HAYS COUNTY SPORTS MEDICINE

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 !

- *Our Legal Responsibilities:*

This Privacy Notice is being provided to you as a requirement of a federal law known as the Health Insurance Portability and Accountability Act (" HIPAA"). The Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control protected health information in some cases. Your " protected health information " means any written and oral health information about you, including demographic data that can be used to identify you.

We are required to follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on April 14, 2003, and will remain in effect until we replace it.

As permitted by law, we reserve the right to change our privacy practices and the terms of this Notice at any time. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available to you at your next visit to our Practice. You may request a copy of our Notice at any time.

- *Examples of Uses and Disclosures of Protected Health Information:*

Our Practice may use your protected health information for purposes of providing treatment, obtaining payment for

treatment and conducting health care operations.

A. Treatment: We may use or disclose your health information to a physician or other healthcare practitioner providing treatment to you. For example, a doctor to whom we refer you for ongoing or further care may need your medical record. We also may disclose medical information about you to people who may be involved in your medical care, which may include your family member, or other personal representatives.

B. Payment: We may use and disclose your health information to obtain payment for services we provide to you. For example, we may need to give your healthcare information, regarding the treatment you received from us, to obtain payment or reimbursement for the care.

C. Healthcare Operations: We may use and disclose your health information in connection with healthcare operations. Healthcare operations include such activities as: quality assessment and improvement activities, training programs, medical reviews, and employee review activities, licensing and credentialing programs.

D. Uses of Information: We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting area when your physician is ready to see you, to contact you to remind you of your appointment.

E. Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

F. To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family

member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

G. Persons Involved In Care: Unless you object, we may use or disclose your protected health information to notify, or assist in notifying a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

H. Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

I. Required by Law: We may use or disclose your health information when we are required to do so by law.

J. Abuse and Neglect: We may disclose your health information to public authorities as allowed by law to report abuse or neglect. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

HAYS COUNTY SPORTS MEDICINE
PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
*Obtain payment from third-party payers.
*Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you and your *Notice of Privacy Practices* containing a more complete description of the used and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notices of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Can we call you at home? Yes No
Can we leave a message on your voice mail/answering machine? Yes No
Can we call you at work? Yes No
Can we leave you a message at work? Yes No

I authorize your office to disclose the specific information below, only for the purposes and parties described below. I may revoke this authorization in writing by contacting your office: (Please list the name & phone number of anyone (Spouse, Parent, Child, etc.) you would allow us to share your medical information with. This includes any information regarding treatment, account balance, appointment date and time, etc.)

____
____
____
____

Patient Name:____
Signature: ________________________________Date:__________

HAYS COUNTY SPORTS MEDICINE

Please Print Information / Fill in all Blanks

PATIENT INFORMATION

Patient Name (Last, First, Middle)	Social Security #	Sex M or F	Marital Status

Email Address	Race	Ethnicity	Language Preferred

Address	Phone #	Age	Date of Birth

City-State-Zip	Cell #	Occupation

Employer Name	Address	City-State-Zip

Family Physician	Referred By	If patient is a student, Name of School

In Case of Emergency Notify	Relationship	Phone #

PHARMACY INFORMATION

Pharmacy Name	Address	City	Phone #

INSURANCE INFORMATION

Primary Insurance Policy Holder	Relationship	Social Security #	Phone #

Date of Birth	Address	City-State-Zip

Employer Name	Address	Phone #

Secondary Insurance Policy Holder	Relationship	Social Security #	Phone #

Date of Birth	Address	City-State-Zip

Employer Name	Address	Phone #

In the event this claim is denied by my insurance company I understand that I am responsible for all charges incurred as a result of this visit. I hereby authorize the above physician to release information to my employer and insurance carrier. I hereby authorize payment directly to the above provider of the surgical and medical benefits if any, otherwise payable to me for his services, but not exceed the reasonable and customary charges for all those services. I understand that this authorization does not release me from my personal responsibility for payment of all charges.

Signed (Patient or Insured) (Parent signature required for minors)

Signature ______________________________ Date ______________ Rev 04/11

History & Review of Systems Screening

PATIENT NAME____________________________ **Date**__________________

Height ________ **Weight** _______ **B/P** ________ **R or L Handed**

Past Medical History:
Please tell the doctor if you have ever been treated or taken medication for: (circle the disease/disorder)

High Blood Pressure	Stroke	Heart Disease
Ulcers	Cancer	Alcoholism
Diabetes	Gout	Depression
Asthma	Hepatitis	Anxiety Disorder
Emphysema	Seizures	Mental Illness
Chronic Bronchitis	Migraine	HIV/AIDS
Kidney/Urinary Trouble	Thyroid Disease	Reaction to anesthesia
Drug or alcohol addiction	Tuberculosis	Malignant Hyperthermia
Blood Disorders (Sickle Cell Disease or Trait, Hemophilia, etc.)		Prostate problems

Other disease or disorder ____

Do you smoke? ☐ NO ☐ YES How many packs per day?____ Never_____
If you have quit smoking, when did you quit? _________
Do you drink alcohol? ☐ NO ☐ YES How much?_______________
If you don’t drink now, did you drink alcohol in the past? ☐ NO ☐ YES
How much? __________

Do you use recreational drugs? ☐ Yes ☐ No If yes, explain:______________________________
Are you allergic to any medications? ☐ NO ☐ YES If so, please list them and your reactions:____

List all surgeries you have had with the approximate date_________________________________

Please list all your medications (including over the counter medications: vitamins, aspirin, etc.)

Medicine	Dose (How much)	Frequency (How many times a day)

History & Review of Systems Screening

PATIENT NAME__________________________ **Date**_________________

Review of Systems **Please circle any problems listed below you have been experiencing recently**

General: Body lumps unexpected weight loss loss of or poor appetite
Tiredness/weakness > 3 weeks

Head/Neck: Sore throat Ear ache Dizziness/lightheadedness
Runny nose Headaches

CV/Resp: Chest Pain Shortness of breath Palpitations Wheezing
Cough more than 3 weeks Coughing up blood or green/yellow sputum Cold symptoms Discoloration of foot, hand, toes, fingers

Gastroint: Belly pain Diarrhea Constipation Indigestion/heartburn

GU: Burning urination excessive urination Blood in urine
Testicular mass Difficulty starting or stopping urination
Night urination

Musculoskeletal: Pain in joints Swelling of joints Back pain
Stiffness Dislocation of a joint Muscle/tendon ache
Giving way of knee or ankle Joint locking popping

Skin: Rash Sores Bleeding moles Easy bruising
Psoriasis

Neuro/psych: Seizures Numbness Burning pain Decreased sensation
Paralysis Frequent crying/sadness Unexplained panic Tremor

Endocrine Unusual thirst, frequent urination, and appetite Loss of hair Hot flushes Nervousness

Hem/lymph Easy bruising Bleeding problems after tooth extraction or surgery Severe bleeding problems with periods

All/immuno Allergy to insect stings, foods, latex frequent infections

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Family History: Arthritis HTN Heart disease Diabetes Cancer Thyroid Problems

Mother: Living or Deceased Father: Living or Deceased
Grandmother: Living or Deceased Grandfather: Living or Deceased
<u>Additional Comments</u>:

Accident/Injury Details

PLEASE PRINT/FILL IN BLANKS

Patient name______________________________

DOB ____/____/______ Last four of SSN#_________

What body part are we seeing you for today? ____________________

Please indicate right/left if applicable ❑ Right ❑ Left

Date of injury/onset ____/____/______

Details of Injury

In Your Own Words please describe in detail When, Where, And How your Problem Happened or Began

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____

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____

Was this a result of a motor vehicle accident? ❑ yes ❑ no

Did the accident involve another party? ❑ yes ❑ no

Did this injury occur on the job? ❑ yes ❑ no

Did you or will you be filing a worker's compensation claim for this injury?
❑ yes ❑ no

At this time is it anticipated that another party (other than your own health insurance or worker's compensation) will be responsible for medical expenses related to this injury? ❑ yes ❑ no
If yes, name, address and phone number of responsible party:

____

____

______________________________ ____/____/______
Signature of Patient or Guardian Date