

PATIENT INFORMATION RECORD

Patient's Name	Marital Status	Date of Birth	Age	Social Security No.
Street Address	City and State	Zip Code	Home Phone #	
Patient's Employer	Occupation	How Long Employed	Business Phone #	
Spouse's Name		Spouse's Phone #		
Name of Primary Person Insured	Primary Insured SS#		Primary Insured D.O.B.	
Primary Insured Employer	Primary Insured Business Address		Primary Insured Business Phone #	
Emergency Contact (Other Than Spouse)				
Who Referred You To Our Practice?				

Confidential Phone Number where we can leave lab results and/or other medical information:

IF THE PATIENT IS A MINOR OR STUDENT

Mother's Name	Mother's Home Address		Mother's Home Phone #
Mother's Employer	Occupation	How Long Employed	Mother's Business Phone #
Mother's Employer's Address			Mother's Social Security #
Father's Name	Father's Home Address		Father's Home Phone #
Father's Employer	Occupation	How Long Employed	Father's Business Phone #
Father's Employer's Address			Father's Social Security #

Insurance Information:

Please make sure the receptionist has your CURRENT Insurance Information such as Insurance card, ID Numbers, Name of Primary Insured etc. Thank you!

AUTHORIZATION: I hereby authorize the physician to furnish information to insurance carriers concerning any illness/accident. I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

Signature: _____

This office applies a \$25 charge to your account for NSF charges and missed appointment that are not cancelled 24 hours prior to the appointment time.



Authorization for Use and Disclosure of Protected Health Information

I _____, hereby authorize, Elite OB/GYN to use and/or disclose the following **protected health information (PHI)** to:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

This PHI is being used or disclosed for the following purposes:

Providing appointment reminders

Describing or recommending treatment alternatives

Providing information about health-related benefits and services that may be of interest to the individual

Soliciting funds to benefit the covered entity

I understand that I have the right to revoke this authorization at any time by submitting a written request and that a revocation is not effective prior to the revocation date. Furthermore, I understand that the information used or disclosed pursuant to the authorization may be subjected to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

I also understand that I have the right to refuse to sign this authorization and my treatment or eligibility for benefits will not be conditioned upon this authorization.

The use or disclosure requested in this authorization will result in direct or indirect compensation to **Lauren Michelsen, D.O.** from a third party.

This authorization will remain in effect until further notice from patient or legal guardian of patient.

Signature of Patient or Representative/Guardian

Date

Printed Name of Patient or Representative/Guardian



CONSENT FOR USE AND DISCLOSURE OF INFORMATION

I have reviewed the “Notice of Privacy Practices” of Elite OB/GYN and have had all questions answered by this office.

I consent to the use or disclosure of my protected health information for the following purposes:

- **TREATMENT**

It will be necessary to share protected health information with all members of the treatment team for treatment purposes. This can include employees in this office as well as other providers.

- **PAYMENT**

Necessary information will be shared with appropriate payer sources and their representative for payment purposes including, but not limited to eligibility, benefit determination, and utilization review. It will also be necessary for billing personnel including but not limited to employees, case managers, claims representatives, third party billing services or clearinghouses to have access to protected health information to carry out their job function.

- **HEALTHCARE OPERATIONS**

Necessary information will be shared for continuing operations of this office. Some examples include, but are not limited to peer review, accreditation, credentialing processes, and compliance with all federal and state laws.

I understand that my treatment may be conditioned upon my consent. This consent is given freely and I understand that I can revoke this consent at any time in writing which will apply to disclosures and uses made subsequent to the revocation date.

Signature of Patient or Representative/Guardian

Date

Printed Name of Patient or Representative/Guardian

NOTICE OF PRIVACY PRACTICES FOR LAUREN MICHELSEN, D.O.

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.

The Health Insurance Portability and Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by ("HIPPA") we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care related services by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a request restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. The right to inspect and copy your protected health information. The right to amend your protected health information. The right to receive and accounting of disclosures of protected health information. The right to obtain a paper copy of the notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. The notice is effective as of April 14th 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protection have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, and violations of the provisions of the notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue S.W.
Washington, DC 20201
(202) 619-0257
Toll Free: 1-877-696-6775