Last Updated: 8/17/17

Privacy Agreement:

Patient Information *(if this is an update, please cross out and correct any information that has changed)* ***Required fields.**

Patient's Name* _____ (First) _____ (Initial) _____ (Last)

Responsible Party (if patient is a child, Parent or Guardian) _____

Address* _____

City* _____ State* _____ Zip Code* _____

Home Phone _____ Work Phone _____ Mobile Phone _____ Primary: ☐ H ☐ W ☐ M

Social Security # _____ Date of Birth* _____ Sex* _____ Email _____

Marital Status Married Single Other _____ (circle) Employment Status FullTime PartTime None (circle) Student Status FullTime PartTime None (circle)

Referring Physician* _____ Primary Physician _____

Is there a place/physician we can send a copy of your test results? _____

Emergency Contact _____ How did you hear about us?* _____

How would you like to receive Appointment Notifications? ☐ Telephone ☐ Text ☐ Email ☐ None

Primary Insurance Information *(if patient is also the insured, enter 'SAME' for name & address)* *(Office only): Insurance Card copy on file?* _____

Insured's Name* _____ (First) _____ (Initial) _____ (Last)

Address _____

City _____ State _____ Zip Code _____

Home Phone _____

Patient Relation to Insured* Self Spouse Child Other (circle) Insured Date of Birth* _____ Insured Sex M F (circle)

Insurance Co. Name* _____ Subscriber ID Num* _____ Group Num _____

Other Insurance Information *(if patient is also the insured, enter 'SAME' for name & address)* *(Office only): Insurance Card copy on file?* _____

Insured's Name* _____ (First) _____ (Initial) _____ (Last)

Address _____

City _____ State _____ Zip Code _____

Home Phone _____

Patient Relation to Insured* Self Spouse Child Other (circle) Insured Date of Birth* _____ Insured Sex M F (circle)

Insurance Co. Name* _____ Subscriber ID Num* _____ Group Num _____

_____ _____ _____

Signature of Patient, Parent, or Legal Authorized Representati | Relationship of Signatory to Patient | Date

Patient Full Name: Joan Burgin

Initial: **Please initial to acknowledge your acceptance of each policy section**. (Strikethrough any section you wish to decline)

_____ We may call out your name when you arrive at our office and when we are ready to see you.

_____ Family member or another person responsible for your care may join you & Specialist throughout duration of your appointment. Please list Name/Relationship of person(s):_____

_____ Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

_____ Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your general condition or, unless y had instructed us otherwise. We may also disclose information to someone who is involved with your care or helps pay for your ca If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, althoug we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

_____ Payment. We use and disclose medical information about you to obtain payment for the services we provide. For examp we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

_____ I authorize the Company to use or disclose any protected health information in my health or treatment record/file to notify me or market to me, or permit third party organizations, such as insurance companies or agencies, marketing agencies, and Company's business associates that sell or market products or services, to notify me or market to me, health-related or non-health-related products, treatments, services or opportunities. I understand that sometimes third party organizations may pay the Company for its disclosure of such information to allow them to notify me about, or their sales to me of, such products, treatments, services, or opportunities.

I understand that:

- **I may revoke this Authorization at any time by providing my written revocation to the address at the top of this Authorization. My revocation will not apply to information already retained, used, or disclosed in response to this Authorization. Unless sooner revoked, the automatic expiration date of this Authorization will be twenty-four (24) months from the date on which I have last received treatment from the Company. I have a right to receive a copy of this Authorization from the Company.**
- **This Authorization is voluntary, and the Company may not condition the provision of treatment or payment for my care on my signing this Authorization.**
- **If the person or entity receiving my protected health information is not a health care provider or health plan covered by federal privacy regulations, my protected health information may be disclosed by such recipients to other individuals or institutions and no longer protected by federal privacy regulations.**

The Privacy Rule portion of the HIPAA regulations requires our practice to submit a copy of the Privacy Notice to each patient, both existing and new. If the patient refuses to sign the notice, this practice is not obligated to treat the patient.

I have been made aware of the Notice of Privacy Practices and I may request a copy.

I authorize any holder of medical or other information about me to release any information needed to process this or other claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Signature of Patient, Parent, or Legal Authorized Representati	Relationship of Signatory to Patient	Date