PROS Miami Homestead, LLC

PERSONAL INJURY
CONFIDENTIAL PATIENT INFORMATION
INFORMACIÓN CONFIDENCIAL DEL PACIENTE

PATIENT DATA / DE DATOS DEL PACIENTE

NAME / NOMBRE: ____AGE / EDAD:__________ ❑ MALE / MASCULINO ❑ FEMALE / FEMENINO
DATE OF BIRTH / FECHA DE NACIMIENTO: __________________ SSN / NÚMERO DE SEGURIDAD SOCIAL:_________ - ________ - ________
ADDRESS / DIRECCIÓN: ____
HOME PHONE # / NÚMERO DE LA CASA: _______________________________ CELL # / NÚMERO DE LA CÉLULAR: ____________________
EMPLOYER / EMPLEADOR: ____ OCCUPATION / OCUPACIÓN: ___________________________
WORK # / NÚMERO DE TRABAJO: _____________________________________ FAX # / NÚMERO DE FAX: ______________________________
DRIVER LICENSE # / NÚMERO DE LICENCIA DE CONDUCIR:____
MARTIAL STATUS / ESTADO CIVIL: ❑ MARRIED / MATRIMONIO ❑ SINGLE / SOLTERA / SOLTERO

SPOUSE'S NAME / NOMBRE DE LA ESPOSA/ESPOSO: ____
SPOUSE'S OCCUPATION / OCUPACIÓN DE LA ESPOSA/ESPOSO: ____
SPOUSE'S EMPLOYER / EMPLEADOR DE LA ESPOSA/ESPOSO: ____
SPOUSE'S PHONE # / NÚMERO DE TELÉFONO DE LA ESPOSA/ESPOSO: ______________________________________

PRESENT COMPLAINT / PRESENTE QUEJA

DESCRIBE YOUR PROBLEM / DESCRIBA SU PROBLEMA: ____
____
____

OTHER DOCTOR(S) SEEN FOR THIS PROBLEM? / ¿OTRO MÉDICO(S) VISTO PARA ESTE PROBLEMA?: ❑ YES / SÍ ❑ NO
IF YES, GIVE DOCTOR'S NAME / EN CASO AFIRMATIVO, DAR EL NOMBRE DEL MÉDICO: ____

WERE YOU TAKEN TO THE HOSPITAL? / ¿FUE LLEVADO AL HOSPITAL?: ❑ YES / SÍ ❑ NO
IF YES, PROVIDE NAME OF HOSPITAL / EN CASO AFIRMATIVO, INDIQUE EL NOMBRE DEL HOSPITAL: ____________________________

HAVE YOU MISSED ANY WORK? / ¿HA FALTADO A CUALQUIER TRABAJO? : ❑ YES / SÍ ❑ NO
IF YES, PROVIDE DATES MISSED FROM WORK / EN CASO AFIRMATIVO, PROPORCIONE FECHAS PERDIDOS DE TRABAJO: ___________
____

MEDICAL HISTORY / HISTORIA DE LA MEDICINA

❑ POLIO / POLIOMIELITIS
❑ ANEMIA / LA ANEMIA
❑ ASTHMA / ASMA
❑ CANCER / CÁNCER
❑ NEURITIS
❑ EPILEPSY / EPILEPSIA
❑ DIABETES
❑ BACKACHES / DOLOR DE ESPALDA
❑ HEPATITIS
❑ ARTHRITIS / ARTRITIS
❑ DIZZINESS / MAREOS
❑ NUMBNESS / ADORMECIMIENTO
❑ NERVOUSNESS / NERVIOSISMO
❑ RHEUMATISM / REUMATISMO
❑ SINUS PROBLEMS / PROBLEMAS DE SINUSITIS
❑ CONCUSSION / CONMOCIÓN CEREBAL
❑ MULTIPLE SCLEROSIS / LA ESCLEROSIS MÚLTIPLE
❑ DIGESTIVE DISORDER / TRASTORNO DIGESTIVO
❑ HIGH BLOOD PRESSURE/ LA PRESIÓN ARTERIAL ALTA
❑ HEART PROBLEMS / PROBLEMAS DE CORAZÓN
❑ OTHER / OTROS: ___________________________________

HAVE YOU HAD ANY SURGERIES? / ¿HA TENIDO ALGUNA CIRUGIA?: ❑ YES / SÍ ❑ NO
IF YES, LIST BELOW TYPE OF SURGERY / EN CASO AFIRMATIVO, LISTA A CONTINUACIÓN EL TIPO DE CIRUGÍA: _________________
____

TREATED BY A PHYSICIAN FOR ANY CONDITION IN THE LAST 12 MONTHS? / ¿TRATADO POR UN MÉDICO PARA CUALQUIER ENFERMEDAD EN LOS ÚLTIMOS 12 MESES? ❑ YES / SÍ ❑ NO
IF YES, DESCRIBE CONDITION / EN CASO AFIRMATIVO, DESCRIBIR LA CONDICIÓN ____

MEDICAL HISTORY / HISTORIA DE LA MEDICINA

DATE OF LAST PHYSICAL EXAM / FECHA DEL ÚLTIMO EXAMEN FÍSICO: ____

DATE OF LAST MENSTRUAL PERIOD / FECHA DE LA ÚLTIMA ÉPOCA MENSTRAUL: ______________________________________

ARE YOU PREGNANT? / ¿ESTÁ EMBARAZADA?: ❏ YES / SÍ ❏ NO

ALLERGIC TO ANY MEDICATION? / ¿ES ALÉRGICA A ALGÚN MEDICAMENTO?: ❏ YES / SÍ ❏ NO
IF YES, WHAT KIND / EN CASO AFIRMATIVO, QUÉ TIPO: ____

TAKING ANY MEDICATION? / ¿TOMANDO ALGUN MEDICAMENTO?: ❏ YES / SÍ ❏ NO
IF YES, WHAT KIND / EN CASO AFIRMATIVO, QUÉ TIPO: ____

ACCIDENTAL INJURY REPORT / INFORME DE LESIONES ACCIDENTALES

DATE OF ACCIDENT / FECHA DE ACCIDENTE: ___________________________

DID YOU REPORT THE ACCIDENT TO YOUR INSURANCE COMPANY?/ ¿REPORTÓ EL ACCIDENTE A SU COMPAÑIA DE SEGUROS?:
❏ YES / SÍ ❏ NO

WHAT KIND OF VEHICLES WERE INVOLVED? / ¿QUÉ TIPO DE VEHÍCULOS ESTUVIERON INVOLUCRADOS?
❏ TRUCK / CAMIÓN ❏ SUV / CAMIONET0A ❏ CAR / COCHE ❏ VAN ❏ MOTORCYCLE / MOTOS

WERE YOU A / ERAS UN: ❏ DRIVER / CONDUCTOR ❏ PASSENGER / PASAJERO ❏ PEDESTRIAN / PEATÓN
IF YOU WERE A PASSENGER PLEASE INDICATE YOUR LOCATION IN THE CAR / SI USTED FUERA UN PASAJERO POR FAVOR, INDIQUE SU UBICACIÓN EN EL COCHE: ____

WAS YOUR VEHICLE MOVING WHEN THE ACCIDENT OCCURRED? / ¿FUE SU VEHÍCULO EN MOVIMIENTO CUANDO OCURRIÓ EL ACCIDENTE?: ❏ YES / SÍ ❏ NO MPH: ________________________

DID YOUR VEHICLE HIT OTHER VEHICLES? / ¿SU VEHÍCULO FUE ALCAMZADO POR OTROS VEHÍCULOS?: ❏ YES / SÍ ❏ NO
WHERE / DONDE: ____

DID OTHER VEHICLES HIT YOUR VEHICLE? / ¿SU VEHÍCULO FUE ALCAMZADO POR OTROS VEHÍCULOS?: ❏ YES / SÍ ❏ NO
WHERE / DONDE: ____

WAS THE ACCIDENT REPORTED TO THE POLICE DEPARTMENT? / EL ACCIDENTE FUE REPORTADO A LA POLICIA? ❏ YES / SÍ ❏ NO

WERE YOU AN UBER OR LYFT DRIVER AT THE TIME OF ACCIDENT? / ESTABA CONDUCIENDO PARA UBER O LYFT EN EL MOMENTO DEL ACCIDENTE? ❏ YES / SÍ ❏ NO

WERE YOU A PASSENGER IN AN UBER OR LYFT AT TIME OF ACCIDENT? ERA PASAJERO EN UN UBER O LYFT EN EL MOMENTO DEL ACCIDENTE? ❏ YES / SÍ ❏ NO

WERE TRAFFIC CITATIONS ISSUED? / ¿MULTAS DE TRÁFICO FUERON EMITIDOS?: ❏ YES / SÍ ❏ NO
WHERE / DONDE: ____

WORK-RELATED INJURY REPORT / INFORME DE LESIONES RELACIONADAS CON EL TRABAJO

DATE OF ACCIDENT / FECHA DE ACCIDENTE:

WAS YOUR EMPLOYER NOTIFIED? / ¿FUE NOTIFICADO A SU EMPLEADOR?: ❏ YES / SÍ ❏ NO
(IF YES, PROVIDE INFORMATION BELOW / ENCASO AFIRMATIVO, PROPOCIONAR INFORMACIÓN A CONTINUCCIÓN)

EMPLOYER'S NAME / NOMBRE DEL EMPLEADOR: ____

EMPLOYER'S ADDRESS / DIRECCIÓN DEL EMPLEADOR: ____

EMPLOYER'S PHONE # / EL NÚMERO DE TELÉFONO DEL EMPLEADOR: ____

MISSED TIME FROM WORK? / ¿TIEMPO PERDIDO DE TRABAJO?: ❏ YES / SÍ ❏ NO
(IF YES, PROVIDE DATES MISSED / EN CASO AFIRMATIVO, PROPORCIONE FEACHS PERDIDAS: ______________________________
____

BRIEF DESCRIPTION OF ACCIDENT / BREVE DESCRIPTIÓN DEL ACCIDENTE: ____
____

SLIP & FALL INJURY REPORT / RESBALAR Y CAER INFORME DE LAS LESIONES

DATE OF ACCIDENT / FECHA DE ACCIDENTE: ____

PLACE OF ACCIDENT? / ¿LUGAR DE ACCIDENTE?: ____

WAS ACCIDENT REPORTED? / ¿EL ACCIDENTE FUE REPORTADO? ____

BRIEF DESCRIPTION OF ACCIDENT / BREVE DESCRIPTIÓN DEL ACCIDENTE: ____
____
____

INSURANCE INFORMATION / INFORMACIÓN SOBRE EL SEGURO

AUTOMOBILE INSURANCE INFORMATION / AUTOMOVILÍSTICO INFORMACIÓN:

INSURANCE COMPANY / COMPAÑIA DE SEGURO: ____

INSURANCE PHONE # / NÚMERO DE TELÉFONO DE SEGURO: ____

SUBSCRIBER'S NAME / NOMBRE DEL SUSCRIPTOR: ____

SUBSCRIBER'S DOB / FECHA DE NACIMIENTO DEL SUSCRIPTOR: ____

POLICY # / NÚMERO DE PÓLIZA: ____________________________ CLAIM # / NÚMERO DE RECLAMAR: _______________________

HEALTH INSURANCE INFORMATION / INFORMACIÓN DE SEGURO DE MÉDICO:

INSURANCE COMPANY / COMPAÑIA DE SEGURO: ____

INSURANCE PHONE # / NÚMERO DE TELÉFONO DE SEGURO: ____

SUBSCRIBER'S NAME / NOMBRE DEL SUSCRIPTOR: ____

SUBSCRIBER'S DOB / FECHA DE NACIMIENTO DEL SUSCRIPTOR: ____

POLICY # / NÚMERO DE PÓLIZA: ____________________________ CLAIM # / NÚMERO DE RECLAMAR: _______________________

CROUP # / NÚMERO DE GRUPO: ____________________________

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Te invitamos a discutir con nosotros cualquier pregunta acerca de nuestros servicios. Los mejores servicios de salud se basan en un entendimiento amistoso y mutuo entre el proveedor y el paciente.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collection your account.

Nuestra politica requiere el pago completo de todos los servicios prestados en el momento de la visita, a menos que otros arreglos se han hecho con el negocio de la gerente de negocios. Si la cuenta no se paga dentro de los 90 dias siguientes a la fecha de la notificación y no hay disposiciones financieras se han hecho, usted será responsable de los honoraios legales, gastos de recaudación, y cualesquiera otros gastos incurridos en el cobro de su cuenta.

If payments for services rendered to you by our office is mailed directly to you by your insurance company you are responsible for paying our office when these checks are received by you. Payment arrangements for these services after your insurance company has paid you is not acceptable. We also request that you provide us with a copy of the Explanation of Benefits that comes with your check so we may record your account properly.

Si cualquiera de los servicios prestados abeto pagos a usted por nuestra oficina nos envían directamente a usted por su compañía de seguros que son responsables para el pago de nuestra oficina cuando estos cheques son recibidos por usted. Modalidades de pago por estos servicios después de que su compañía de seguros ha pagado no es aceptable. También pedimos que nos proporcione una copia de la Explicación de Beneficios que viene con su cheque para que podamos registrar su cuenta correctamente.

I authorize PROS Miami Homestead to bill me for all payments that I receive that have not been turned over in a timely manner.

Yo autorizo a PROS Miami Homestead a enviarme una factura por todos los pagos que recibo que no han sido entregados de manera oportuna.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.

Yo autorizo al personal a realizar cualquier servicio necesario durante el diagnóstico y tratamiento. También autorizo el proveedor y / o organización de cuidado administrado, para liberar toda la información necesaria para procesar reclamaciones de seguros.

I have read, understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status

He leído, entiendo la información anterior y la garantía de esta forma se completó correctamente a lo mejor de mi conocimiento y entiendo que es mi responsabilidad informar a esta oficina de cualquier cambio en mi estado médico.

SIGNATURE / FIRMA: ____ DATE / FECHA: ________________________

❏ Adult Patient / Paciente Adulto ❏ Parent or Guardian / Padre/Madre o Guardián ❏ Spouse / Esposa/Esposo

PROS Miami Homestead, LLC

CONSENT TO MEDICAL CARE

PLEASE READ THIS FORM CAREFULLY & COMPLETELY BEFORE SIGNING

I ___________________________, understand that I have a condition that requires medical treatment. I authorize the Doctor(s) of PROS Miami Homestead to determine what kinds of diagnostic procedures (tests) must be done in order to learn more about my condition. These may include x-rays, pathological testing, diagnostic testing, or other testing. I understand that if my doctor advises a more complex test, or one, which has special risks, that it will be explained to me. Further, I authorize the personnel of PROS Miami Homestead to assist in giving, or to give, the tests, which my doctor will order.

I also authorize my doctor to determine what kind of treatment is to be given, and to perform such procedures as he/she may deem necessary, in his/her professional judgment to preserve my health.

Additionally, I authorize the personnel of PROS Miami Homestead to assist in the giving, or to give, the therapy, which my doctor may order. I fully understand that medical tests or treatments may involve certain unavoidable risks. If part of my treatment is very complex or carries special risks, it will be explained to me.

I understand that it is not practical to list every aspect of medical care, nor every procedure or treatment, which I might receive. However, I acknowledge that my doctor is available to answer any questions I might have.

FOR FEMALES OF CHILD BEARING AGE: I certify that to my knowledge that I am not, or could be, pregnant and that failure to disclose this condition could result in harm to my unborn child if exposed to radiation through x-ray. Therefore, I consent to any diagnostic x-rays that my doctor would need to diagnose my condition and enable him/her to render treatment.

I certify that I have read this form and have had it explained to me. I further certify that I fully understand its contents.

For patients unable to sign or minors please have your parent or legal guardian sign on your behalf.

SIGNATURE: ________________________________ DATE: ____________

❏ Adult Patient ❏ Parent or Guardian

WITNESS: ___________________________

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, a/k/a Personal Injury Protection (hereinafter PIP), Uninsured Motorist, and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes the cost of transportation, medications, supplies, over due interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid. The patient agrees before the services are provided that the provider's charges for services are reasonable, usual and customary.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of Medicare then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days**. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the specific attention of the Office Manager. See Fla. Stat. §673.3111.**

EUOs and IMEs: If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose. This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider and to request a copy of any statements or examinations under oath given by patient.

Express Consent and Release of information: I authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney and hired experts via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file, the property damage file, and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney and experts in connection with any pending lawsuits. The patient's other medical providers are authorized to sign affidavits and testify justifying the patient's care and treatment. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide the patient's medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute and when the policy is exhausted.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name____________________________________ (Please Print)

Patient's Signature ____ (If patient is a minor, signature of parent/guardian)

Date ____________________________

12/4/14

PROS Miami Homestead, LLC

____

____
____
____
____

RE: HEALTH REPORTS AND DOCTOR'S LIEN

Dear

I hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regards to the accident in which I was involved.

I hereby authorize and direct you, you my attorney, to pay directly to said doctor such sums as may be due and owing him for professional services rendered me both by reason of the aforesaid accident and by reason of any other bills that are due and owing to this office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of pending payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Patient's Signature: __________________________________ Date: ____________________

❑ Adult Patient ❑ Parent or Guardian

Date of Accident: ________________________

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect the said doctor above.

Attorney's Signature: _________________________________ Date: ___________________

ATTORNEY: PLEASE SIGN, DATE, AND RETURN THIS DOCUMENT TO THE DOCTOR'S OFFICE. KEEP ONE COPY FOR YOUR RECORDS.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS SUMMARY CAREFULLY
SUMMARY:

By law, we are required to provide you with our notice of privacy practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

Effective Date of this Notice: ______________________________
Contact Person: __Office Manager ___________________________
Phone Number: __305-248-3880_______________________________

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any.

____
Patient or Representative's Name (please print)

______________________________ ______________________
Patient or Representative's Signature **Date**

❑ Patient refused to sign ❑ Patient was unable to sign because
____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- ❑ Home Telephone ______________________________
- ❑ O.K. to leave message with detailed information
- ❑ Leave message with call-back number only
- ❑ O.K. to fax to this number
- ❑ Work Telephone______________________________
- ❑ O.K. to leave message with detailed information
- ❑ Leave message with call-back number only ___________________________________

- ❑ Written Communication
- ❑ O.K. to mail to my home address
- ❑ O.K. to mail my work/office address
- ❑ Other ____________________________

____ Patient Signature

___________________________________ Date

____ Print Name

___________________________________ Date of Birth

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type Key: T=Treatment Records, P=Payment Information, O=Healthcare Operations
(3) Enter how disclosure was made: F=Fax, P=Phone, E=Email, M=Mail, O=Other