If complete and accurate information is not provided, you may be responsible for the full balance of your bill.

PATIENT INFORMATION

Name: _____ Age: _____ DOB: ___/____/____ SSN: _____ - ____ - _____

Street Address _____ Sex: M / F

City _____ State _____ Zip _____ Marital Status _____

Phone (cell): _____ Phone (home):. _____

E-mail address: _____ @ _____

Patient Employer: _____ Phone (business): _____

Spouse's Name _____ Spouse's Employer _____ Bus. No. _____

Responsible Party: _____ Relationship: _____

Primary Care Physician and Phone Number: _____

Pharmacy Name and Phone Number: _____

PERSON TO CALL IN CASE OF EMERGENCY

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

PRIMARY INSURANCE COVERAGE

Policy Holder's Name _____ Policy Holder's DOB ____/____ /_____ SSN: _____- ___ -_____

Insurance Co. Name & Address_____HMO: ____No _____Yes

Name of Employer _____ Policy Holder Relationship to Patient _____

Release of Benefits and Information: I authorize benefits to be paid directly to Weston MedSurg Center. I understand that all services may not be covered by my insurance plan and that I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for payment of claims. A copy of this is as valid as the original.

x_____ _____

Signed **Date**

NOTICE OF PRIVACY PRACTICES

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you the NOTICE about your privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this NOTICE while it is in effect. The NOTICE takes effect (10/01/2006), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this NOTICE at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our NOTICE effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this NOTICE and make the new NOTICE available upon request.

You may request a copy of our NOTICE at any time. For more information about our privacy practices or for additional copies of this NOTICE, please contact me using the information listed at the end of this NOTICE.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

- *Treatment:* We may use or disclose your health information to a physician or other healthcare provider providing treatment to your.
- *Payment:* We may use and disclose your health information to obtain payment for services we provide you.
- *Healthcare Operations:* We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditations, certification, licensing, or credentialing activities.
- *Your Authorization:* In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless your give us a written authorization, we cannot use or disclose your health information for nay reason except those described in the NOTICE.
- *To Your Family and Friends:* We must disclose your health information to you, as described in the Patient Rights section of this NOTICE. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
- *Persons involved in care:* We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care of your location, general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
- *Marketing Health-Related Services:* we will not use your health information for marketing communications without your written authorizations.
- *Required by Law:* We may use or disclose your health information when required to do so by law.
- *Abuse or Neglect:* We may disclose your information to appropriate authorities if we reasonable believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other health and safety or the health and safety of others.
- *National Security:* We may disclose to military authorities the health information of Armed Forces required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to the correctional institution or law enforcement offcials having lawful custody of protected health information of an inmate or patient under certain circumstances.
- *Appointment Reminders:* We may use or disclose your health information to provide you with appointment reminders, such as voicemail messages, postcards, or letters.

PATIENT RIGHTS

Access*:* You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of the NOTICE. We will charge you a reasonable cost-based fee for expenses-such as copies and staff time. You may also request access by sending us a letter to the address at the end of this NOTICE. If you request copies, we will charge you $0.10 for each page, $15.00 per hour for staff time to locate and copy your health information, and postage, if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for the purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to this additional request.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or location. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payment will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our web site or by electronic mail, you are entitled to receive this Notice in written form.

I, _____, have received a copy of Weston Notice of Privacy Practice.

x_____ _____

Signed **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

CONTACT INFORMATION

You may contact me by the following means and leave a voice mail:

_____Home Phone _____Cell phone _____Work Phone _____E-mail _____Mail

You may discuss my information with the following persons:

_____ _____

Name Relationship

_____ _____

Name Relationship

x_____ _____

Signed **Date**