PATIENT REGISTRATION FORM			
Name		**Social Security #**	
Address		**Marital Status**	
Home Phone		**Employer**	
Work Phone		**Referred By**	
Cell Phone		**Language and Ethnicity**	
Email		**Responsible Party Name, (policy holder) Address, Phone, and Relationship**	
Gender			
Date of Birth			

PRIMARY INSURANCE			
Insurance Plan (aetna, none, etc.)		**Subscriber's Employer**	
Insurance Company Address		**Policy ID #**	
Subscriber Name (policyholder)		**Group #**	
Subscriber Phone		**Insurance Effective Date**	
Subscriber DOB/ Social Security #		**Copay**	

SECONDARY INSURANCE			
Insurance Plan (aetna, none, etc.)		**Subscriber's Employer**	
Insurance Company Address		**Policy ID #**	
Subscriber Name (policyholder)		**Group #**	
Subscriber Phone		**Insurance Effective Date**	
Subscriber DOB/ Social Security #		**Copay**	

I request that payment of authorized insurance or medicare benefits be made payable to Maxwell Medical Group for any services provided to me by the physician. I authorize any holder of my medical information to release to the insurance company or to CMS and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of all medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, whether or not paid by my insurance. I agree to pay my account in accordance with the regular rates and payment terms of this office. If my account is referred for collection, I agree to pay the balance due plus a collection fee of 35% of the remaining balance and all attorney fees.

Patient or Parent/Guardian 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 4/14/03 and remains in effect until we replace it.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

The privacy of your medical information is important to us. We understand that your medical information is person and and we are committed to protecting it. We create a record of the care and services you receive at Maxwell Medical Group. 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.

OUR LEGAL DUTY:

Law requires us to:

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

We have the right to:

- Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law
- 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 change

Notice of change to privacy practices:

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

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 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 to provide 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 Healthcare 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.

ADDITIONAL USES AND DISCLOSURES:

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

- 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 an 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 medication information for you.
- Disaster Relief: Medical information shared with a public or private organization or person who can legally assist in disaster relief efforts.
- 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 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, 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 a court order, warrant, or grand jury subpoena, we may share your medical information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim, or missing person. We may share the 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.
- 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 help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.
- Worker's Compensation: We may disclose health information when authorized and necessary to comply with laws relating to worker's 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, administrating, 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, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

YOUR INDIVIDUAL RIGHTS:

You have a right to:

- 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 $1.00 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.
- Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
- 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).
- 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.
- 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.

QUESTIONS AND COMPLAINTS:

If you have any questions about his notice, or if you think that we may have violated your privacy rights, please contact the Maxwell Medical Group Office Manager at 11000 N. Scottsdale Rd., #225, Scottsdale, AZ 85254 or by telephone (602) 508-8055. 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.

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the “Notice of Privacy Practices” and I have been provided an opportunity to review it.

Name (printed)		**Date of Birth**	
Signature		**Today’s Date**	