HIPAA PRIVACY ACT

(PRINT CLEARLY)

Patients Full Name:_____

Social Security No.: _____ DOB: _____

Home Phone #:_____ Cell phone #:_____

Spouse Full Name: _____

Social Security #: _____DOB: _____

Spouse's Phone#: _____ 2nd Phone #_____

Email Address: _____

Guardian information for minors or caregivers of an incompetent patient:

Guardian's Full Name: _____

Social Security #_____

Phone #: _____Relation to PT:_____ Insurers DOB: _____

I acknowledge receiving a copy of **the Notice of Privacy Practices** detailing how my medical information may be used and disclosed in the compliance with the Department of Heath and Human Services in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of the 1996, and outlining my rights regarding my medical information.
Patient/Guardian Initials Indicating Receipt: _____

PAYMENT AUTHORIZATION

I, _____, hereby authorize my medical provider to furnish information concerning my present illness. I direct the insurer to pay, without equivocation directly to this office, all benefits due to them as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all changes. A copy of this authorization will be valid as the original.

Signature of PATIENT/Gaurdian:_____Date:_____

CONFIDENTIALITY QUESTIONAIRE

Please list below family/friend, if any, who we may inform about your care, treatment, medical condition, and payment. We ask for **no more than (2) people** be designated as the **contact people.** The names and phone numbers of your contact people will be listed below, and this sheet will become part of your medical record. It is important for our staff to maintain your confidentiality; therefore, we will not give detailed information about you unless you have requested us to do so and then **only** to your contact individuals named below. To protect your confidentiality, your contact people will be asked to provide us with the password you indicate below. **All other persons who request information about you will be referred to your contact people.** This system has been designed so that you can participate in case and determine your own spokesperson. We are aware that your family and friends are concerned about your welfare and progress. **Please inform them to call your contact people for information about you.**

Please print the address of where you would like your billing statements (For example, if there is any balance remaining after your insurance company has paid, any deductibles not met, copays not paid, or if you have no insurance) and/or other correspondence:

Billing Statement Address: Mail to my home address

-Mailing Address: _____

_____

Correspondence address: Mail to my home address listed above

-Other address: _____

_____

May we contact you at work to remind you of appointments, lab results, etc? YES NO

I have read and understand this policy. I hereby designate the following people to be the contact individuals for communication while I am under the care of this office. This right of information ends when I am discharged from services and I can change these contact people at any time.

Contact Person #1: _____Password:_____

Relationship: _____Home Phone#:_____Work #:_____

Contact Person #2: _____Password:_____

Relationship: _____Home Phone#:_____Work #:_____

Signature: _____Date: _____

PAIN MANAGEMENT POLICY AND AGREEMENT

In accordance with 24 DE **Admin. Code 1700 Regulation 32** we wish to inform you of our policy regarding prescription medication for pain. It is the policy of Physicians and Physician Assistance of this office, to minimize the use of narcotic pain medicine due to the addictive nature of these medicines**. Our providers may prescribe pain medication in conjunction with surgical cases or as part of treatment for an acute injury up to 90-days.** Our providers will not prescribe long-term pain medication, nor will our providers prescribe pain medication for chronic pain issues. In those circumstances, our providers will refer you to your primary care physician or to a pain management physician. As our patients, we ask that you acknowledge and agree to the following standard issued by our practice:

- I will keep all scheduled appointments related to my condition. I understand that pain medications will only be refilled during regular business hours and will not be refilled if appropriate follow-up care is not maintained and prescriptions do take 24 to 48 hours to refill.
- I will make you aware of other physicians who are treating me and agree that during my treatment with you, I will receive pain medication from only one physician.
- I understand that if I am given a prescription from my medical provider and it is in anyway altered or changed, that I will be immediately dismissed from the practice and the authorities notified of such forgery.
- I understand, if I am under a pain management contract, I will not receive **ANY** pain medications from this office.
- I further understand that if I fail to follow these guidelines, that this office may terminate my treatment immediately.

I understand and have read the Pain Management Policy and Agreement above.

Print Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Witness: _____