Patient HIPAA Consent

for Use and Disclosure of Protected Health Information

I hereby give my consent for Pinchot Family Medicine, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO.)

The Notice of Privacy Practices provided by Pinchot Family Medicine, P.C. describes such uses and disclosures more completely. I have the right to review the Notice of Privacy Practices prior to signing this consent.

Pinchot Family Medicine, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Pinchot Family Medicine, P.C., 7475 Carlisle Road, Wellsville, PA 17365.

With this consent, Pinchot Family Medicine, P.C. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Pinchot Family Medicine, P.C. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

With this consent, Pinchot Family Medicine, P.C. may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Pinchot Family Medicine, P.C. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Pinchot Family Medicine, P.C. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Pinchot Family Medicine, P.C. may decline to provide treatment to me.

_____ _____

Print Patient's Name Date

_____

Signature of Patient or Legal Guardian

_____

Print Name of Legal Guardian, if applicable

Document Revision Log

Revision	Date	Description	Requested By	Completed By
00	9/21/10	Initial Release	S. Moyer	A. Koontz
01	11/11/11	Annual Review	S. Moyer	A. Koontz
02	9/15/12	Annual Review	S. Moyer	A. Koontz

HIPAA Notice of Privacy Practices Acknowledgment

I, _____ acknowledge receiving on _____
Patient Name Date

a copy of the Pinchot Family Medicine, P.C. HIPAA Notice of Privacy Practices.

_____
Patient Signature

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Financial Agreement, Assignment of Benefits and Release of Medical Records

Patient Name (Print) _____

Authorized Signer Name (Print) (if patient is unable to sign)_____

All Patients' and/or Authorized Person's Signature Required:

Insurance Authorization and Assignment:	
"I authorize that payment be made directly to the doctor for all medical, surgical and hospital benefits entitled to me. I understand that I am financially responsible to the doctor for charges not covered by this assignment and/or remaining (outstanding) balances."	
Signature	**Date**

"I agree that if I do not pay my full account balance within 30 days, Pinchot Family Medicine, P.C. may refer this account to its collection agency and/or attorneys for collection efforts. I will also be responsible for, and agree to reimburse Pinchot Family Medicine, P.C. for any and all reasonable collections fees (currently 25% of unpaid balance due,) including legal fees, filing fees, interest, service cost, and disbursement incurred as a result of the collection efforts."	
Signature	**Date**

MEDICARE PATIENTS ONLY
Medicare Patient or Authorized Person's Signature:

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of the provider of service and/or supplier for any services furnished to me by that provider of service and/or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related service."	
Signature	**Date**

Medicare/Medigap (Secondary Insurance) Patient or Authorized Person's Signature:

"I request that payment of authorized benefits be made either to me or on my behalf to the provider of service and/or supplier for any services furnished to me by that provider of service and/ or supplier. I authorize any holder of Medicare information about me to release to (Name of Medigap Insurer) _____ any information needed to determine these benefits payable for related services."	
Signature	**Date**

New Patient Medical History

Name			Birth Date
First Name	Middle Name	Last Name	

MEDICAL HISTORY

Do you currently have…

- ☐ Diabetes Type 2
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ COPD or Emphysema
- ☐ Tobacco Use
- ☐ Obesity or Overweight
- ☐ Anxiety
- ☐ GERD
- ☐ Hypothyroidism
- ☐ History of Cancer (if yes, what type?)
- ☐ Congestive Heart Failure
- ☐ Atrial Fibrillation
- ☐ Colon Polyps
- ☐ Arthritis
- ☐ Headaches
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Asthma
- ☐ Environmental Allergies
- ☐ History of Stroke or TIA

List below other health issues you have been treated for in the past:

DRUG ALLERGIES

Name of Medicine	What was the reaction? (rash, short of breath, etc.)

SOCIAL HISTORY

☐ Y ☐ N	Alcohol Use (if yes, how much per day? _____)
☐ Y ☐ N	Have you ever used tobacco? (if yes, how much and when? _____)
☐ Y ☐ N	Do you have an advance directive?

FAMILY HISTORY

Please list if a relative has had one of the following conditions:

☐ Y ☐ N Colon Cancer	☐ Y ☐ N Heart Disease
☐ Y ☐ N Prostate Cancer	☐ Y ☐ N Stroke
☐ Y ☐ N Breast Cancer	☐ Y ☐ N Diabetes
☐ Y ☐ N Ovarian Cancer	☐ Y ☐ N Depression
	☐ Y ☐ N Osteoporosis

Please list any other important conditions that have affected family members:

New Patient Medical History

IMMUNIZATION & HEALTH MAINTENANCE HISTORY	
Date of last tetanus shot	Date of pneumonia vaccine
Date of most recent colonoscopy	
Women only:	
Date of last pap test	Date of most recent mammogram

CURRENT MEDICATIONS	
Nam of Medication and Dose	**How is it taken? (once per day, twice per day, etc.)**
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	

NUTRITIONAL SUPPLEMENTS (currently taking)	
1	2
3	4

PAST SURGERIES AND HOSPITALIZATIONS	
Type of Surgery/Reason for Hospitalization	**Year**
1	
2	
3	
4	
5	
6	
7	
8	

Document Revision Log

Revision	Date	Description	Requested By	Completed By
00	9/16/10	Initial Release	S. Moyer	A. Koontz
01	10/15/11	Annual Review	S. Moyer	A. Koontz
02	8/15/12	Annual Review	S. Moyer	A. Koontz
03	11/15/12	Added advance directive inquiry	S. Moyer	A. Koontz

Patient Demographics Sheet

Patient Information

Name

First Name | Middle Name | Last Name

Address

Street | City | State | Zip Code

Sex ☐M ☐ F	Date of Birth	Race	Ethnicity

Marital Status ☐ M ☐ S ☐ D ☐ W

Preferred Language

Primary Phone

Secondary Phone

Spouse Name

Legal Guardian/Healthcare Proxy

Email

Primary Caregiver

Emergency Point of Contact

Name | Relationship

Phone

Employer Information

Employer | Occupation/Employment Status

Work Address

Street | City | State | Zip Code

Work Number (+ext) | Work Fax

Primary Insurance

Insurance Name

Member ID | Group Number

Plan | Copay

Subscriber (☐ same as above)

First Name | Last Name

Date of Birth | Employer

Secondary Insurance (if applicable)

Insurance Name

Member ID | Group Number

Plan | Copay

Subscriber (☐ same as above)

First Name | Last Name

Date of Birth | Employer

Records Transfer Request

Authorization to Release Medical Information

Patient Information

Name*			Date of Birth*
First Name	Middle Name	Last Name	
Address*			Home Phone*
Street	City	State Zip Code	

I authorize an appropriate workforce member of

Releasing Party Information (Previous Physician)

Name of Releasing Party*			
Address			
Street	City	State	Zip Code
Phone Number*	Fax Number		

to release my medical record to **Pinchot Family Medicine, P.C., 7475 Carlisle Road, Wellsville, PA 17365**

For the purpose of:		Specific information to release:	
☐ **Continuation of medical treatment***		☐ **Complete Record***	
☐ Worker's Compensation		Please exclude:	
☐ Payment of Bill	☐ Education	☐ Discharge Summary	☐ Pathology Report
☐ Legal Purposes	☐ Insurance purposes	☐ Catheterization Report	☐ History and Physical
☐ At the request of the patient or patient's legal representative for the personal access or other (specify):		☐ Clinic Notes	☐ X-ray Reports
		☐ Consultation Reports	☐ Emergency Room Notes
This information will cover the time period from: to		☐ X-ray Films	☐ Operation Reports
This authorization will expire on or upon (insert date or event):		☐ Laboratory Reports	☐ Itemized Bills
		☐ Other (specify)	

Special Authorization**

The following items must be **INITIALED to be included in the use of disclosure of protected health information pursuant to this authorization form.

☐ _____ HIV/AIDS related information and/or records	☐ _____ Mental health information and/or records
☐ _____ Genetic testing information and/or records	☐ _____ Drug/alcohol diagnosis, treatment and/or referral information

Pennsylvania law restricts the purposes for which disclosures may be made. Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Reception Office Staff. I understand that the revocation will not apply to information that already has been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that once the above information is disclosed, it may no longer be protected by Pennsylvania or federal privacy law, and the person or organization that receives this information may have the legal right to disclose the information to other people or organizations without my knowledge or consent.

I understand that I may refuse to sign this authorization and that I need not sign this form to receive healthcare treatment from my current provider. I understand that there could be a fee for record copies.

Authorization Signatures

If a patient is under 14 years of age and is not an emancipated minor, the parent or guardian must sign.

Date:*	**Patient Signature:***		
Date:	Witness Signature:		
If patient is unable to sign authorization form because of physical condition or age, list the reason why and sign below.			
Date:	Signature:	Relationship:	Reason:
Date:	Witness Signature:		

* Required items