Lake Havasu OB/GYN Care, LLC
2130 Mesquite Ave Suite 100
Lake Havasu City, Arizona 86403
Telephone: 928.302.5100 Fax: 928.302.5103

PLEASE PRINT

Your Legal Name _____
Last First Middle Maiden

Social Security Number _____-_____-_____ Date of Birth _____

Mailing Address: _____
Street City State ZIP

Physical Address: _____
Street City State Zip

Marital Status: Single____ Married____ Divorced____ Widowed____ Separated____ Other_____

Race_____ Ethnic Group: Hispanic or Non-Hispanic Language _____
Circle One

Home PH # _____ Cell PH # _____ E-mail _____

Employer _____ Employer's Telephone # _____

Emergency Contact_____ Telephone_____ Relationship to You _____

Primary Care Physician _____ **Preferred Pharmacy** _____

Insurance Information (*Please provide receptionist with your insurance card)*

Primary Insurance _____Policy # _____ Group #_____

Secondary Insurance _____ Policy #_____ Group #_____

Subscriber Information on Insurance Policy If Different than Yours

Name _____Telephone/Cell # _____
Last First Middle

Address _____ Relationship to You _____

Social Security Number _____-_____-_____ Date of Birth _____ Employer _____

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Insurance coverage is considered by Lake Havasu OB/GYN Care, LLC as an agreement between the patient, the insurance company, and the employer, where applicable. Lake Havasu OB/GYN Care, LLC is not a part to that agreement and, as a result, is not bound by any of the covenants, limitations, restrictions of that policy, unless they are a provider for my particular insurance carrier. I also understand that I am responsible for all non-covered services pertaining to my particular insurance carrier. In the event I do not notify Lake Havasu OB/GYN Care, LLC of any insurance changes or requirements, I will be responsible for all charges. ALL charges must be paid in full to receive a refund, within 30 to 60 days; on any overpayments regardless of date payment was made. Lake Havasu OB/GYN Care, LLC does accept Medicare assignment; however, I will be responsible for payment of non-covered services and supplies. Should outstanding charges remain unpaid and my account placed in the hands of an attorney or a collection agency, I agree to pay and be responsible for all costs of collection including, but not limited to, collection fee of 50% or less on outstanding balance, attorney fees, court cost, and interest. I hereby authorize the release of any medical information necessary to process and consider health insurance claims submitted on behalf of me and/or dependents by Lake Havasu OB/GYN **Care, LLC. I authorize payment of benefits due on such claims to be made directly to the provider of services should the provider choose to forward unless revoked in writing. Photocopies of** this authorization will be as valid as original authorization. Having read and understood the above statement, I agree to the terms set forth.

Patient OR Legal Guardian Signature _____ Today's Date _____

Medical Records Authorization
HIPAA Compliant Form to Release/Obtain Information

PLEASE PRINT OR TYPE

Name _____
Last First Middle

Social Security # _____-_____-_____ Date of Birth_____ Telephone # _____

Please give the complete name and address of the medical facility or organization you are authorizing your medical records to be released from:

Physician/Clinic _____

Telephone # _____ **Fax #**_____

I authorize my medical records be sent to:

Lake Havasu OB/GYN Care, LLC
Dr. Kevin Hooker
2130 Mesquite Ave Suite 100
Lake Havasu City, Arizona 86403
Telephone: 928.302.5100 **Fax: 928.302.5103**

_____All medical records _____Other_____

I further understand that:

- I may refuse to sign this authorization and that my refusal will have no impact on receiving treatment.
- I can inspect or copy any information disclosed under this agreement.
- My signing of this document is voluntary.
- I can revoke this authorization at any time and the revocation must be in writing.
- I will receive a copy of this authorization.
- The federal privacy laws will not cover the information released.

Patient/Legal Guardian Signature _____ Date _____

Note: Patients 18 and older must sign their own authorization. Spouses must sign their own authorization. The information which relates to privileged information is subject to the following statement: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making further disclosure of such information without specific written consent of the person to whom the information pertains or is otherwise permitted by state law.

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Receipt of Notice of Privacy Practices
Written Acknowledgement Form

(You may refuse to sign this acknowledgement)

I,_____, received a copy of **Lake Havasu OB/GYN Care's Notice of Privacy Practices.**

_____ _____
Patient Signature Date

Please specify who can have information pertaining to your relationship with this office
(i.e., results, appointment reminders, account balances, etc.)

1. Name _____Relationship _____Contact #_____

2. Name _____Relationship _____Contact # _____

3. Name _____Relationship _____Contact # _____

May we leave a message on your answering machine regarding appointments
and/or lab results? **Yes_____ No_____**

Would you like information regarding an Advance Directive? Yes_____ No_____

_____
For Office Use Only

We attempted to obtain written acknowledgement of receipt of our **Notice of Privacy Practices**, but acknowledgement could not be obtained because:

_____ Patient refused to sign

_____ Communication barriers

_____ An emergency situation

_____ Other/please specify_____

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928-302-5100

Office Policies

Cancellations:

This office has a policy of charging a fee for missing an appointment or canceling with less than two working days' notice. The fee is $50.00. The purpose of this fee is to encourage our patients to take their appointments as seriously as we do. That time is reserved for you, and if you do not keep the scheduled appointment, then other patients who need "same day" urgent visits, or earlier appointments than the schedule permits, are being obligated to wait longer than necessary. Obviously, acute health problems and family crises are expected. Cancellations of convenience or last-minute schedule conflict will be your responsibility. Thank you for understanding. Please give us at least 48-hour notice if you cannot make it to your appointment. In the event that you do not provide the required notice, you may be charged a missed appointment fee of $50. Three or more missed appointments or late cancellations may result in dismissal from our practice.

Late Arrivals:

If you arrive more than 15 minutes late, your appointment may have to be rescheduled. We will make an effort to work you in, however that cannot be guaranteed.

Appointment Order:

In general patients are seen in the order in which they arrive. However, patients who have arrived early will not be seen before patients who are on time and have earlier appointments.

Insurance Disclaimer:

"A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service."

Insurance Liability for Payment:

Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service.

Beneficiary Agreement:

I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

Insufficient Funds:

If a check is returned due to insufficient funds, there will be a $25.00 fee.

Collections:

Should outstanding charges remain unpaid and my account is placed in the hands of an attorney or a collection agency, I agree to pay and be responsible for all costs of collections including, but not limited to, a collection fee of 50% or less, attorney fees, court cost, and interest.

By signing below, I acknowledge that I have read, understand, and agree to the preceding Office Policies.

_____ _____

Patient Name (Print) **Patient Signature**

Date of Birth_____ **Social Security #:** _____-_____-_____

_____

Date

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Patient's Bill of Rights

As a patient, you have the right:

- To be treated with respect by all office staff.
- To have a doctor who is responsible for your care.
- To know the name and professional status of those giving your care.
- To receive complete and current information about your diagnosis, treatment, and prognosis in terms you can understand.
- To participate with your doctors and other healthcare providers in planning your healthcare treatment.
- To have your stated personal, cultural, and spiritual values and beliefs taken into account when treatment decisions are made.
- To make advance treatment directives and to have them honored.
- to have any proposed procedure or treatment explained in terms you can understand, including:
    - A description of the nature and purpose of the procedure of treatment.
    - The possible benefits.
    - The known serious side effects, risks, or drawbacks.
    - Problems related to recovery.
    - The chance for success.
    - Alternate procedures or treatments.
    - Cost—particularly costs that you will need to pay.
- To accept or refuse any procedure, drug, or treatment (to the extent allowed by law) and to be informed of the possible consequences of any such decision.
- To consent or refuse care that involves research, experimental treatments, or educational projects.
- To appoint a person to make healthcare decisions on your behalf in the event you lose the capacity to do so.
- To personal privacy. Care discussion, consultation, examination, and treatment are confidential and will be conducted discreetly.
- To confidentiality of your records.
- To have access to your health records and to have them explained to you.
- To receive services in response to reasonable requests that are within the capacity of this office. We will refer, consult, or transfer as needed in a responsible manner.
- To be informed about ongoing healthcare needs and options for meeting them after you leave the office.
- To not be discriminated against because of race, color, religion, sex, age, national origin, sexual preference, disability, or source of payment.
- To be informed of office policies, procedures, and rules that apply to your care.
- To complain about your care without fear of recrimination or penalty and to have your complaints reviewed and, when possible, resolved.
- To supportive care including rapid and appropriate management of pain, treatment of uncomfortable symptoms, and support of your psychological and spiritual concerns and needs.
- To request consultation regarding ethical issues surrounding your care from the ethics committee or other sources.
- To be free from physical or emotional abuse or harassment by the staff.
- To carefully look at your bill and to have the charges explained to you.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally , are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a skin biopsy.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may send you a post-card with your name, appointment time and date. We may call you at home or at work to confirm your appointment. We may leave a message on your answering machine or with a person that answers the phone.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.

- The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.
This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from the office.
You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Right, about violation of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA Or to file a complaint:

The US Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue S.W.
Washington, D.C. 20201
(202) 619-0257 Toll Free: 1877-696-6775