NORTHSHORE PRIMARY CARE

Patient Information

First Name: _____ Middle Initial:_____ Last Name:_____
DOB: ___/___/____ Social Security #: _____ Marital Status: _____
Address:_____ City:_____ State: _____Zip Code:_____
Home Phone:_____ Cell Phone: _____ Work Phone:_____
Employed? full time ____ part time ____ no ____ retired ____ other _____
Employer Name: _____ Address: _____
Email Address: _____ How did you hear about our office:_____

Insurance Information

Primary Insurance: _____
Primary Insurance Phone Number: _____
Primary Insurance Address: _____
Policy Holder Name: _____Date of Birth : _____
Subscriber ID_____Group Number: _____ SSN:_____
Relation to Patient _____

Secondary Insurance: _____
Secondary Insurance Phone Number: _____
Secondary Insurance Address: _____
Policy Holder Name: _____ Date of Birth: _____
Subscriber ID: _____ Group Number: _____ SSN:_____
Relationship to Patient: _____Guarantor Name: _____
Guarantor Address: _____

Other Information

Emergency Contact Name:_____ Phone #: _____ Relationship: _____
Local Pharmacy Name: _____Pharmacy Phone: _____
If you have a mail away pharmacy, list here: _____
Race_____ Ethnicity_____ Primary Language_____

Do you have Advanced Directives? ("Living Will", etc,)? __ yes __no __I have no idea what that means
_____
_____
_____

I hereby assign all medical and or surgical benefits to which I am entitled including all major medical, Medicare, Medicaid, private insurance, and any other health plans to NorthShore Healthcare. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize NorthShore Healthcare to release all information necessary to secure payment.

Signature: _____ Date: _____

Please review this information, make any corrections necessary, and return form to the front desk when complete

RECORDS RELEASE

NorthShore Healthcare

Patient's Name: _____ Patient's birthdate: ___/___/_____

Patient's Address:_____

FROM:Physician/facility releasing Records:	TO: Physician/person/facility to receive records:	
Facility:_____	**Rebecca Ware, MD**	**Jennifer Carandang, MD**
Address:_____	Amherst Health Center	**Sheila Rice, MD**
_____	254 Cleveland Avenue, #101	36711 American Way, Suite A
Phone: _____	Amherst, OH 44001	Avon, OH 44011
Fax: _____	440-455-3090	440-653-8091
	Fax: 440-455-3059	Fax: 440-653-8089

Purpose for release: continuation of care___ relocating___ my personal records___ other: _____

_____	Only these specific items: immunization record☐ consultation reports from☐ _____ Most recent medication list☐ Other specific item(s):☐ _____
_____	Medical record from _____ to _____ ***INCLUDING*** information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information relating to testing or treatment of sexually transmitted diseases.
_____	Medical record from _____ to _____ ***EXCLUDING*** information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information relating to testing or treatment of sexually transmitted diseases.
_____	Entire medical record ***INCLUDING*** information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information relating to testing or treatment of sexually transmitted diseases.
_____	Entire medical record ***EXCLUDING*** information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information relating to testing or treatment of sexually transmitted diseases.
_____	Psychotherapy notes

This applies to all information in my medical record, protected under the Code 42 Of Federal Regulations, Part 2. I need not sign this form to ensure healthcare treatment.

No HIV information can be given out with this consent form. A separate HIV Consent form just be used.

I authorize medical information to be released as indicated above. I understand this release is effective until _____, but that I may revoke my consent at any time by providing a written revocation of consent to NorthShore Healthcare I understand that once the above information is disclosed, it may be re-disclosed by the recipient and may not be protected by federal privacy laws and regulations.

Signature: _____ Date:_____
Witness Signature_____ Date:_____

NorthShore Healthcare

FINANCIAL POLICY

Patient Name: _____ DOB: __/__/_____

We are committed to providing you with the best possible care. We are anxious to help you receive your maximum allowable benefits if you have medical insurance. In order to do this, we need your assistance and your understanding of our **FINANCIAL POLICY**. We will also be asking you to periodically update your information.

Payment for services is **DUE AT THE TIME SERVICES ARE RENDERED**, unless payment arrangements have been approved in advance by our office manager. **We accept CASH, CHECKS, MASTERCARD, VISA, and DISCOVER**. Returned checks are subject to a $30.00 NSF FEE. Non-payment of returned checks may result in your termination as a patient of NorthShore Healthcare.

If there is a divorce involved, please remember that our policy requires that regardless of which parent is responsible for the bills, **PAYMENT IS DUE AT THE TIME OF SERVICE**. The person that brings the child to the office for the appointment is expected to make payment. As you should be able to understand, we will not get involved with divorce disputes. Please feel free to discuss this with our office manager if you have any questions.

Auto accident claims will either be paid at the time of service or be billed through your medical insurance coverage.

We will submit your insurance forms for you with a current signature on file permitting us to do so. Please remember that:

1. Your insurance is a contract between YOU, YOUR EMPLOYER, and the insurance company. We are not a party to that contract.
2. Not ALL services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will NOT cover.

We must emphasize that as a provider of medical services, our relationship is to YOU, not your insurance company. While the filing of patient insurance forms is a courtesy we extend to our patients, all charges are YOUR responsibility from the date the service is rendered.

We are not providers for Workers' Comp care, and do not do any type of Workers' Comp paperwork or billing.

We realize that temporary financial problems may affect your timely payment of your account. If such problems DO arise, we encourage you to contact us promptly for assistance in the management of your account.

Patient Signature:_____ Date:_____

NorthShore Healthcare
Yearly Consent Forms

✓ **Consent to bill insurance**

I hereby assign all medical and or surgical benefits to which I am entitled including all major medical, Medicare, Medicaid, private insurance, and any other health plans to NorthShore Healthcare. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize NorthShore Healthcare to release all information necessary to secure payment.

_____

✓ **Consent to verify prescription records**

I also consent to my physician to retrieve prescription records from external sources.

_____

✓ **Consent to verbally release records (HIPAA)**

This is my authorization to allow VERBAL discussion of my condition, care, reminders of appointment times, or other medical information regarding the following patient:

- ☐ Me
- ☐ My child or ward, name: _____
- ☐ Other: _____

The following are <u>AUTHORIZED</u> to receive the patient's protected health information:

1. _____ Relationship:_____
2. _____ Relationship:_____
3. _____ Relationship:_____
4. _____ Relationship:_____

I have received today or at a previous visit a copy of NorthShore Healthcare HIPAA "Notice of Privacy Practice:

Printed Name: _____ Date:_____

Patient Signture: _____

Patient Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have received the notice electronically.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this document.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you: We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, or preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address law enforcement, and other government requests

We can use or share health information about you:

- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

About the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site. We never market or sell personal information. We will never share any substance abuse treatment records without your written permission, unless required by law.

This notice is effective 12/1/2016