Patient Registration

Patient Information

Name: _____

Date Of Birth: _____ Patient Social Security #: _____Language_____

Address: _____City/Zip Code_____

Home #: _____ Cell #: _____ Work #: _____

Gender: F M Marital Status: M D S W

Race: [ ] American Indian [ ] Asian [ ]Black/African American [ ] Native Hawaiian [ ] White

[ ] Hispanic/Latino [ ] Refuse to Answer [ ] Other: _____

Emergency Contact Information

Name: _____ Phone #: _____

Address: _____Relationship to you:_____

Patient Past Medical History

Major Medical Problems: _____

_____

_____

Major Surgeries: _____

_____

Current Medications: _____

_____

_____

Allergies to Medications: _____

Pharmacy Name & Zip Code:_____

Social History

Smoker: Y N **Quit Date**:_____ **Alcohol Consumption:** Y N **How Often:** _____

Recreational Drugs: Y N

Insurance Information

Insurance Company: _____

Subscriber Name: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Insurance Company Address: _____

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1. **Insurance/Proof of Insurance.** If you are not insured by a plan we do business with, payment in full is expected at each visit. Please contact your insurance company with any questions you may have regarding your coverage. All patients must provide their insurance card(s) and photo ID to the receptionist at the time of check-in.

2. **Referrals, Co-payments and deductibles.** Referrals must be presented at the time of service. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Your appointment will be rescheduled if any of these items are not available at time of service. **A receipt will be provided for all payments at the check-out desk.**

3. **Coverage Changes or Information Changes.** If you have changes to your insurance information or personal information, such as address or phone number, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If you fail to provide us with the correct information in a timely manner, **you may be responsible for the balance of a claim.**

4. **Prescriptions Refills/Renewals.** Please do not wait until you prescription runs or has expired. Allow *72 hours notice* to review your refills or renewal request. Refill and/or renewal requests will only be processed *Monday-Friday during normal business hours*. Controlled drug substance (narcotic) prescriptions must be picked up in the office in which you are seen and *will not be refilled after hours, on weekends or by the on-call physician*. **Any lost or stolen narcotics will not be replaced.**

5. **Appointments.** We greatly appreciate you allowing us to provide you with the best patient care possible. Our physicians and staff know your time is important and we hope you understand the value of our time. We want to be able to provide every patient with all the attention they require. Therefore, if you are not on time for your appointment and are late 15 minutes or more, it may be necessary to reschedule for another day. Please provide us with 24 hour notice if you will not be able to maintain your appointment. **If you do not provide a 24 hour notice or if you are more than 15 minutes late, the first this happen there will be no charge, the second time there will be a charge of $30.00, after four occurrences you will be dismissed from our office.**

I have read and understand the above and agree to abide by its guidelines. A copy will be provided to you upon request.

_____ _____

Signature of patient or responsible party **Date**

Patient Registration

This summary briefly describes how we, Mason Family Medicine & Associates, may use and disclose your Protected Health Information (PHI) to carry out your treatment, payment activities, health care operations, and for other purposes that are permitted or required by law, and your rights to access and control your PHI. For a more complete description of how we may use and disclose your PHI, feel free to refer to attached Notice of Privacy Practices.

Our Responsibilities

We are required by law to maintain the privacy of your PHI. In accordance with the HIPAA Privacy Regulations, we have the right to use and disclose your PHI for treatment, payment activities and health care operations as explained in the Notice of Privacy Practices. We are most likely to use and/or disclose your PHI for these functions.

Additionally, we may use or disclose your PHI as permitted and required by law. For example, we may use or disclose your PHI for public health activities, legal proceedings, or law enforcement purposes.

Amended to include HIPAA-HITECH as of November 1, 2009, which is as follows:

1. **Overview of HIPAA.** HIPAA requires covered entities to keep confidential protected health information, PHI. A **covered entity** is a healthcare provider that transmits any information in an electronic form. Mason Family Medicine & Associates is a "covered entity."

PHI is individually identifiable health information held or transmitted by a covered entity or its business associate. This includes demographic data related to:

The individual's past, present, or future physical or mental health or condition, the provision of healthcare to the individual, or the past, present, or future payment for the provision of healthcare services to the individual, and that identifies the individual, or for which there is a reasonable basis to believe it can be used to identify the individual. Individually identifiable health information includes many common identifiers, such as name, address, birth date, and Social Security number.

2. **HITECH Notification Requirements.** Under HITECH, Mason Family Medicine & Associates is required to notify a patient whose protected health information, PHI, has been breached. The notification must occur by first class mail within 60 days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of PHI if it **poses a significant risk for financial, reputational, or other harm to the individual.**

The notice must:

1. Contain a brief description of what happened, including the date of the breach and the date of discovery;
2. The steps the individual should take to protect themselves from potential harm resulting from the breach;
3. A brief description of what the covered entity is doing to investigate the breach, mitigate losses, and to protect against further breaches.

No model notice form has been proposed.

Not every impermissible use or disclosure constitutes a reportable breach. The determination of whether an impermissible breach is reportable hinges on whether there is a significant risk of harm to the individual as a result of impermissible activity. For example, if PHI on a patient was inappropriately shared with a billing clerk and she understood her confidentiality obligations, the patient would not need to be notified by Mason Family Medicine & Associates of the breach. If Mason Family Medicine & Associates disclosed that a patient received services at our hospital, without more specifics, inadvertently to someone outside our organization, this also may not be cause for a breach under HITECH because it may not have been a significant risk of financial or reputational harm. The key in determining potential harm is whether sufficient information was released that would allow identity theft or harm the person because of the likelihood of sharing sensitive health data.

3. **Business Associates.** Effective May 16th 2011, Mason Family Medicine & Associates Business Associate Agreements have been amended to provide that all of the HIPAA security administrative safeguards, physical safeguards, technical safeguards and security policies, procedures, and documentation requirements apply directly to the business associate.

4. **Cash Patient/Clients.** HITECH states that if a patient pays in full for their services out of pocket they can demand that the information regarding the service not be disclosed to the patient's third party payer since no claim is being made against the third party payer.

Your Rights

You have the following rights to your PHI:

- You have the right to request that we restrict the PHI we use or disclose about you for treatment, payment or healthcare operations.
- If you believe that a disclosure of all or part of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location.
- Generally, you have the right to inspect and copy your PHI that is contained in a designated record set.
- If you believe that your PHI is incorrect or incomplete, you may request that we amend your information.
- You have a right to an accounting of certain disclosures of your PHI that are for reasons other than treatment, payment, or health care operations.

Complaints

If you believe we have violated your privacy rights you can let our staff know and we will take care of it. You can call us at (513) 492-8541, or file a complaint by mail at:

6394 Thornberry Ct, Ste 820

Mason, Oh 45040

Mason Family Medicine & Associates Internet Privacy Policy

Personal privacy is an important initiative to Mason Family Medicine & Associates. We hold the following privacy principles as being critical to our Internet privacy policy: Mason Family Medicine & Associates does not sell, trade or otherwise convey the name, street address, telephone number, email address or other personal identifiers supplied by visitors of our web sites to outside parties. Mason Family Medicine & Associates compiles non-personal information from our web site visitors to provide regularly updated statistics. Such information allows us to better assess which resources best meet our visitors' needs.

Mason Family Medicine & Associates provides an appropriate level of security in our computer systems, databases and communication networks to protect web site visitors' information contained in our systems.

Please be advised that electronic mail and other Internet communications channels are not necessarily secure against interception. While we take precautions, such as encrypting communications where appropriate, if your communication is very sensitive, or includes information like your diagnosis or medical history, you might want to send it by postal mail instead.

I have read and understand the above information. A copy will be provided upon request.

_____ _____

Signature of patient or responsible party Date

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I _____ give permission for **Mason Family Medicine & Associates** to give me medical treatment.

I allow **Mason Family Medicine & Associates** to file for insurance benefits to pay for the care I receive.

I understand that:

- **Mason Family Medicine & Associates** will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian Signature Date

(for children under 18)

_____ _____

Print name Date

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Authorized medical contact is a person or people that you are comfortable with releasing medical information and or prescriptions for pick up. By signing this form you are allowing Mason Family Medicine & Associates to release your medical information to the people you list below.

1. Name: _____
   Phone Number: _____
   Relationship to patient: _____

2. Name: _____
   Phone Number: _____
   Relationship to patient: _____

3. Name: _____
   Phone Number: _____
   Relationship to patient: _____

4. Name: _____
   Phone Number: _____
   Relationship to patient: _____

5. Name: _____
   Phone Number: _____
   Relationship to patient: _____

The material I authorize to be released is:

[ ] All [ ] Limited: _____

I, _____, authorize that Mason Family Medicine & Associates can release the listed amount of medical information to the designated people listed above.

_____ _____

Signature of patient or legal guardian Date

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