Wadsworth Clinic, P.A.

PLEASE PRINT CLEARLY

Name: ______________________ S.S.# ____________

Street Address: ______________________ D.O.B ____________ M/F

City: ________ State: ________ Zip ________ Email: ____________

Cell Phone: ________ Alt. Phone: ________ Spouse's Name: ____________

Spouse's Employer & Address ______________________

Emergency Contact: ________ Tel # ________ Relationship: ____________

Patient Employer Information:

Employer Name: ________ Tel # ________ Occupation: ____________

Employer Address: ________ City/State: ________ Zip: ________

Insurance Information:

Subscriber Name: ________ Relationship: ________ D.O.B. ____________

Subscriber S.S.# ________ Tel # ________ Employer: ____________

Patient hereby agrees should his/her (their) account become more than 90 days delinquent (Past Due) and the account is referred to collections, the undersigned hereby agrees to pay ALL cost of collections and/or attorney fees/court cost.

Patient's or Patient's Representative (if minor) Signature: ______________________

Medical Information and Assignment of Benefits:

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

Signature: ______________________ Date: ____________

I hereby authorize Dr. Wadsworth to apply for benefits on my behalf for covered services rendered by him or his orders. I request that payment from my insurance company be made directly to Wadsworth Clinic, P.A. (or to the party who accepts assignment of care).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at anytime in writing.

PATIENT CONSENT FORM

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 the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* 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* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below 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 requested 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: ______________________________

Signature: ______________________________

Relationship to Patient: ______________________________

Date: ______________________________

NEW OFFICE POLICY EFFECTIVE January 1, 2001

(1) If you do not have your insurance card with you when you come to see the doctor you MUST PAY for your office visit that day. Paper receipts written with policy numbers are NOT ACCEPTABLE.

(2) If you have TWO insurance policies it YOUR responsibility to know which is first payer (Primary) and which is second payer (Secondary). We will file it as you direct, however WE WILL NOT refile it to correct an error as to the primary and secondary payer. State here the first and second payer:
(1)
(2)

(3) If you give us the incorrect insurance information on the day of your office visit we WILL NOT refile it to correct your error. Please state your insurance information here:

(4) Any questions concerning how your insurance applied your claim i.e. deductibles, co-pay, etc. is between you and your insurance company. YOU are responsible to contact your insurance company. YOU are responsible for payment of your bill.

(5) We ARE NOT accepting new Medicaid.

(6) If you are a new patient we must have a copy of your drivers license in your chart to confirm your address.

Patient Signature X

I understand the above policies and confirm the information given to Wadsworth Clinic, P.A. is correct. I understand I am the responsible payer of my account.

WADSWORTH CLINIC, P.A.

Result Notification Release

Patient ______________________________

When notifying me of lab or test results or matters relating to prescriptions, my physician or a representative of WADSWORTH CLINIC, P.A. may:

Leave results/messages on my home answering machine.	____	Yes	____	No	N/A
Leave results/messages with a spouse.	____	Yes	____	No	N/A
Leave results/messages with a family member.	____	Yes	____	No	N/A
Please specify name/s of family member: ______________					
Discuss test results/message with a family member.	____	Yes	____	No	N/A
Please specify name/s of family member: ______________					
Call you at work.	____	Yes	____	No	N/A
Leave a message on your work voice mail.	____	Yes	____	No	N/A

Are there any other ways to reach you we should know about?

Cell Phone? ______________

Pager? ______________

Fax? ______________

Are there any other special instructions we should know about? ______________

____

______________________________ ______________

Patient Signature *Date*

____

I authorize the doctors of WADSWORTH CLINIC, P.A. to fax/send lab/test results to any physician I am referred to for consultation. Only results that would be pertinent to my consultation are to be sent.

______________________________ ______________

Patient Signature *Date*

NOTICE OF PRIVACY PRACTICES

(MEDICAL)

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.

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 physical examination.
- **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.

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 a paper copy of this notice from us upon request.

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 this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

WADSWORTH CLINIC, P.A.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PHI ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Wadsworth Clinic, P.A. is dedicated to protecting your medical information ("protected health information" or "PHI"). We are required by law to maintain the privacy of your PHI and to provide you with this Notice of our legal duties and privacy practices with respect to your PHI. Wadsworth Clinic, P.A. is required by law to abide by the terms of this Notice.

HOW YOUR PHI WILL BE USED AND DISCLOSED:

We will use your PHI as part of rendering patient care. For example, your PHI may be used by the doctor or nurse treating you, by the business office to process your payment for the services rendered and by administrative personnel reviewing the quality of the care you receive.

We may also use and/or disclose your PHI in accordance with federal and state laws for the following purposes:

<u>Appointment Reminders.</u>
- We may contact you to provide appointment reminders.

<u>Treatment Information.</u>
- We may contact you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

<u>Disclosure to Department of Health and Human Services.</u>
- We may disclose your PHI when required by the United States Department of Health and Human Services as part of an investigarion or determination of our compliance with relevant laws.

<u>Family and Friends.</u>
- Unless you object, we may disclose your PHI to family members, other relatives or close personal friends when the PHI is directly relevant to that person's involvement with your care.

<u>Notification.</u>
- Unless you object, we may use or disclose your PHI to notify a family member, a personal representative or another person responsible for your care of your location, general condition or death.

<u>Disaster Relief.</u>
- We may disclose your PHI to a public or private entity, such as the American Red Cross, for the purpose of coordinating with that entity to assist in disaster relief efforts.

<u>Health Oversight Activities.</u>
- We may use or disclose your PHI for public health activities, including the reporting of disease, injury, vital events and the conduct of public health surveillance, investigation and/or intervention. We may disclose your PHI to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and/or legal proceedings.

<u>Abuse or Neglect.</u>
- We may disclose your PHI when it concerns abuse, neglect or violence to you in accordance with federal and state law.

<u>Legal Proceedings.</u>
- We may disclose your PHI in the course of certain judicial or administrative proceedings.

<u>Law Enforcement.</u>
- We may disclose your PHI for law enforcement purposes or other specialized governmental functions.

<u>Coroners, Medical Examiners and Funeral Directors.</u>
- We may disclose your PHI to a coroner, medical examiner or a funeral director.

<u>Organ Donation.</u>
- If you are an organ donor we may disclose your PHI to an organ donation and procurement organization.

<u>Public Safety.</u>
- We may use or disclose your PHI to prevent or lessen a serious threat to the health or safety of another person or to the public

<u>Workers' Compensation.</u>
- We may disclose your PHI as authorized by laws relating to workers' compensation or similar programs

<u>Business Associates.</u>
- We may disclose your PHI to a business associate with whom we contract to provide services on

We will not use or disclose your PHI for any other purpose without your written authorization except as otherwise permitted or required by law. Once given, you may revoke your authorization in writing at any time except to the extent that Wadsworth Clinic, P.A. has taken an action in reliance on the use or disclosure as indicated in the authorization. To request a Revocation of Authorization form, you may contact:

Wadsworth Clinic, P.A.
Attn: Kim Phillips
2240 Highway 51 S.
Hernando, MS 38632
Telephone: (662) 429-5231

YOUR RIGHTS REGARDING YOUR PHI:

You have the following rights with respect to your PHI:

- You may ask us to restrict certain uses and disclosures of your PHI. We are not required to agree to your request, but if we do, we will honor it.
- You have the right to receive communications from us in a confidential manner.
- Generally, you may inspect and copy your PHI. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your PHI.
- You may ask us to amend your PHI. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.
- You have the right to receive an accounting of the disclosures of your PHI made by Wadsworth Clinic, P.A. during the last six years (or following April 14, 2003), except for disclosures for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types. The right to receive this information is subject to certain exceptions, restrictions and limitations.
- You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us, please contact:

Wadsworth Clinic, P.A.
Attn: Kim Phillips
2240 Highway 51 S.
Hernando, MS 38632
Telephone: (662) 429-5231

If you would like further information regarding your rights or regarding the uses and disclosures of your PHI, you may contact:

Wadsworth Clinic, P.A.
Attn: Kim Phillips
2240 Highway 51 S.
Hernando, MS 38632
Telephone: (662) 429-5231

THIS NOTICE IS EFFECTIVE AS OF JANUARY 25, 2009.

REVISION OF NOTICE OF PRIVACY PRACTICES

We reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice at Wadsworth Clinic, P.A. and will make paper copies of the revised Notice of Privacy Practices available upon request.

ACKNOWLEDGMENT:

I hereby acknowledge that I have received a copy of and had an opportunity to ask questions concerning Wadsworth Clinic, P.A.'s Notice of Privacy Practices.

Patient or Patient's Representative　　　　Date

Representative's Relationship to Patient

Patient Name ____________________ D.O.B ________________________

Please list the names of any family member (s) with any of the following:

Heart Disease* ____

High blood Pressure* ____

Stroke* ____

Cancer (specify which)* ____

Glaucoma* ____

Diabetes* ____

Epilepy* ____

Bleeding Disorder* ____

Kidney Disease* ____

Thyroid Disease* ____

Mental Illness* ____

Osteoporosis* ____

WADSWORTH CLINIC, P.A.

FAMILY PRACTICE

HISTORY & PHYSICAL

Name ______ SS# ______ Date ______

Address ______ Occupation ______

Phone (home) ______ (work) ______ Date of birth ______ Age ______

Chief complaint ______

DRUG ALLERGIES

______

______

______

______

______

CURRENT MEDS

______

______

______

______

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Epilepsy/Convulsions	❑	❑	❑	❑	❑	❑
Bleeding Disorder	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

WOMEN ONLY: Pregnant? ❑ Yes ❑ No Planning pregnancy? ❑ Yes ❑ No

MEDICAL HISTORY

❑ Headache ______
❑ Shortness of breath ______
❑ Heart palpitations ______
❑ Heart murmur ______
❑ Chest pain ______
❑ Dizziness/Fainting ______
❑ Peripheral vascular disease ______
❑ Allergies/Hay fever ______
❑ Asthma ______
❑ Bronchitis ______
❑ Pneumonia ______
❑ Ulcer ______
❑ GI disorder ______

❑ Lactose intolerance ______
❑ Gallbladder disease ______
❑ Prostate disease ______
❑ Bowel irregularity ______
❑ Incontinence ______
❑ Sexual/menstrual dysfunction ______
❑ Venereal disease ______
❑ Frequent infections ______
❑ Hepatitis ______
❑ Anemia ______
❑ Arthritis ______
❑ Osteoporosis ______
❑ Nervousness ______

❑ Depression ______
❑ Gout ______
❑ Scarlet fever ______
❑ Chronic rashes ______
❑ Rheumatic fever ______
❑ Mumps ______
❑ Measles ______
❑ Rubella ______
❑ Polio ______
❑ Diphtheria ______
nus ______
❑ Other ______
❑ Other ______

HABITS

❑ Smoke: Packs daily ______
How long? ______
Interested in stopping? ______

❑ Exercise routine: ______

______

❑ Coffee: Cups daily ______
Other caffeine ______

❑ Alcohol: Type ______
Amount ______

❑ Diet: Salt intake ______
Fat intake ______

❑ Sleep: Difficulty falling asleep ______
Continuity disturbances ______
Snoring ______
Early morning awakening ______
Daytime drowsiness ______
Other ______

Hepatitis C risk factor: ❑ Blood transfusion prior to 1992 ❑ IV drug use (1+ times) ❑ Contact with blood/bodily fluid

Name

Triple i/CliniForms ©1999 FP014 800-969-7237