Patient Information Form

PLEASE PRESENT YOUR CURRENT INSURANCE CARD AND ID FOR PHOTOCOPYING

GENERAL INFORMATION

Last Name: ______________________ First Name: ______________________

Social Security Number: ______________________ Date of Birth: ______________________

Address: ______________________ City: ______________________

State: __________ Zip: __________

Home Phone #: ______________________ Cell # ______________________

Email: ______________________

Pharmacy Name: ______________________ Pharmacy Phone #: ______________________

Emergency Contact: ______________________ Relationship: ______________________

Emergency Home Phone # ______________________ Emergency Cell #: ______________________

Primary Language Spoken at Home: ______________________

Household Income per year (circle one)

<$10,000 $10,000-15,000 $15,000-20,000 $20,000-$30,000 $30,000-40,000, $40,000-50,000 >$50,000

PRIMARY INSURANCE

Primary Insurance: ______________ Member ID: ______________ Group #: __________

Relationship to insured: ____Self ____Spouse ___Child ___Other

Policy Holder: ______________________ Policy Holder Date of Birth: ______________

Mailing Address: ____

SECONDARY INSURANCE

Primary Insurance: ______________ Member ID: ______________ Group #: __________

Relationship to insured: ____Self ____Spouse ___Child ___Other

Policy Holder: ______________________ Policy Holder Date of Birth: ______________

Mailing Address: ____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate
for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff .You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or
Informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ____ Date______________
do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patient Release

I herby authorize and direct my insurance carrier to pay directly to **Saint James Health ,Inc.** any benefits due me under my insurance plan. I agree to pay the balance of expenses not paid under this plan.

I also authorize **Saint James Health, Inc.** to release to my insurance company any medical information necessary to process this claim.

I assign **Saint James Health, Inc.** all my right and benefits under any insurance contracts for payment for services rendered to me by **Saint James Health, Inc.**

I furthermore and additionally authorize **Saint James Health, Inc.** to file insurance claims on my behalf for services rendered to me as a result of an Automobile Accident/Workman's Compensation/Personal Liability Claim, including filing arbitration and litigation. I direct all such payments to go to **Saint James Health, Inc.**

I authorize **Saint James Health, Inc.** to act on my behalf. You're responsible for your co-pay at the time of service. We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form please speak to someone in our office in person or by phone at our main phone number. Signature is only acknowledgment that you have received this notice of our privacy practices.

I herby give permission to contact my Physician or Health Care Facility to obtain prior reports.

I acknowledge that I have received a copy of the BILL OF RIGHTS FOR PATIENTS

Signature:____ **Date**____________

(Signature of insured or authorized person, patient or parent if minor)

Release of Medical Records

Please complete this section with name of any person, other than yourself that you would like to have access to your medical information. If there are no names listed we will only be able to speak with you regarding your healthcare. Please consider if you want family members of friends to have any access to your health information.

Name:________________________________ Relationship:_________________________

Name:________________________________ Relationship;_________________________

I have read and agree to release my medical records to the persons listed above.

Signature:____ **Date**____________