

Holmes Family Medicine, Inc.

Authorization for Disclosure of Health Information

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure: **(example doctor, hospital, transferring facility, etc)**

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Professional relation to patient: (doctor, hospital, etc.): _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

_____ Complete health records

_____ Lab results/X-ray reports

_____ Physical exam

_____ Consultation reports

_____ Immunization record

_____ Other (please specify): _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_____ initials

5. This information may be disclosed to and used by the following individual or organization.

HOLMES FAMILY MEDICINE, INC.
151 Parkview Drive
Millersburg OH 44654
Phone: 330-674-1200 Fax: 330-674-3320

For the purpose of: _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

7. If I fail to specify an expiration date, event or condition, this authorization will expire in one year. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact:

Scott Brown, M.D., Privacy Officer for Holmes Family Medicine, Inc.

Signature of patient or legal representative

Signature of witness

Date: _____

Date: _____

Holmes Family Medicine
151 Parkview Dr
Millersburg, OH 44654

Patient Information Form

Date

Patient last name: _____
 Patient first name: _____
 Patient middle initial: _____ Nickname: _____
 Patient maiden name: _____
 Mailing address: _____
 Street address: _____
 City: _____ State: _____ Zip: _____
 Home Telephone: _____
 Cell Phone: _____
 E-mail: _____

Gender: _____
 Date of Birth: _____
 Patient SSN: _____
 Work phone: _____
 Work extension: _____
 Spouse's name: _____
 Father's name: _____
 Mother's name: _____

Payment (please check one):

- Self-Pay
- Insurance

As part of the government's electronic medical records program, we are now expected to record your race and ethnicity. Like the rest of your chart, this information is protected and private under HIPAA, but if you do not wish us to record it, simply check "Prefer not to report."

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino
- Prefer not to report

Race:

- American Indian or Alaska Native
- Asian
- Black or African American
- More than one race
- Native Hawaiian
- Other Pacific Islander
- Prefer not to report
- White

Thank you for understanding.

In case of emergency, notify:

(Name)	(Relationship)	(Phone Number)
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I hereby authorize Holmes Family Medicine to furnish information to insurance companies as may be requested for illness or injury. This authorization shall apply to my records or any minor listed either above or below.

I authorize payment for these services to be made directly to Holmes Family Medicine.

I also understand that I am responsible for payment of services not covered by my insurance company and that payments for co-pays are required at the time of service.

Signature of responsible party _____ Date _____

Printed name (if other than patient) _____

Other Family Members	Date of Birth	Relationship	Is payment type same as above?
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No

If you need more room for additional names, circle yes and write them on the back of this sheet: Yes / No

Holmes Family Medicine Medical History Form

Name: _____ Date of Birth: _____ Family Doctor: _____

<i>Past Medical History</i>		
Medical Problems/Conditions:	Yes	No
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension (high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Acid Reflux/GERD	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (if yes, give type)	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		

<i>Family History</i>			
Condition:	Yes	No	Family Member:
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer (if yes, give type)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Autoimmune Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____			

Surgical History:	Year:	Hospital:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Colonoscopy/Endoscopy	_____	_____
Anesthesia Complications	_____	_____

<i>Social History</i>	
Marital Status	_____
Employment	_____
Alcohol Consumption	_____
Caffeine Consumption	_____
Exercise	_____
Smoking History	<input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Ex-smoker
Packs Per Day	_____
# years (smoker or smoke free)	_____

Medication Use (dosage and frequency):

<i>Childbirth History</i>	
Number of Children	_____
Number of Pregnancies	_____
Vaginal Deliveries	_____
Cesarean Deliveries	_____

<i>Allergies</i>	
Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Holmes Family Medicine, Inc.
Payment Policy — Effective June 1, 2004

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Self Pay.** Self pay patients are considered those who do not have medical health insurance coverage. **Payment in full is expected at each visit.** As a courtesy, we will provide a 15% discount for each Office Visit when payment is made.

2. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted except in special cases of financial hardship approved by the physicians. Please be aware that if your balance remains unpaid, we may refer your account to a collection agency, and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and/or certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physicians will only be able to treat you on an emergency basis.

3. **Missed appointments.** You may be charged a No-Show fee of \$25 - \$75, depending on the type of visit, for missed appointments that are not cancelled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointments.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding the payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient/responsible party

Date of birth

Today's date

****List ALL family members (with their date of birth) under the age of 18 residing in your home who attend this office:**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Holmes Family Medicine, Inc.
151 Parkview Drive
Millersburg, OH 44654

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 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 the treatment directly and indirectly
- Obtain payment from third party payers (like your health insurance company)
- Conduct normal health-care operations such as quality assessment and physician certifications
- Notify me of upcoming appointments

I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 above to obtain the current copy of the Notice 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 understand you are not required to agree to my requested restrictions but if you do then you are bound to abide by such restrictions.

Print Patient Name _____

Date of Birth _____

Relation to Patient (self) _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason