PATIENT DATA FORM

Please fill out completely and sign bottom, Thank you

Name_____ SS#_____

Address_____ City_____ State_____ Zip_____

Phone #_____ Birthdate_____ Sex – Male / Female

Cell #_____ E-mail address_____

Marital status: Single Married Divorced Widowed

Spouse name_____

If a minor --- Guardian / Parents name_____

Insurance information:

Cardholders name and relationship to patient_____

SS#_____ Birthdate_____

Are you – Employed / Disabled / Retired / Other_____

If you are retired is your spouse still employed? YES / NO

If you are employed – occupation_____

Name of employer_____

Phone #_____

Referred By:_____

Alternate contact person we could call if we cannot reach you with the number listed above:

Name/Relationship_____ Phone#_____

It is my responsibility to provide all necessary insurance information to process payment of my claim. I authorize payment of my insurance benefits to be made directly to my doctor. As a courtesy, the doctors office will submit my claims to my insurance carriers, but I understand that I am financially responsible for all services rendered not covered or payable by my insurance carrier including deductibles, co-payments or noncovered services.

If I need an authorization/referral, it is my responsibility to obtain it from my primary care physician prior to my appointment or I will be held responsible for payment of services rendered.

Patients who have BCBS Mastermedical, no office visit coverage or have no insurance will be expected to pay full at the time medical services are rendered.

Signature_____ Date_____

☐ No Changes Signature_____ Date_____

☐ No Changes Signature_____ Date_____

☐ No Changes Signature_____ Date_____

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

☐ 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 to my work/office address
- ☐ O.K. to fax to this number

☐ Other_____

_____

_____ _____

Patient Signature Date

_____ _____

Print Name Birthdate

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.

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; A=Authorization on File; D=Discretionary
(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

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