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Patient Registration Form

Account No.	Entered Date
Reg. By	Office Site
☐ New ☐ Change	Info. Change:

Please complete this form in order to ensure proper billing of your services. **Please Print.** Today's Date: _____

Patient Information

Patient Last Name: _____

First Name: _____ MI: _____

Other Name: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other

Addr1: _____

Addr2: _____

City, State, Zip: _____

Preferred Method of Contact: ☐ Alt Phone Number ☐ Email ☐ Letter ☐ Phone Call (Cell) ☐ Phone Call (Home)

Driver's License # _____ State _____

Emp. Status: ☐ Employed Full Time ☐ Employed Part Time ☐ Unemployed ☐ Disabled ☐ Homemaker ☐ Student ☐ Active Military ☐ Self-Employed ☐ Other _____

Language: ☐ English ☐ Spanish ☐ Other _____

Social Security Number: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Race: (please choose one of the following):
☐ American Indian or Alaska Native ☐ Black or African American
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Asian
☐ Patient Declined

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Patient Declined

Home Phone: (_____) _____

Alt Phone: (_____) _____

Home E-Mail: _____

Cell Phone: (_____) _____

Employer: _____

Address: _____

City, State, Zip: _____

Work Phone: (_____) _____

Insurance Information

(A separate form is required for worker's compensation, automobile liability, or legal services.)

PRIMARY CARRIER: _____

Address: _____

Group/Plan #: _____ Effective Date: _____

Subscriber's DOB: _____ SSN: _____ Sex: ☐ M ☐ F

Subscriber's Employer: _____

Telephone #: (_____) _____

ID/Cert #: _____

Subscriber's Name: _____

Relationship to Patient: _____

SECONDARY CARRIER: _____

Address: _____

Group/Plan #: _____ Effective Date: _____

Subscriber's DOB: _____ SSN: _____ Sex: ☐ M ☐ F

Subscriber's Employer: _____

Telephone #: (_____) _____

ID/Cert #: _____

Subscriber's Name: _____

Relationship to Patient: _____

Primary Care Phys.: _____

Address: _____

City, St., Zip: _____

Telephone #: (_____) _____

Refer. Phys. (if different): _____

Address: _____

City, St., Zip: _____

Telephone #: (_____) _____

Pharmacy Name, Address & Phone #: _____

Guarantor Information

Please complete if guarantor is other than self. (Guarantor is the person financially responsible for this patient's bill.)

Guarantor: _____ Patient's Relationship to Guarantor: _____

Addr1: _____ Social Security Number: _____

Addr2: _____ Date of Birth: _____ Sex: ☐ M ☐ F

City, State, Zip: _____ Home Phone: (_____) _____

Employer: _____ Cell Phone: (_____) _____

Address: _____ City, State, Zip: _____

Work Phone: (_____) _____

Driver's License # _____ State _____ Guarantor E-Mail: _____

Emerg. Cont.: _____ Patient's Relationship to Emerg. Cont.: _____

Home Phone: (_____) _____

Alt Phone: (_____) _____ Cell Phone: (_____) _____

How did you hear about our practice? ☐ Billboard ☐ Brochure ☐ Health Fair ☐ Health Plan ☐ Internet ☐ Mass Mailing ☐ Newspaper/Magazine ☐ Ongoing Care ☐ Patient ☐ Phone Book ☐ Phys. Off/ER ☐ Relative ☐ Radio ☐ TV ☐ Word of Mouth ☐ Other

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Account #:

Assignment of Benefits / Authorization / Notice of Collection Action

I understand that I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I further understand that all co-payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductibles, charges denied by my insurance company as not covered or not medically necessary, and/or any fees incurred should my account require collection action. (e.g. late fees, collection agency, court or attorney costs). Also, please be advised our office may contact you via an automated system regarding appointments and/or account status. I agree this authorization shall remain valid unless/until I rescind in writing. (Please see the Consensus Health Medical Group Payment Policy and Notice of Privacy Practices for more information.)

Use of Photograph

The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's record and may be used by the patient's health care provider solely for the purposes of patient identification.

Vaccine Registry (if applicable)

Please be advised that our office submits confidential data of children and adult vaccinations to your State Immunization Registry per the Statewide Immunization Registry Act. The purpose of this program is to keep a central record or patient's immunization history.

Signature Required

The undersigned acknowledges that I have read and understand the above terms and conditions.

Patient Name **(Please Print)** _____ Patient Signature _____

Guarantor/Parent/Guardian completing this form **(Please Print)** _____ Date _____

Guarantor/Parent/Guardian Signature _____ Date _____

Please complete this section if the patient is covered by Medicare

In order to comply with Medicare regulations, please answer the following questions:

Are you or your spouse employed?	☐ Y ☐ N	Has treatment been authorized by the V.A.?	☐ Y ☐ N
Do you or your spouse have other insurance?	☐ Y ☐ N	Are you covered under the Black Lung Program?	☐ Y ☐ N
Are you disabled or have end stage renal disease?	☐ Y ☐ N	Is there Medigap coverage secondary to Medicare?	☐ Y ☐ N
Is illness/injury the result of an auto accident?	☐ Y ☐ N	Is there insurance coverage primary to Medicare?	☐ Y ☐ N
Did illness/injury occur at work?	☐ Y ☐ N	Is there employer supplemental coverage secondary to Medicare?	☐ Y ☐ N

The undersigned certifies that the questions have been answered truthfully and hereby authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

Patient Name **(Please Print)** _____ Patient Signature _____

Guarantor/Parent/Guardian completing this form **(Please Print)** _____ Date _____

Guarantor/Parent/Guardian Signature _____ Date _____

Payment Policy

Insurance: We participate with most major insurance plans, including Medicare. Knowing what benefits your insurance plan provides for you is your responsibility. Please contact your insurance company with any questions. **IF WE PARTICIPATE WITH YOUR INSURANCE CARRIER**, all services provided in our office (unless otherwise indicated) will be submitted to your insurance. All co-payments are due at time of service. Deductibles and coinsurance are your responsibility, and will be billed to you by our office. All insurance carriers have a fee schedule from which they will reimburse. The doctor's fees may be higher than what the insurance carrier reimburses, or it may not be a covered service. Therefore, any balances not covered by insurance become the responsibility of the patient.

IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE CARRIER OR IF YOU DO NOT HAVE HEALTH INSURANCE, payment in full is expected from you at the time of your visit.

Proof of Insurance: All patients must complete our patient registration form before seeing the doctor. Photo identification and a current valid insurance card are required at every visit to provide proof of insurance. It is your responsibility to verify that the office staff has the most current and correct information regarding your health insurance policy. Failure to provide current information may result in non-coverage for services provided, and the resulting charges will be your responsibility.

Co-payments and Deductibles: In accordance with your insurance plan and services provided, you are responsible for any and all co-payments, deductibles, and coinsurances at the time of service.

Referrals: In accordance with your insurance carrier, it is your responsibility to know if a written referral is required to see a specialist, or for a certain procedure. When a referral is not presented at the time of service to the provider, the patient may be responsible for payment in full at the time of service.

Claims Submission: Submission of claims is a courtesy extended to our patients. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you. Your insurance coverage is a contract between you and your insurance carrier. We are not party to that contract.

Non-covered Services: Certain office procedures or services may not be covered, or may be considered "not medically necessary", "experimental", "cosmetic" or simply "non-covered" by your insurance carrier. You are responsible for payment of these services. In the event your care exceeds a plan limitation, the balance becomes your responsibility.

Non-payment of patient balances: Should your account become delinquent, the patient or guarantor agrees to pay all costs associated with collecting the balance due. This includes, but is not limited to, attorney, collection, and contingent fees.

Non-sufficient funds (NSF)/ Returned Checks: A fee of $35.00 will be charged for all returned checks.

Missed Appointments: Failure to cancel your appointment without 24 hours notice from your scheduled visit may result in a fee of $50.00.

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CONSENT, DISCLOSURE AND AUTHORIZATION FORM

Patient Name: _____ Medical Record #: _____

Address: _____ DOB: _____

As used in this form, the words "I," "me," "my" and similar references mean the patient whose name appears above, or the parent, legal guardian or other legally responsible person on behalf of the minor or incapacitated patient named above.

General Consent for Examination and Treatment

I hereby consent and authorize Consensus Health and all physicians and ancillary medical personnel of Consensus Health, to perform medical examinations and provide routine medical care for all my visits to Consensus Health. This may include routine diagnostic and laboratory procedures and tests, medication administration, and other routine care for which a specific informed consent form will not be signed by me. This consent includes consent and authorization to photograph or otherwise take images of me and/or parts of my body for purposes of identification, diagnosis, treatment, payment and healthcare operations of Consensus Health. Any photographs or other images taken will become part of my medical record. Consensus Health will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require a specific informed consent, and that Consensus Health will provide me with information and forms prior to such procedures.

Acknowledgment of Receipt of Notice of Privacy Practices

I have read and understand Consensus Health's HIPAA Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information ("PHI"). I understand that Consensus Health has the right to change its HIPAA Notice of Privacy Practices from time to time and that whenever an important change is made, Consensus Health will post a new notice in the office. I may contact Consensus Health at any time to obtain a current copy of the HIPAA Notice of Privacy Practices. I may also access a copy on its website.

Consent To Use and Disclose Protected Health Information for Treatment, Payment and Health Care Operations

I hereby consent and authorize Consensus Health to use and disclose my health information, which includes all or any part of my medical records, including drug or alcohol treatment information, genetic, genetic counseling and genetic testing information, HIV/AIDS information, and any other information concerning my diagnosis or treatment, as well as demographic information, by and to its workforce members and to health care professionals, insurance companies, medical facilities, physicians and vendors or suppliers involved, or who may become involved, with my treatment, the payment for my treatment and/or the health care operations of Consensus Health. I understand that, for example, my health information may be used or disclosed by Consensus Health to: provide for my care and treatment; communicate among various health care professionals who are involved in my care or treatment; bill for and obtain payment for care and treatment provided by Consensus Health; provide information to and obtain payment from my health insurance company or plan; assess and review the quality of my care; and conduct its business and health care operations. In addition, I understand Consensus Health may release my protected health information as required by law or court order.

Patient Name: _____ DOB: _____

Disclosures to Authorized Individuals

I understand that Consensus Health may release my PHI to a family member, friend, or other person I indicate is involved in my care unless I object. I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for my health care (circle as applicable), to whom the information circled "yes" below may be released:

Name: _____ Relationship: _____

Address: _____

Phone: _____ Health Info: ☐ Yes ☐ No Payment Info: ☐ Yes ☐ No

Name: _____ Relationship: _____

Address: _____

Phone: _____ Health Info: ☐ Yes ☐ No Payment Info: ☐ Yes ☐ No

Name: _____ Relationship: _____

Address: _____

Phone: _____ Health Info: ☐ Yes ☐ No Payment Info: ☐ Yes ☐ No

Name: _____ Relationship: _____

Address: _____

Phone: _____ Health Info: ☐ Yes ☐ No Payment Info: ☐ Yes ☐ No

Contact Information

I understand that if I have checked the box "detailed message," I agree that Consensus Health may leave any of the following detailed messages at the indicated telephone number: appointment reminders, insurance/financial issues, biopsy or other test results, and any other information regarding care/treatment.

I wish to be contacted in the following manner (Please check all that apply):

☐ Home Telephone: (_____) _____ ☐ Detailed Message ☐ Call Back Message Only

☐ Work Telephone: (_____) _____ ☐ Detailed Message ☐ Call Back Message Only

☐ Cell Telephone: (_____) _____ ☐ Detailed Message ☐ Call Back Message Only

☐ Mail to Home Address: _____

☐ Mail to Work Address: _____

Consent and Authorization

A copy of this consent and authorization may be used in place of the original. I have read and understand the terms of this document. I have had an opportunity to ask questions about the use or disclosure of my health information and about the contents of this form. I acknowledge, consent and agree to the terms and conditions of this document:

Patient Name: _____ Date: _____

Patient Signature: _____

Authorized Individual (Parent/Guardian) Name: _____

Authorized Individual Signature: _____

Basis of Authority (e.g., parent, guardian): _____

HIPAA Acknowledgement
Notice of Privacy Practices

Printed Name of Patient: _____

Patient Date of Birth: _____

I acknowledge receipt of Consensus Health's Notice of Privacy Practices.

Signature of Patient/Legal Representative: _____ Date: _____

****

Office Use:

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained.

Reason: _____

Signature of Consensus Representative: _____

Printed Name: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This Notice describes how medical information about you (as a patient of this Practice) may be used and disclosed, and how you can get access to this information. Please review this notice carefully.

A. Our Commitment to Your Privacy

Our Practice is dedicated to maintaining the privacy of your Protected Health Information. "Protected Health Information" or "PHI" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you, or the payment for your health care. In conducting our business, we will create records regarding you and the treatment and services, we provide to you. We are required by law to maintain the confidentiality of health information that identifies you.

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out treatment, payment and health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this Notice will be effective from the date of revision or amendment forward. Our facility will post a copy of our current Notice in our office in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. How We May Use and Disclose Your Protected Health Information (PHI)

The following are examples of the types of uses and disclosures of how your Protected Health Information may be used and disclosed by your physician, and other treatment providers and our office staff. These uses and disclosures are permitted under HIPAA and other applicable laws and regulations and may be made without your specific written authorization.

1. **Treatment:** We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we may disclose your PHI to another physician who may be treating you or to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may ask you to have laboratory tests (such as blood or urine tests), and we may receive and use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you.

2. **Payment:** Our Practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members or to other health care providers and entities to assist in their billing and collection efforts.

3. **Health Care Operations:** Our Practice may use and disclose your PHI to operate our business. For example, Consensus Medical Group may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our Practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations. We will share your PHI with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

4. **Public Health Activities:** For example, we may disclose PHI to report information about births, deaths, various diseases, adverse events and product defects to government officials in charge of collecting that information; to prevent, control, or report disease, injury or disability as permitted by law; to conduct public health surveillance, investigations and interventions as permitted or required by law; or to notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.

5. **Health Oversight:** We may disclose your PHI to a health oversight agency for activities authorized by law. For example, we may disclose PHI to assist the government or other health oversight agency with activities including audits; civil, administrative or criminal investigations, proceedings or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

6. **Legal Proceedings:** We may disclose your PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

7. **Law Enforcement/ Criminal Activity:** We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. For example, we may disclose PHI when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds; or for the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

8. **Coroners, Funeral Directors, and Organ Donation:** We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may also be used and disclosed for cadaveric organ, eye or tissue donation purposes.

9. **Research:** Research is defined as a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge. In limited circumstances, we may use or disclose PHI to conduct medical research.

10. **Military Activity and National Security:** If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authority we may use or disclose PHI for

activities deemed necessary by appropriate military command authorities; for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to federal officials for intelligence and national security activities authorized by law.

11. **Workers' Compensation:** We may disclose your PHI as authorized to comply with workers' compensation laws and other similar legally-established programs.

12. **Inmates:** We may use or disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary for the institution to provide health care services to you; for the safety and security of the institution; and/or to protect your health and safety or the health and safety of other individuals.

13. **To Avoid Harm:** In order to avoid a serious threat to the health or safety of you, another person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

14. **Appointment Reminders and Health-Related Benefits or Services:** We may use and disclose PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer. Please let us know if you do not wish to have us contact you for these purposes, or you would rather we contact you at an alternate telephone number or address.

15. **Childhood immunizations:** We may disclose immunizations list to schools required to obtain proof of immunization prior to admitting the student so long as we have obtained and documented the patient or patient's legal representative's "informal agreement" to the disclosure.

16. **Decedents**: In certain circumstances, we may disclose PHI about a decedent to family and others involved in the decedent's health care or payment for health care. Other disclosures may require written authorization from the executor administrator of the decedent's estate.

The following are additional examples of the types of uses and disclosures of your Personal Health Information by your physician and other treatment providers and our staff. These uses, and disclosures are permitted under HIPAA but require you to have the opportunity to object or agree prior to the discloser.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

C. Circumstances Requiring Your Written Authorization for Use and Disclosure

Other than as stated in this Notice, we will not use and disclose your PHI without written authorization. You can later revoke your authorization in writing except to the extent we have already acted in reliance on your authorization.

D. Your Privacy Rights

You have the following rights regarding the PHI we maintain about you:

1. **Inspect and copy:** In most cases, you have the right to look at or get copies of your PHI that we maintain, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you in writing our reasons for the denial and explain your right to have the denial reviewed when applicable. If you request a copy of your information, we may charge you reasonable fees for the costs of copying, mailing or other costs incurred by us in complying with your request. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance. Note also that, you have the right to access your PHI in an electronic format (to the extent we maintain the information in such a format) and to direct us to send the e-record directly to a third party. We may charge for the labor costs to transfer the information; and charge for the costs of electronic media if you request that we provide you with such media.

   Please note: If you are the parent or legal guardian of a minor, certain portions of the minor's records may not be accessible to you. For example, records relating to care and treatment to which the minor is permitted to consent himself/herself (without your consent) may be restricted unless the minor patient provides an authorization for such disclosure. *

2. **Request a Restriction:** This means you may ask us, in writing, not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations. We will consider your request, but we are not legally required to accept it, except in the following circumstance. You have the right to ask us to restrict the disclosure of your PHI to your health plan for a service we provide to you where you have directly paid us (out of pocket, in full) for that service, in which case we are required to honor your request. If we accept your request for a restriction, we will put any limits in writing and abide by them except in emergency situations. Under certain circumstances, we may terminate our agreement to a restriction.

3. **Confidential Communications**: You have the right to request that our Practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you by telephone at home, rather than work, or at a particular address. We must agree to your request so long as we can easily abide by it in the manner your requested.

4. **Amendment:** You may ask us to amend your health information if you believe it is incorrect or incomplete, so long as the information is maintained in our records. You must put your request in writing and provide us with a reason that supports your request for amendment. We will respond within 60 days of receipt of your written request. We may deny your request if you fail

to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the Practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our Practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures**: You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures made for purposes of treatment, payment, or health care operations, those made pursuant to your written authorization, or those made directly to you or your authorized representative. The list also will not include uses and disclosures made for national security purposes, or to corrections or law enforcement personnel. We will respond within 60 days of receiving your written request. The list we will give you will include disclosure made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including the address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide one list during any 12- month period without charge, but if you make more than one request in the same year, we will charge you a reasonable fee for each additional request.

6. **Breach of PHI:** Our Practice will notify individuals following a breach of their unsecured PHI. A breach means the acquisition, access, use, or disclosure of unsecured PHI in a manner not permitted under HIPAA and compromises the security or privacy of the PHI.

7. **The Right to Get This Notice by E-Mail:** You have the right to get a copy of this Notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this Notice.

E. Other Activities Involving the Use and Disclosure of Your PHI

1. **Marketing Communications:** We will obtain your written authorization prior to using or disclosing your PHI for marketing purposes. However, we are permitted to provide you with marketing materials in a face-to-face encounter, without obtaining a marketing authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without obtaining a marketing authorization. In addition, as long as we are not paid to do so, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings. We may use or disclose PHI to identify health-related services and products that may be beneficial to your health and then contact you about the services and products.

2. **Sale of PHI:** We will disclose your PHI in a manner that constitutes a sale only upon receiving your prior authorization. Sale of PHI does not include a disclosure of PHI for a public health purposes; research; treatment and payment purposes; sale, transfer, merger or consolidation of all or part of our business and for related due diligence activities; to the individual; as required by law; or for any other purpose permitted by and in accordance with HIPAA.

3. **Fundraising Activities:** We may use certain information (name, address, telephone number, dates of service, age and gender) to contact you for the purpose of various fundraising activities. If you

do not want to receive future fundraising requests, please write to the Privacy Officer at the below address.

4. **Incidental Uses and Disclosures:** Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure. However, such incidental uses or disclosure are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient within the office that might be overheard by persons not involved in your care would be permitted.

5. **Business Associates:** We may engage certain persons or companies to perform certain functions on our behalf and we may disclose certain PHI to these persons or companies. For example, we may share certain PHI with our billing company or computer consultant in order to facilitate our health care operations or payment for services provided in connection with your care. We will require our business associates to enter into an agreement to keep your PHI confidential and to abide by certain terms and conditions.

F. How to Complain About Our Privacy Practices

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the Privacy Officer listed below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave., S.W., Room 615F, Washington, DC 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.
If you have any questions about this Notice or any complaints about our privacy practices, please contact our HIPAA Privacy Officer at:

Consensus Medical Group
402 Lippincott Dr
Marlton, NJ 08053
Attn: Privacy Officer
Telephone: (856) 782-3300

G. Effective Date of Notice:

_____ _____

Signature of employee/volunteer/affiliate Date

_____

Print Your Name

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Comprehensive Adult Health History Questionnaire

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. Please fill in the next five pages. It is long because it is comprehensive. We really want to know you well, so we can properly care for you. If you cannot remember specific details, please provide your best guess, if you are uncomfortable with any questions you don't have to answer it. Thank you.

Main Reason for Today's Visit: _____

Other Concerns: _____

_____

Medications: Please list (or show us your own printed record) all prescriptions and non-prescriptions medications. This includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter pain pills (Advil, Aleve, Tylenol, etc.)

__ Check if you do not take any prescription or over the counter medications.

__ Check if you brought a list of your medications (please give to the front desk with your paperwork)

Medications	**Dose (Mg/Mcg/Pill)**	**How Many Times Per Day**

Pharmacy Information

Pharmacy Name: _____ Phone Number: _____

Address, City, State: _____

Mail Order Pharmacy: _____

Allergies or Intolerance to Medications

_____

_____

_____

Personal Medical History: Do you have now, or have you had any of the following conditions?

Condition	Yes	Year	Comments
Alcohol/Drug abuse			
Allergy (Hay Fever)			
Anemia			
Anxiety			
Arthritis (Rheumatoid)			
Arthritis (Osteoarthritis)			
Asthma			
Bladder/Kidney Problems			
Blood Clot (leg)			
Blood Clot (lung)			
Blood Transfusion			
Breast Lump (benign)			
Cancer of the Breast			
Cancer of the Colon			
Cancer of any other type			
Cancer of the Ovarian			
Cancer of the Prostate			
Cataracts			
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Diabetes (adult onset)			
Diabetes (childhood onset)			
Diverticulosis			
Emphysema (COPD)			
Fractures			Where?
Gallbladder Disease			
Gastroesophageal Reflux (GERD/Heartburn)			
Glaucoma			
Gout			
Gynecological Conditions (endometriosis)			
Gynecological Conditions (fibroids)			
Gynecological Conditions (other)			
Heart Attack			
Hepatitis – Type A			
Hepatitis – Type B			
Hepatitis – Type C			
Hepatitis - Other			
High Blood Pressure			
High Cholesterol			

Personal Medical History Continued

Condition	Yes	Year	Comments
Hip Fracture			
Irritable Bowel Syndrome			
Kidney Disease / Failure			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate (enlargement)			
Prostate (nodules)			
Seizure / Epilepsy			
Skin Condition (eczema)			
Skin Condition (psoriasis)			
Skin Condition (abnormal moles)			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid High (overactive) Hyperthyroidism			
Thyroid Low (underactive) Hypothyroidism			
Other (list)			
Other (list)			

Surgical & Procedure History – Please check off any procedure or surgeries. List any abnormal finding, details or complications under comments.

Surgical Procedure	Yes	Year	Comment
Abdominal Surgery			
Angiogram (heart)			
Angiogram (vascular)			
Appendectomy (appendix removal)			
Back Surgery (lumbar)			
Biopsy (location in comments)			
Breast Biopsy			Circle: Right Left Both
Breast Surgery			Circle: Right Left Both
Cataract Surgery			
Colonoscopy			
Coronary Bypass			
Coronary Stent			
C-Section			
Echocardiogram (heart)			
EGD (stomach endoscopy)			
Gallbladder Removal			Circle: Laparoscopic

Surgical & Procedure History Continued

Surgical Procedure	Yes	Year	Comment
Heart Surgery (other than coronary bypass checked above			
Hip Surgery			Circle: Right Left Both
Hysterectomy (partial, ovaries left)			Circle: Laparoscopic Vaginal Both
Hysterectomy (total, including ovaries)			Circle: Laparoscopic Vaginal Both
Knee Surgery			Circle: Right Left Both
LEEP (cervix Surgery)			
Neck (spine) Surgery			
Ovary Removal			Circle: Right Left Both
Pulmonary Function Test			
Sigmoidoscopy			
Sinus Surgery			
Stress Test (stress echo)			
Stress Test (thallium/perfusion)			
Stress Test (treadmill)			
Tonsillectomy			
Tubal Ligation			
Vasectomy			
Other (list)			

Family History

Indicate which relative has had the following diseases (parents, brothers and sisters are the most important) Write in the number of siblings in the appropriate boxes. If some siblings are alive and some are deceased use the space to the right to explain further.

	Mother	Father	Sister(s)	Brother(s)
Alive				
Deceased				
Age currently or at time of death				

Diseases & Conditions

	Mother	Father	Sister(s)	Brother(s)	List age(s) at diagnosis if known and if this was the cause of death
No significant history known					
Hypertension (high blood pressure)					
Hyperlipidemia (high cholesterol)					
Heart Attack, Angina (coronary artery disease)					

Diseases & Conditions

	Mother	Father	Sister(s)	Brother(s)	List age(s) at diagnosis if known and if this was the cause of death
Diabetes Type II (adult onset)					
Cancer Breast					
Cancer Colon					
Cancer Prostate					
Osteoporosis					
Depression					
Alcoholism/Drug Abuse					
Alzheimer's					
Asthma					
Autoimmune Disease					
Bleeding or Clotting Disorder					
Cancer, Lung					
Cancer, Ovarian					
Cancer, Other Type					
Colon Polyp					
Diabetes Type I (childhood onset)					
Emphysema (COPD)					
Genetic Disorder (explain)					
Glaucoma					
Heart Disease (CHF)					
Heart Disease (other)					
Hepatitis B or C					
Hip Fracture					
Hypothyroidism/Thyroid Disease					
Kidney Disease					
Kidney Stones					
Macular Degeneration					
Stroke					
Sudden Cardiac Death					
Other (list)					
Other (list)					

Immunizations

Influenza (flu shot) _____ Pneumovax 23 (pneumonia)_____ Prevnar 13 (pneumonia)_____
Date: _____ Date: _____ Date: _____

Colonoscopy Date:_____Year: _____ Abnormal_____ Normal_____Polyps_____

Retinal Exam Date:_____Year:_____Where: _____

Women only:

Mammogram: Most Recent date/where_____ Abnormal_____Normal_____

Pap Smear: Most Recent date/where_____Abnormal_____Normal_____

Social History:

Tobacco Use:
Non-Smoker_____Smoker_____Former Smoker_____Cigarettes_____Pipes_____Cigars_____

Current Smoker: Packs per day_____ Number of years_____

Former Smoker: Quit date_____ Approximately how many years did you smoke_____
Approximately how many packs did you smoke_____

Alcohol Use:
Do you drink alcohol? Yes_____No_____
Number of drinks per week:_____Beer_____Wine_____Liquor_____

Exercise:
Do you exercise regularly? Yes_____ No_____

Seatbelt Use:
Do you use your seatbelt consistently? Yes_____No_____

Sun Exposure: Frequent_____Occasionally_____Rarely_____Remote_____

Caffeine Use:
How much caffeine do you intake daily? Type_____ Cups_____