ADVANCED INTERNAL MEDICINE, P.C.

PATIENT INFORMATION

DATE______/_____/______

Mr. / Ms. / Mrs.: ____
(FIRST) (M.I.) (LAST)

BIRTH DATE_______________________ **AGE**__________ **GENDER: Male / Female**

Social Security#_______________________ **Marital Status:** __________________

STREET____

CITY _________________ **STATE**____________ **ZIP**______________

PHONE (H) ______________ **(W)**______________ **(CELL)**____________

EMAIL:____

PLACE OF EMPLOYMENT____

PERSON RESPONSIBLE FOR PAYMENT: ______________________________

ADDRESS (IF DIFFERENT FROM ABOVE): ____________________________

PRIMARY INSURANCE

INSURANCE COMPANY: ______________ **HOLDER'S NAME** ______________

INSURANCE ID# __________________ **GROUP#** ____________________

BIRTHDATE OF HOLDER _____________ **RELATIONSHIP** _______________

SECONDARY INSURANCE (if applicable)

INSURANCE COMPANY: ______________ **HOLDER'S NAME** ______________

INSURANCE ID# __________________ **GROUP#** ____________________

BIRTHDATE OF HOLDER _____________ **RELATIONSHIP** _______________

EMERGENCY CONTACT PERSON AND PHONE # ____________________________

I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS) I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I WILL NOTIFY YOU OF ANY CHANGES IN THE ABOVE INFORMATION.

SIGNATURE ______________________ ***DATE*** ______________________

ADVANCED INTERNAL MEDICINE, P.C.

PATIENT MEDICAL HISTORY

Current Medical Problem / Concern (Reason for visit today):

____

____

____

MEDICAL HISTORY (Illnesses, hospital visits, previous diagnosis)

____

____

____

____

____

SURGICAL HISTORY

Date:	Surgery:
____________	______________________________
____________	______________________________
____________	______________________________
____________	______________________________

Family History:

____

____

Smoking History: (YES / NO / PAST)

DRUG ALLERGY	REACTION:
______________	______________________________
______________	______________________________
______________	______________________________
______________	______________________________

MEDICATION:	DOSE (mg):	HOW MANY TIMES A DAY
__________	________	________________
__________	________	________________
__________	________	________________
__________	________	________________
__________	________	________________
__________	________	________________
__________	________	________________
__________	________	________________
__________	________	________________

ADDITIONAL INFORMATION: ______________________________

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ADVANCED INTERNAL MEDICINE, P.C.

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.

This Notice of Privacy Practices describe how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information." Protected health information "is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and/or on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. These activities include, but are not limited to, quality assessment activities, employee review, training of medical students, or to get your health plan to authorize services or referrals. We may also share your medical information with our "business associates", such as our billing service, which perform administrative services for us. We require that they appropriately safeguard your information.

   We may also share your information with other health care providers, medical students or others in training, health care clearing houses or health plans that have a relationship with you. In addition, we may use a sign- in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by your name in the waiting room when your physician is ready to see you.

4. Appointment Reminders, Notification and Communication with family. We may use or disclose, using our best judgment, your health information to notify or assist in notifying a family member, other relative, close personal friend or any another person you identify or is involved in your care. We may also use your health information, as necessary, to remind you of an appointment. We may leave this information on your answering machine or in a message left with the person answering the phone.

5. Disclosure without Authorization. We may use or disclose your protected health information without your authorization under the following circumstances: as required by Law, in the interest of Public Health and Safety to prevent communicable diseases or avert a threat to public safety, to the FDA regarding adverse events, Health Oversight Abuse or Neglect, Research Coroners Funeral Directors, and Organ Donation, Law Enforcement, Judicial and Administrative proceedings including subpoenas and medical review, Military Activity and National Security, Worker's Compensation, and in the case of transfer of ownership of the practice.

B. Your Health Information Rights

1. You have the Right to Request Restrictions *of your protected health information*. This means you may ask us not to use or disclose part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your case or for notification purpose as described in this Notice of Privacy Practices. Your request must be written and state the specific restriction requested and to whom you want the restriction to apply.
   a. Your physician is not required to agree to a restriction that you may request. If physicians believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.
2. Right to Inspect and Copy. You may request in writing to inspect and copy your health information, with limited exceptions. You may be charged a fee for copying and staff time.

3. Right to Amend or Supplement. You have a right to request in writing that we amend your health information that you believe is incorrect or incomplete, but must include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, if we believe our information to be correct. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

3. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this practice does not have to account for disclosures as described in A. 1,2,3,4,5.

4. *You may revoke this authorization*, at any time, in writing, except to the extent that your physician or physician's practice has taken an action in reliance on the use or discloser indicated in the authorization

5. You have a right to a paper copy of this Notice of Privacy Practices.

We also post the current notice on our website: www.AIMOlney.com

C. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to us. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services, Office of Civil Rights,
Hubert H. Humphrey Bldg., 200 Independence Avenue, S.W., Room 509F HHH Building,
Washington, DC 20201.

You will not be penalized for filing a complaint.
This notice becomes effective April 14, 2003

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices.

Signature: ____Date____________________

Print Name: ____

ADVANCED INTERNAL MEDICINE, P.C.

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name____ Date ________________________

I hereby authorize the office of Advanced Internal Medicine, P.C. to disclose any patient medical information for the above named patient via any of the methods designated below:

My telephone at:

☐ HOME

☐ WORK

☐ CELL PHONE

Please indicate by *checking the boxes* above where we may leave a message regarding your medical results.

List any person(s) if they are a patient's representative i.e., caregiver, power-of-attorney, spouse

Name of Representative: ____

Relationship of Representative to Patient: ____

Phone Number: ____

May we leave personal medical information with this person YES / NO (circle one)

Name of Representative: ____

Relationship of Representative to Patient: ____

Phone Number: ____

May we leave personal medical information with this person **YES / *NO* (circle one)**