergies
__ Eye Issues	__ Arthritis	__ Gallbladder issues	__ Gout
__ Substance Abuse	__ Anemia	__ High Cholesterol	__ Thyroid Issues

Any other significant History/Diseases/Diagnoses: _____

Current Medications: _____

_____

Allergies to Medications?: _____

Hospital Admissions:

Date:	Illness:	Type of Operation:	Location:
_____	_____	_____	_____
_____	_____	_____	_____

PERSONAL HABITS:

Consume Alcohol: No ____ Yes ____ How often: _____ (daily/weekly/monthly) *circle one*
Coffee/Tea/Caffeine: No ____ Yes ____ (if yes) # of cups per day? _____ *(8oz = 1 cup)*
Contraception Use: No ____ Yes ____ (if yes) type(s)? _____ *(pill, patch, condom, iud,etc.)*

Tobacco:
Do you use tobacco? Y or N
(if yes) # of packs per day?_____
Tobacco use in past? Y or N

♀ FEMALES ONLY:

Menstrual History-
Age of first cycle: _____
Regular?: No ____ Yes ____
Date of last period: _____

Pregnancies -
Number of pregnancies: _____
Number of live births: _____
Number of miscarriages: _____

***FAMILY HISTORY:** *(If any family member has had any of the following please indicate which relative.)*

Tuberculosis:_____	Epilepsy: _____	Arthritis: _____
Hypertension: _____	Stroke: _____	Diabetes: _____
Gout: _____	Heart Disease: _____	Migraines: _____
Cancer: _____	Kidney Disease: _____	Mental Illness: _____
Allergies: _____	Glaucoma: _____	

Please provide the following information about your immediate family:

Relationship:	Age *(if living)*	or	Age of Death	State of health or Cause of Death
Father:	_____		_____	_____
Mother:	_____		_____	_____