

Pinchot Family Medicine, P.C.
Patient HIPAA Consent
for Use and Disclosure of Protected Health Information

I hereby give my consent for Pinchot Family Medicine, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO.)

The Notice of Privacy Practices provided by Pinchot Family Medicine, P.C. describes such uses and disclosures more completely. I have the right to review the Notice of Privacy Practices prior to signing this consent.

Pinchot Family Medicine, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Pinchot Family Medicine, P.C., P.O. Box 88, Rossville, PA 17358.

With this consent, Pinchot Family Medicine, P.C. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Pinchot Family Medicine, P.C. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Pinchot Family Medicine, P.C. may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Pinchot Family Medicine, P.C. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Pinchot Family Medicine, P.C. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Pinchot Family Medicine, P.C. may decline to provide treatment to me.

Print Patient's Name

Date

Signature of Patient or Legal Guardian

Print Name of Legal Guardian, if applicable

Pinchot Family Medicine, P.C.
HIPAA Notice of Privacy Practices Acknowledgment

I, _____ acknowledge receiving on _____
Patient Name Date

a copy of the Pinchot Family Medicine, P.C. HIPAA Notice of Privacy Practices.

Patient Signature

Financial Agreement, Assignment of Benefits and Release of Medical Records

Patient Name (Print) _____

Authorized Signer Name (Print) (if patient is unable to sign) _____

All Patients' and/or Authorized Person's Signature Required:

Insurance Authorization and Assignment:	
"I authorize that payment be made directly to the doctor for all medical, surgical and hospital benefits entitled to me. I understand that I am financially responsible to the doctor for charges not covered by this assignment and/or remaining (outstanding) balances."	
Signature	Date

"I agree that if I do not pay my full account balance within 30 days, Pinchot Family Medicine, P.C. may refer this account to its collection agency and/or attorneys for collection efforts. I will also be responsible for, and agree to reimburse Pinchot Family Medicine, P.C. for any and all reasonable collections fees (currently 25% of unpaid balance due,) including legal fees, filing fees, interest, service cost, and disbursement incurred as a result of the collection efforts."	
Signature	Date

MEDICARE PATIENTS ONLY

Medicare Patient or Authorized Person's Signature:

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of the provider of service and/or supplier for any services furnished to me by that provider of service and/or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related service."	
Signature	Date

Medicare/Medigap (Secondary Insurance) Patient or Authorized Person's Signature:

"I request that payment of authorized benefits be made either to me or on my behalf to the provider of service and/or supplier for any services furnished to me by that provider of service and/ or supplier. I authorize any holder of Medicare information about me to release to (Name of Medigap Insurer) _____ any information needed to determine these benefits payable for related services."	
Signature	Date

Pinchot Family Medicine, P.C.
New Patient Medical History

Name			Birth Date
First Name	Middle Name	Last Name	

MEDICAL HISTORY	
Do you currently have...	
<input type="checkbox"/> Diabetes Type 2 <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Heart Disease <input type="checkbox"/> COPD or Emphysema <input type="checkbox"/> Tobacco Use <input type="checkbox"/> Obesity or Overweight <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> GERD <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Colon Polyps <input type="checkbox"/> History of Cancer (if yes, what type?) <input type="checkbox"/> Arthritis <input type="checkbox"/> Headaches <input type="checkbox"/> Liver Disease <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Environmental Allergies <input type="checkbox"/> History of Stroke or TIA
List below other health issues you have been treated for in the past:	

DRUG ALLERGIES	
Name of Medicine	What was the reaction? (rash, short of breath, etc.)

SOCIAL HISTORY	
<input type="checkbox"/> Y <input type="checkbox"/> N	Alcohol Use (if yes, how much per day? _____)
<input type="checkbox"/> Y <input type="checkbox"/> N	Have you ever used tobacco? (if yes, how much and when? _____)

FAMILY HISTORY	
Please list if a relative has had one of the following conditions:	
<input type="checkbox"/> Y <input type="checkbox"/> N Colon Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Prostate Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N Stroke
<input type="checkbox"/> Y <input type="checkbox"/> N Breast Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes
<input type="checkbox"/> Y <input type="checkbox"/> N Ovarian Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N Depression
	<input type="checkbox"/> Y <input type="checkbox"/> N Osteoporosis

Please list below any other important conditions that have affected family members:

IMMUNIZATION & HEALTH MAINTENANCE HISTORY

Date of last tetanus shot	Date of pneumonia vaccine
Date of most recent colonoscopy	
Women Only:	
Date of last pap test	Date of most recent mammogram

CURRENT MEDICATIONS

Name of Medication and Dose	How is it taken? (once per day, twice per day, etc.)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	

NUTRITIONAL SUPPLEMENTS (currently taking)

1	3
2	4

PAST SURGERIES AND HOSPITALIZATIONS

Type of Surgery/Reason for Hospitalization	Year
1	
2	
3	
4	
5	
6	
7	
8	

Pinchot Family Medicine, P.C.
Patient Demographics Sheet

Patient Information			
Name			
First Name	Middle Name	Last Name	
Address			
Street	City	State	Zip Code
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Race	SSN
Marital Status <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W		Employment Status	
Home Phone		Cell Phone	
Spouse or Guardian Name			
First Name		Last Name	
Email		Do we have permission to email results to you? <input type="checkbox"/> Y <input type="checkbox"/> N	

Emergency Point of Contact	
Name	Relationship
Phone	

Employer Information			
Employer	Occupation		
Work Address			
Street	City	State	Zip Code
Work Number (+ext)	Work Fax		

Insurance	
Insurance Name	
Member ID	Group Number
Plan	Copay
Subscriber (<input type="checkbox"/> same as above)	
SSN	
First Name	
Last Name	
Date of Birth	Employer

Secondary Insurance	
Insurance Name	
Member ID	Group Number
Plan	Copay
Subscriber (<input type="checkbox"/> same as above)	
SSN	
First Name	
Last Name	
Date of Birth	Employer

Records Transfer Request Authorization to Release Medical Information

Patient Information				
Name				Date of Birth
First Name	Middle Name	Last Name		
Address				Home Phone
Street	City	State	Zip Code	

I authorize an appropriate workforce member of

Releasing Party Information (Previous Physician)				
Name of Releasing Party				
Address				
Street		City	State	Zip Code
Phone Number			Fax Number	

to Pinchot Family Medicine, P.C., PO Box 88, Rossville, PA 17358

For the purpose of:	Specific information to release:
<input type="checkbox"/> Continuation of medical treatment	<input type="checkbox"/> Complete Record
<input type="checkbox"/> Worker's Compensation	Please exclude:
<input type="checkbox"/> Payment of Bill	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Legal Purposes	<input type="checkbox"/> Pathology Report
<input type="checkbox"/> At the request of the patient or patient's legal representative for the personal access or other (specify):	<input type="checkbox"/> Catheterization Report
	<input type="checkbox"/> History and Physical
	<input type="checkbox"/> Clinic Notes
	<input type="checkbox"/> X-ray Reports
	<input type="checkbox"/> Consultation Reports
	<input type="checkbox"/> Emergency Room Notes
This information will cover the time period from: _____ to _____	<input type="checkbox"/> X-ray Films
This authorization will expire on or upon (insert date or event): _____	<input type="checkbox"/> Operation Reports
	<input type="checkbox"/> Laboratory Reports
	<input type="checkbox"/> Itemized Bills
	<input type="checkbox"/> Other (specify) _____

Special Authorization*	
*The following items must be INITIALED to be included in the use of disclosure of protected health information pursuant to this authorization form.	
<input type="checkbox"/> _____ HIV/AIDS related information and/or records	<input type="checkbox"/> _____ Mental health information and/or records
<input type="checkbox"/> _____ Genetic testing information and/or records	<input type="checkbox"/> _____ Drug/alcohol diagnosis, treatment and/or referral information

Pennsylvania law restricts the purposes for which disclosures may be made. Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Reception Office Staff. I understand that the revocation will not apply to information that already has been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that once the above information is disclosed, it may no longer be protected by Pennsylvania or federal privacy law, and the person or organization that receives this information may have the legal right to disclose the information to other people or organizations without my knowledge or consent.

I understand that I may refuse to sign this authorization and that I need not sign this form to receive healthcare treatment from my current provider. I understand that there could be a fee for record copies.

Authorization Signatures			
If a patient is under 14 years of age and is not an emancipated minor, the parent or guardian must sign.			
Date:	Patient Signature:		
Date:	Witness Signature:		
If patient is unable to sign authorization form because of physical condition or age, list the reason why and sign below.			
Date:	Signature:	Relationship:	Reason:
Date:	Witness Signature:		