PROHEALTH PARTNERS PATIENT INFORMATION SHEET

PATIENT INFORMATION (*please print*)

First Name:______________ Middle Initial:______ Last Name:______________
Home Address :______________ City:______ State:______ Zip Code:______
Billing Address (if different):______________
Work Address (if different): ______________
Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________
Preferred Contact # ______________ Email Address ______________
Drivers License # ______________ Date of Birth:______________ Social Security # ______________
Sex: ❑ M ❑ F Marital Status: ❑ S ❑ M ❑ D ❑ W ❑ Other: How did you hear about us?______________
Primary Care Physician: ______________ Primary Language:______________
Race: ______________ Ethnicity (circle one) Hispanic or Latino Not Hispanic or Latino
Employer: ______________ Employer Phone: ______________ Occupation: ______________
Emergency Contact: ______________ Relationship:______________ Phone: ______________
GUARANTOR / PARENT / INSURED INFO (SEND BILL TO):
Guardian Last Name (if applicable): ______________ First:______________ Initial: ______
Date of Birth:______________ Social Security # ______________ Relationship: ______________
Employer: ______________ Address: ______________ Phone:______________

INSURANCE INFORMATION

Primary Insurance: ______________
Policy Holder Name: ______________ DOB:______________ Social Security # ______________
Billing Address: ______________ City, State, Zip: ______________
Group or Policy # ______________ Cert. or Member # ______________ Local Union # ______________
Co-Pay Amount: ______________ Policy Effective Dates: From: ______________ To: ______________
Patient Relation to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other:______________
Secondary Insurance: ______________
Policy Holder Name: ______________ DOB: ______________ Social Security # ______________
Billing Address: ______________ City, State, Zip: ______________
Group or Policy # ______________ Cert. or Member # ______________ Local Union # ______________
Co-Pay Amount: ______________ Policy Effective Dates: From: ______________ To: ______________
Patient Relation to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other: ______________

PHARMACY INFORMATION

Pharmacy Name: ______________ Address: ______________ Phone:______________
Signature (Patient or Parent of Minor):______________ Date: ______________

FINANCIAL POLICY

AGREEMENT TO PAYMENT POLICY: I acknowledge that I received a copy of PROHEALTH PARTNERS, INC. financial policy and agree to the terms of payment due.
AUTHORIZATION TO RELEASE INFORMATION: I authorize release of my medical record information, pursuant to applicable federal and state law, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state and local laws. I further authorize any other individual or entity that has provided health care to me to release to PROHEALTH PARTNERS, INC., any and all of my medical records information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.
ASSIGNMENT OF BENEFITS: I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to PROHEALTH PARTNERS, INC. for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.
GUARANTEE OF PAYMENTS: I agree to pay all applicable charges, which are not paid in full by my insurance. If amounts due to PROHEALTH PARTNERS, INC. are not paid according to this financial policy, the account shall be deemed delinquent. In the event that I default on payment of my account, I understand I am responsible for any and all cost incurred on the collection of my account, including court cost and reasonable attorney's fee. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amount in default.

______________________________ ______________________________
Patient Signature Date Responsible Party Relationship to Patient

PLEASE MARK THE APPROPIATE BOX IF YOU HAVE THESE SYMPTOMS

		NEVER	SOMETIMES	FREQUENTLY
1.	CHEST PAIN	☐	☐	☐
2.	SHORTNESS OF BREATH			
	AT REST	☐	☐	☐
	WITH EXERCISE	☐	☐	☐
3.	ANKLE SWELLING	☐	☐	☐
4.	PALPITATION	☐	☐	☐
5.	SKIPPED HEART BEATS	☐	☐	☐
6.	COUGH	☐	☐	☐
7.	PHLEGM (MOCOUS)	☐	☐	☐
8.	COUGH BLOOD	☐	☐	☐
9.	INDIGESTION	☐	☐	☐
10.	VOMITING	☐	☐	☐
11.	DIARRHEA	☐	☐	☐
12.	CONSTIPATION	☐	☐	☐
13.	BLOOD IN STOOL	☐	☐	☐
14.	BLACK STOOL	☐	☐	☐
15.	PAINFUL OR BLOODY URINE	☐	☐	☐
16.	VAGINAL BLEEDING (FEMALES)	☐	☐	☐
17.	SLOW URINARY STREAM	☐	☐	☐
18.	ARTHRITIS	☐	☐	☐
19.	PARALYSIS	☐	☐	☐
20.	TINGLING	☐	☐	☐
21.	LEG CRAMPS WITH WALKING	☐	☐	☐
22.	SEIZURES	☐	☐	☐
23.	BLEEDING	☐	☐	☐
24.	URINARY INCONTINENCE	☐	☐	☐

NAME: ______________________________ DATE: ____________ DOB: ____________

PAST MEDICAL HISTORY

MEDICAL PROBLEMS:

OPERATIONS:

ALLERGIES TO MEDICINES:

MEDICATION YOU ARE NOW TAKING:

HAVE YOU EVER BEEN REQUIRED TO PRE-MEDICATE FOR DENTAL WORK? YES NO

IF YES, NAME OF MEDICATION: DOSAGE:

SOCIAL HISTORY:

SMOKE

ALCOHOL

OCCUPATION

CHANGE IN WEIGHT RECENTLY

MEDICAL HISTORY IN FAMILY:

FATHER

MOTHER

BROTHERS, SISTERS

GRANDPARENTS

OTHERS

NAME: ______________________ DOB __________ DATE: __________

PF 5000
AUTHORIZATION TO COMMUNICATE PATIENT'S MEDICAL INFORMATION

COMMUNICATION WITH FAMILY & OTHERS INVOLVED IN YOUR CARE

PATIENT IDENTIFICATION

Name: ______________________

Date of birth: ______________________

S.S.#: ______________________

Medical Record/Account #: ______________________

(Signed original to be placed in the central medical record and copy to patient).

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

Name:	Relationship to Patient:	TYPE OF INFORMATION			
		All	Scheduling/ Appointment	Medical	Billing/ Insurance
________	________	❑	❑	❑	❑
________	________	❑	❑	❑	❑
________	________	❑	❑	❑	❑
________	________	❑	❑	❑	❑
________	________	❑	❑	❑	❑
________	________	❑	❑	❑	❑

Specific instructions or limitations: ______________________

Validation code: ______________ (Please give this to any individual who may be involved in coordinating your care or payment for care. They will be asked to give this code to our staff before we release information over the phone.)

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify your physician's office if you wish to alter the designations above.

AUTHORIZATION TO LEAVE MESSAGE

I give my permission for the staff of **ProHealth Partners, Inc.** to leave messages on my telephone answering machine regarding my healthcare, test results or for any appointment

______________________ ______________________
Patient's Signature / Representative Date

______________________ ______________________
Print Name Date

Acknowledgement of Receipt of Notice of Privacy Practices

The Practice reserves the right to modify the privacy practices outlined in this notice.

I have received a copy of the Notice of Privacy Practices.

____
Name of Patient (Print or Type)

____
Signature of Patient

____
Date

____
Signature of Patient Representative
(Required if patient is a minor or an adult who is unable to sign this form.)

____
Relationship of Representative

Documentation of Attempt to Obtain Acknowledgement of Receipt of Privacy Practices

Attempt to Obtain Acknowledgement

An attempt was made to obtain an acknowledgement of the Notice of Privacy Practices on ________________________. The acknowledgement was not obtained because:

- ☐ The patient was undergoing emergency treatment
- ☐ The patient declined to sign the acknowledgement
- ☐ Other ____________________________________

Signature ____

Name of the Patient (Print or Type) ______________________________

Name of Staff Member ____

Date ____

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This ***Notice of Privacy Practices*** is being provided to you as a requirement of the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes under what circumstances our medical practice (the "Practice") may use and disclose medical information about you to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control medical information about you. Your medical information (i.e., "protected health information" for purposes of HIPAA) 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. We are required by law to maintain the privacy of your medical information and we must abide by the terms of this notice.

In this notice we provide descriptions of the different ways that we may use and disclose your medical information. In some cases, an example is provided to describe the types of uses and disclosures of your medical information that may be made by us.

In addition to the privacy protections provided under federal law (which are described in more detail below) and except in certain limited circumstances, California law requires us to obtain your written consent (or, under some statutes or rules, written consent from your attorney, guardian, or upon court order) before we can use or disclose your information if you qualify as a patient that:

- Suffers from a sexually transmitted disease;
- Is HIV+ or has Acquired Immune Deficiency Syndrome;
- Suffers from a mental disorder;
- Has a problem with substance abuse;
- Is eligible to receive benefits for the State of California for certain developmental disabilities or mental retardation;
- Receives rehabilitative services through the California MediCal program;
- Is eligible to receive certain other benefits through California's MediCal program

Uses and Disclosures of Protected Health Information

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, residents, or other health care professionals who are involved in taking care of you. For example, we may disclose your medical information to another doctor or health care provider (such as a specialist, your primary care doctor, a pharmacist or clinical laboratory) who, at the direction of your doctor, is involved in your treatment or care. California Law may also limit these uses or disclosures of your medical information.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or others. For example, your insurance company may need to know certain information about the diagnostic test (such as a stress test or electrocardiogram) or procedure (such as a sigmoidoscopy or conization) you received so they will pay us or reimburse you for the test or procedure. We may also use and disclose medical information about you to obtain prior approval or to determine whether your insurance company will cover a proposed treatment. California Law may also limit these uses or disclosures of your medical information.

For Health Care Operations. We may use and disclose medical information about you for health care operations. This is necessary to make sure that all or our patients receive quality care and to support the business operations of our Practices. These uses or disclosures of your medical information may also be limited by California Law.

A few examples of our health care operations are quality improvement, doctor/employee review activities, compliance, and the training of health care professionals. Also included in healthcare operations are the day-to-day tasks that are required to keep our Practice locations functioning and to provide you with quality care. For example, in our waiting rooms we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor or there may be an individual check-in sheet that will ask additional information of you. We may also call you by name in the waiting room when your doctor is ready to see you. In addition, we may contact you (e.g., by telephone or mail or Email) to remind you about an appointment, to provide instructions prior to a diagnostic test or procedure, to provide information about treatment alternatives or other health-related benefits that may be of interest to you, to advise you of normal test

discuss your account. In such cases, we may leave a message on your answering machine, if available. The departments that may have reason to communicate with you regarding your care include the following:

- Reception/Communications (i.e., appointment reminders)
- Diagnostic Testing
- Authorizations
- Research
- Clinical Services
- Business Office
- Quality Improvement (i.e., patient satisfaction)

As another part of health care operations, we may use and disclose medical information about you to our "business associates". Our business associates, such as transcription services, collection agency, and call answering service, just to name a few, perform services on behalf of the Practice. Whenever an arrangement between our Practices and a business associate involves the use or disclosure of medical information about you, we will have a written contract with that business associate that will require such business associate to agree to protect the privacy of your medical information.

Uses and Disclosures of Protected Health Information Not Discussed in This Notice

Uses and disclosures of your medical information that have not been described in this notice will not be made without your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by such permission. However, you should understand that we are unable to take back any actions we have already taken with your permission, and that we are required to retain our records of the care we provided to you.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Agreement or Opportunity to Object

You have the opportunity to agree or object to the use or disclosure of all or parts of medical information about you in the situations discussed in the following paragraph. If you are not present or able to agree or object to the use or disclosure of your medical information in such instances, then your doctor may, using his or her professional judgment, use or disclose your medical information if believed to be in your best interest. California Law may also limit these uses or disclosures of your medical information.

Individuals Involved in Your Care or Payment for Your Care. Unless you object, in an urgent situation we may release medical information about you to a friend, family member, or any other person you identify who is involved in your medical care. We may also give information to someone who helps pay for your care. We may use or disclose medical information about you to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your location, general condition or death.

Research

We may use and disclose medical information about you for research purposes under certain circumstances. However, other than obtaining medical information in preparation for a research program or protocol, your specific permission is generally required if such research will involve the use or disclosure of your medical information.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

Unless California Law requires otherwise, we may use or disclose your protected health information in certain situations without your specific permission or without giving you an opportunity to agree or object. Among these situations are the following:

Required By Law. We are permitted to disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. In certain circumstances, we may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of

the public or another person.

To Notify and Employer of Medical Information Related to an Employee It:

- or to evaluate whether an employee has a work-related injury or illness,
- the use or disclosure of information is related to these purposes,
- the use and disclosure is required for the employer to comply with its legal obligations,
- and the covered entity was providing services at the request of an employer for medical surveillance the employee is given notice that the information will be disclosed (notice can be handed

Military and Veterans. If you are a member of the armed forces, in certain circumstances we may release information about you to an appropriate government body.

Workers' Compensation. We may release medical information about you to comply with workers' compensation (or similar) laws.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may in certain circumstances release medical information about you to the correctional institution or law enforcement official.

Public Health Activities. We may disclose medical information about you for public health activities. These activities generally include, without limitation, the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse and neglect;
- to report animal bites;
- to report reactions to medications or problems with products;
- to notify people of recalls or products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading disease or condition; or
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities related to the monitoring of the health care system, government programs or compliance with civil rights laws. These oversight activities include, for example, audits, investigations, inspections, and licensure.

Lawsuits and Disputes. In certain circumstances, we may disclose medical information about you in response to a subpoena, discovery request, or other lawful order from a court.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official as part of law enforcement activities in certain circumstances.

Coroners, Medical Examiners and Funeral Directors. If authorized by law, we may release medical information to a coroner or medical examiner. We may also release medical information to a funeral director, as consistent with applicable law, in order to permit the funeral director to carry out his or her duties. Also, medical information may be used and disclosed for organ, or tissue donation purposes.

Protective Services for the President, National Security and Intelligence Activities. We may disclose medical information about you to authorized federal officials so they may, without limitation, (i) provide protection to the President; other authorized persons or foreign heads of state or conduct special investigations, or (ii) conduct lawful intelligence, counter-intelligence, or other national security activities authorized by law.

Your Rights Regarding Medical Information We Maintain About You

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that relates to you. To do so, you must submit your request in writing to our Privacy Officer at the address below. If you request a copy of the information, we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

  We may deny your request to inspect and copy in certain circumstances. If you are denied access to medical information, you may in certain circumstances request that the denial be reviewed. In such cases, another licensed health care professional