Patient Information PCP:_________ Date Created:______________

Last Name:____________________ First Name:________________ Middle:__________________

Sex: M___F Date of Birth:____________

SSN:____________________ Driver's License:____________________ State:________

Address:__________________________________ City, State, Zip:________________________

Home Phone:__________________ Marital Status:_________________

Cell Phone: __________________ Employer:____________________________

Work phone:__________________ Occupation:___________________________

Whom may we thank for referring you?________________ (Check One) Full time___Part time___Retired___

Student? Y or N (Check One) Full Time ___Part time___

****

Responsible Party Information (if different from above)

Name:_________________________________ Sex: M___F___ Date of Birth:_______________

SSN:_________________________________ Relationship to patient:_____________________

Address:______________________________ City, State,Zip:____________________________

Home Phone:_______________________ Marital Status:__________________

Cell Phone:_______________________ Employer:_________________________

Work Phone:_______________________ Occupation:_______________________

****

Primary Insurance Information

Name of Insurance Company:____ ______________________________

Policy #:____________________________ Group #:______________________

Insurance Address:_______________________________ City,State,Zip:________________

Name of Policy Holder:______________________ Relationship to Patient:______________

(If Different from Above) SSN:_______________________ Date of Birth:_______________

Address:______________________________________ Home Phone:____________________

Employer:_____________________ Occupation:____________ Work Phone:________________

Other Dependents on this plan:____

****

Secondary Insurance (Only filed for Medicare Patients with Medigap Policies)

Name of Insurance Company:________________________________

Policy #:________________________ Group #:_________________________

Insurance Address:_________________________________

City, State, Zip:_________________________________

Name of Policy Holder:______________________ Relationship to patient:_____________

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I certify that the above information is correct to the best of my knowledge. I certify that I, and/or my dependent(s) have coverage with the above insurance and assign directly to my physician all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for ALL CHARGES WHETHER OR NOT PAYED BY INSURANCE, per practice policies. I authorize use of my signature on all insurance claims. By signing this form, I am giving consent for medical treatment by my provider. This consent will end when my treatment plan is completed OR one year from the date signed below.

____ ____________________

Signature of Patient/Guardian Date

Revised 2/2008

Name: ______________________________ Date: ______________

Personal Past Health History (Chronic health problems, surgeries, etc.).

Pregnancies

Year of Birth	Sex of Child	Complications if Any	Year of Birth	Sex of Child	Complications if Any

Other Doctors I see. (Name and Specialty): ______________________________

Please list your occupation: ______________ ***Are you exposed to any hazardous substances? Y or N***
If yes, what type? ______________

Family Health History

Check if any of your blood relatives had any of the following. Include Parents, brothers, sisters, and Grandparents:

	Condition:	Relationship to you:		Condition:	Relationship to you:
	Stroke			**Arthritis**	
	Heart Disease			**Kidney disease**	
	High Blood Pressure			**Cancer**	
	Diabetes			**Type:**	
	Asthma				
	Other (describe):			**Other (describe):**	

Social History (Indicate (x) which you use and describe how much and how often you use them.)

Tobacco		
Alcohol		
Caffeine		
Have you ever used recreational/street drugs? If so, what type?		

Do you have a living will or advanced directive? Y or N

Medications

Name	Dosage	Directions	Name	Dosage	Directions

Allergies: ______________________________
Pharmacy: Name and Location
#1 ______________ ***#2*** ______________

Please list an Emergency Contact: Name: ______________________________
Relationship: __________ ***Phone #:*** __________ ***Alternate #:*** __________
Address: ______________________________

Patient: ____ **DOB:** ______________

Prosper Family Medicine, P.A.
Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Prosper Family Medicine to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). The Notice of Privacy Practices describes these disclosures more completely.

I have been provided with the Notice of Privacy Practices and I understand that I have the right to review it prior to signing this consent. Prosper Family Medicine reserves the right to revise its Notice of Privacy Practices at any time. A revised notice of privacy practices may be obtained by written request at any time.

With this consent, Prosper Family Medicine may contact me in reference to any items that 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.

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

This consent acknowledges receipt of the Notice of Privacy Practices. I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. Treatment will not be based on whether or not I sign this consent.

I wish to allow the following people access to my PHI for purposes of communicating with me regarding my treatment or payment for services. Such communications may include appointment reminders, insurance items and calls regarding my clinical care, including laboratory test results, among others.

Name:	Relationship

I DO NOT wish the following people to have access to my information without my express written consent:

Name:	Relationship

Signed by: ________________________________ ____________ ______________
Signature of Patient or Legal Guardian — Date — Relationship

Printed Name: ________________________________

Effective April 2003

Prosper Family Medicine, P.A.

Notice of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information

PLEASE REVIEW THIS NOTICE CARFULLY

WE ARE REQUIRED TO MAINTAIN RECORDS OF YOUR CARE

- **If you have questions about this notice, please contact: Linda Derani, HIPPA Compliance Officer**

Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we use and disclose your PHI
- Your rights regarding your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all you Records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. We will post a copy of our current notice in our office in a visible location at all times, and you may request a copy of our current Notice of Privacy Practices at any time.

We may use and disclose your PHI in the following ways:

1. **Treatment**. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice- including, but not limited to, our doctors and medical assistants- may disclose your PHI to treat you or to assist in your treatment. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.
2. **Payment**. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits and for what range of benefits. We may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. We may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care entities to assist their billing and collection efforts.
3. **Health care operations**. Our practice may use and disclose your PHI to operate our business. For example, we may use or disclose your information for our operations to evaluate the quality of care you received from us or to conduct cost management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their healthcare operations.
4. **Appointment reminders.** Our practice may use your PHI to contact you to remind you of an appointment.
5. **Release of information to family and friends.** Our practice may release your PHI to a family member or friend that is involved in your care, with your consent. For example, a parent or guardian may ask that a babysitter take their child to be seen by the doctor to treat an ear infection. If the babysitter brings a letter stating consent from the parent, then the babysitter would have access to the child's medical information. You may indicate any person to have access to your PHI. You can also restrict access if you desire. Parents have access to the medical information regarding a child, except in special cases.

Use and disclosure in special situations.

- **Public Health risks- We may release your PHI to public health authorities that are authorized by law to collect information for the purpose of:**

1. Maintaining vital records, such as birth or death
2. Reporting child abuse or neglect

3. Preventing or controlling disease
4. Notifying a person regarding potential exposure to communicable diseases
5. Notifying a person about potential risks for spreading a communicable disease
6. Reporting reaction to drugs or problems with devices or immunizations
7. Notifying individuals if a product has been recalled
8. Notifying government agencies and authorities regarding potential abuse or neglect of an adult patient. We will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.

- **Health oversight activities.** We may use or disclose your information to a health care oversight agency for activities authorized by law, such as investigations, audits, or surveys.
- **Lawsuits and similar proceedings.** Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding.
- **Law enforcement.** We may release your PHI if asked to do so by a law enforcement official:
  1. Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
  2. Concerning a death we believe has resulted from criminal conduct
  3. Regarding criminal conduct at our offices
  4. In response to a warrant, summons, court order, subpoena, or similar legal process.
  5. To identify/locate a suspect, material witness, fugitive or missing person
  6. In an emergency to report a crime
- **Serious threats to health and safety.** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Your rights regarding your PHI. You have the following rights concerning the PHI that we maintain about you:

1. **Confidential communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may prefer we contact you at home rather than at work. You can indicate that request on the consent form.
2. **Requesting restrictions.** You have the right to request a restriction in our use or disclosure of your PHI. You have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care. We are not required to agree to your request; however, if we do agree, we are bound by that agreement except when otherwise required by law or in emergencies In order to restrict the use of your PHI, you must make a request in writing. Your request must include:
   - The information that you wish restricted
   - To whom you want the limits to apply
3. **Inspection and copies.** You have the right to inspect and obtain copies of the PHI that MAY BE USED TO MAKE DECISIONS ABOUT YOU, INCLUDING PATIENT MEDICAL RECORDS AND BILLING RECORDS, BUT NOT INCLUDING PSYCHOTHERAPY NOTES. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however you may request a review of our denial. Another healthcare professional chosen by us will conduct reviews.
4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by our practice. To request an amendment, you must make your request in writing. You must provide us with reasons which support your request. Our practice will deny your request if you fail to submit your request and the reasons supporting your request in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect or copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of disclosures.** All of our patients have the right to request an "accounting of disclosures". This is a list of certain "non routine" disclosures our practice has made of your PHI for purposes not related to treatment, payment, or operations. Use of you PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the medical assistants, or the billing department using your information to file a claim for our services provided to you. All requests for accounting of disclosures must be submitted in writing and must state a time period, which may not be longer than 6 years from the date of disclosure and may not include dates before April 14, 2003. Our practice may charge you for costs involved in these requests and you may withdraw the request at any time.
6. **Right to a paper copy of this notice.** You are entitled to receive a paper copy of this notice at any time.
7. **Right to file a complaint.** If you believe your privacy rights were violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. **Right to provide an authorization for other uses and disclosures.** Our practice will obtain your written consent for uses and disclosures that are not identified by this notice or permitted expressly by law. Any authorization you provide us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke authorization, we will no longer use or disclose your PHI for the reasons described on the authorization.