Patient Contact Information

Please Print Legibly

Name _____

Date of Birth _____

Social Security # _____

Address _____

City, State, Zip Code _____

Home Phone _____ Work/ Cell _____

Employer Name _____

Employer Address _____ Phone _____

Referring Physician _____

Primary Care Physician _____

Emergency Contact/ Relationship _____

Phone _____

Health Insurance Company ** Policy number is not needed if card has been copied**

Primary _____ Policy _____

Secondary _____ Policy_____

Please present your insurance company card upon office visit. A photocopy must be made before services are rendered.

Payment Guarantor (If name on insurance card is not your own).

Name _____

Date of Birth _____

Social Security # _____

Patient Authorization to Release Medical and Payment Information

Our medical practice accepts and processes many types of insurance company coverage options. It is the patient's responsibility to inform us if there is a copay, deductible, surgical pre-certification, and/or second surgical opinion required by your insurance company. It is also the patient's responsibility to inform us if you would like to arrange an installment payment plan.

Our medical practice will only communicate the patient's protected health information according to the terms of our Notice of Privacy Practices. Please list any party, other than yourself, you authorize the medical practice to release your protected health information (family, spouse, or friends).

_____ _____
_____ _____
_____ _____

Medical
I hereby authorize the release of any and all protect health information to the above parties. I understand if their name is not listed, the medical practice is forbidden to communicate my protected health information to anyone other than the parties in the Notice of Privacy Practices. I understand I may add or remove anyone from the above list at any time, if given in writing to the medical practice's Privacy Officer.

I further understand this authorization includes the release of information concerning psychiatric or psychological conditions, drug abuse, alcohol abuse, HIV testing and treatment, or related conditions contained in my medical records.

Payment
I hereby authorize the release of any and all protected health information the medical practice may need to process payment for medical and surgical services received. I also hereby authorize any insurance company payments be made directly to the medical practice or Dr. Ricardo Vasquez.

I understand I am responsible for any collection of payment amounts incurred including third-party collection efforts and attorneys fees.

If I am not currently insured, I understand that I have sole responsibility, and agree to pay, for all services received.

_____ _____
Signature Date

HEALTH HISTORY

Medical Conditions: Current or Past History

( ) AIDS	( ) Emphysema	( ) Kidney Disease	( ) Other
( ) Arthritis	( ) Epilepsy	( ) Liver Disease	_____
( ) Asthma	( ) Gout	( ) Pacemaker	_____
( ) Bleeding Disorder	( ) Heart Disease	( ) Prostate Problems	_____
( ) Cancer	( ) Hepatitis	( ) Stroke	
( ) Diabetes	( ) High Cholesterol	( ) Thyroid Problems	

Family History

( ) Cancer	( ) Heart Disease	( ) Stroke	_____
( ) Diabetes	( ) High Blood Pressure	( ) Other	_____

Social History

( ) Smoking ( ) Alcohol

Current Symptoms

GENERAL	CARDIOVASCULAR	GASTROINTESTINAL
( ) Chills	( ) High Blood Pressure	( ) Poor Appetite
( ) Depression	( ) Irregular Heartbeat	( ) Bloating
( ) Dizziness	( ) Poor Circulation	( ) Hemorrhoids
( ) Fainting	( ) Vericose Veins	
( ) Headache	( ) Swelling of Arms/ Legs	
( ) Loss of Weight		
( ) Numbness		
( ) Sweats		

GENITO-URINARY	HEAD AND NECK
( ) Frequent Urination	( ) Blurred Vision
( ) Painful Urination	( ) Double Vision

Medications

Name _____

Name _____

Name _____

Name _____

Name _____

Prior Surgeries

Name _____

Name _____

Name _____

Name _____

Name _____

Allergies

Name _____

Name _____

Name _____

NOTICE OF PRIVACY PRACTICES - Please review carefully

Our commitment to your privacy

Our Practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). 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 and to provide you with this notice of our legal duties and the privacy practices concerning your IIHI.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all or your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in your patient file and you may request a copy of our most current Notice at any time.

We may use and disclose your IIHI in the following ways:

Treatment. Our practice may use your IIHI to treat you. For example we may ask you to have laboratory tests , and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

Payment. Our practice may use and disclose your IIHI 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 IIHI to obtain payment from third parties that may be responsible for such service costs, such as family members. Also, we may use your IIHI to bill you directly for service and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the way in which we may use and disclose your information for operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

Appointment Reminders: to contact you and remind you of an appointment.
Treatment Options: to inform you of potential treatment alternatives.
Health-Related Benefits and Services: to inform you of health-related benefits or services that may be of interest to you.
Release of Information to Family/Friends: that is involved in your care, or who assists in taking care of you.
Disclosures Required by Law: when we are required to do so by federal, state, or local law.

Use and disclosure of your IIHI in certain special circumstances

Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate governmental agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures 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.

Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- ❑ Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement.
- ❑ Concerning a death we believe has resulted from criminal conduct.
- ❑ Regarding criminal conduct at our offices.
- ❑ In response to a warrant, summons, court order, subpoena or similar legal process.
- ❑ To identify/locate a suspect, material witness, fugitive or missing person.
- ❑ In an emergency, to report a crime (including the location or victim[s] of the crime, or the description, identity or location of the perpetrator).

Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain written authorization to use your IIHI for research purposes except when Internal Review Board of Privacy Board has determined that the waiver of your authorization satisfies the following:

(i) the use or disclosure involves no more than a minimal risk to your privacy based on the following:
a. An adequate plan to protect the identifiers from improper use and disclosure;
b. An adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and
c. Adequate written assurances that the IIHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

(ii) the research could not practicably be conducted without the waiver; and
(iii) the research could not practicably be conducted without access to and use of the IIHI.

Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

Inmates. Our practice may disclose your IIHI 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: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

NOTICE OF PRIVACY PRACTICES - Please review carefully

Your Rights Regarding Your IIHI

Confidential Communication. 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 at home, rather than work. In order to request a type of confidential communication, you must make a written to the Privacy Officer specifying the requested method of contact and/or the location where you wish to be contacted. Our practice will accommodate *reasonable* requests. You do not need to give a reason for your request.

Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to the Privacy Officer. Your request must describe in a clear and concise fashion:

- ❑ the information you wish restricted;
- ❑ whether you are requesting to limit our practice's use, disclosure or both; and
- ❑ to whom you want the limits to apply.

Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to our Privacy Officer in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our Privacy Officer. You must provide us with a reason that supports your request for amendment. Our practice will 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 correct; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI 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.

Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures" which is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented (for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim). In order to obtain an accounting of disclosures, you must submit your request in writing to our Privacy Officer. All requests for an accounting must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of other costs involved with additional requests, and you may withdraw your request before you incur any costs.

Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice contact our Privacy Officer.

Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice contact our Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time ***in writing***. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note we are required to retain records of your care.

I hereby acknowledge that I have received this Notice. _____ _____

Signature Date