REGISTRATION FORM

How did you hear about CareMEDICA?
☐ Television Ad ☐ Social Media ☐ Website ☐ Referral ☐ Other: _____

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____

ADDRESS: _____ APT#/FL: _____

CITY: _____ STATE: _____ ZIP: _____

CELLULAR PHONE: _____ HOME PHONE: _____

BIRTH DATE: _____ SOCIAL SECURITY NUMBER: _____

EMAIL ADDRESS: _____ PREFERRED LANGUAGE: _____

MARITAL STATUS: (Please circle one) *SINGLE, MARRIED, DIVORCED, WIDOWED* SEX: *MALE, FEMALE, OTHER*

ETHNICITY: (Please circle one) *LATIN/HISPANIC, NON-LATIN/HISPANIC, REFUSE TO REPORT* RACE: _____

EMPLOYER: _____ EMAIL: _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE: _____

PRIMARY PHARMACY: _____ PHONE: _____

ADDRESS: _____

MAIL-AWAY PHARMACY: _____

CURRENT INSURANCE INFORMATION:

PRIMARY: _____ ID#: _____ GROUP#: _____

SECONDARY: _____ ID#: _____ GROUP#: _____

All professional services rendered by CareMedica is the responsibility of the patient set forth by their insurance carrier. If the patient feels to remit payments, disclose proper insurance information and/or does not list a CareMedica provider as their Primary Care Provider; patient will be turned over to collections. When an account is turned over to collections, the patient is responsible for any bills, interest and attorney fees incurred. **AUTHORIZATION OF PAYMENT:** I hereby authorize payment directly to the rendering Physician and/or CareMedica for services provided. **AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize my rendering provider and/or CareMedica to release any information required from my examination and/or treatment to my insurance company for payment of services or to another provider for continuation of medical care. **MEDICARE STATEMENT (if applicable):** Claims will be submitted to Medicare for you by CareMedica. Medicare may not cover some services in which the patient may be responsible to pay if no other supplemental policy exists. Such identified services may include yearly physicals etc. In addition, you will be responsible to pay for your Annual Medicare deductible and coinsurance set forth by Medicare if you have chosen a supplemental policy to Medicare then it might cover your balance based on the coverage.

SIGNATURE: _____ DATE: _____

CareMedica

AUTHORIZATION TO RELEASE INFORMATION

52 Washington Ave, Suite 4,
North Haven, CT 06473
Fax: (203) 672-2801

821 N Main Street Ext, Suite 210
Wallingford, CT 06492
Fax: (203) 672-2801

2200 Whitney Avenue, Suite 100
Hamden, CT 06518
Fax: (203) 672-2801

3401 PGA Blvd, Suite 310
Palm Beach Gardens, FL 33410
Fax: (561) 766-2159

PATIENT NAME:_____ Previous Names: _____

Address: _____ City:_____ State:_____ Zip:_____

Date of Birth:_____ Phone Number: _____ Email:_____

I hereby Authorize CareMedica to:

Please choose one: ☐ Release my Medical Information to ☐ Obtain medical information from

Name/Facility: _____ Attention: _____ Address: _____

Phone Number: _____ City:_____ State:_____ Zip:_____ Fax #:_____

Purpose of Request: ☐ Personal ☐ Referral or 2nd Opinion ☐ Legal ☐ Insurance ☐ Other: _____

Workers Comp (only) Date of Injury_____ Body Part(s) Treated _____

Specific Records/Report(s) to be released: (allow 7-10 days for turnaround of request)

Date of Service: _____

☐ Consultation/Progress Reports ☐ Radiology Reports ☐ Physical Therapy Notes ☐ All Immunizations ☐ Med List ☐ Problem List ☐ Labs ☐ Bills

☐ Other Please Specify_____

☐ Entire Record (ONLY when subsections of the record will not serve the intended purpose of the disclosure.)

Restricted Authorization to Release Protected Information:

IMPORTANT- It is extremely important that you select either "**DO**" or "**DO NOT**" for each item contained in this section **Authorization to Release Protected Information**. Please do not skip any line item as it could impact our ability to fulfill your request and cause additional delays. Release Records? Check one

I ☐ DO ☐ DO NOT want **Mental/Behavior Health or Disability Services Provider Documentation *** released.
I ☐ DO ☐ DO NOT want **HIV/AIDS Screening Test Results** released.
I ☐ DO ☐ DO NOT want information about **Alcohol and/or Substance Abuse Treatment *****released.
I ☐ DO ☐ DO NOT want **Genetic Testing/Test Results ****released.
I ☐ DO ☐ DO NOT want **Confidential Communications with a Social Worker** released.
I ☐ DO ☐ DO NOT want information about **Rape/Sexual Assault Victim's Counseling** released.
I ☐ DO ☐ DO NOT want **Child/Elder Abuse or Neglect & Abuse of an adult with a Disability** released.
I ☐ DO ☐ DO NOT want information about **Sexually Transmitted Diseases (STD's)** released.
I ☐ DO ☐ DO NOT want information about **Domestic Violence Victims Counseling** released.

*This Authorization is not valid for use or disclosure of psychotherapy notes

** The term "genetic tests" means only those tests which determine your future chances of developing a disease, not test done to diagnose a current condition or problem. This includes information related to the testing of embryos created during IVF.

*** Only applicable to records that are created by an "individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral for treatment" (42 CFR Part 2). Does not include records created or maintained by a general Medical Facility.

I understand the following:

A: I may revoke this authorization at any time by providing written notice to the practice.
B: I may not be able to revoke this information if the practice has already acted utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance information.
C: The practice will not condition treatment or payment based on my signing this authorization.
D: I am signing this authorization freely.
E: No one has pressured me to sign this authorization.
F: The information disclosed in this authorization for may be subject to re-disclosure by the practice and no longer protected by federal law. **G:** I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.
H: I have received a copy of this authorization.
I: I understand that, based on state guidelines, there is a per page fee for my records. I will receive an invoice from Datavant.

This authorization shall automatically expiration 6 months from the date of signature unless otherwise specified in the space provided here. **Date of Expiration:**_____

Signature of Patient and/or Personal Representative of Patient: _____

Date: _____

CareMedica

Patient Medical History Intake Form

Patient Name: _____DOB: _____ Today's Date:_____

Reason for Today's Visit:

❑ New Patient ❑ Illness ❑Pre-Surgical Clearance
❑Hospital Discharge Follow-Up ❑ Work Injury ❑ Auto Accident
❑ Hormone Replacement ❑Medically Supervised Weight Loss Program

Preferred Pharmacy:_____ Pharmacy Phone: _____

Pharmacy Address: _____

Mail Order Pharmacy: _____

Current/Previous Primary Care Provider(s)

Name: _____ Phone: _____

Name: _____ Phone: _____

Current/Previous Specialists:

Cardiologist: _____ Phone: _____

Dermatologist: _____ Phone: _____

Gastroenterologist: _____ Phone: _____

Ophthalmologist: _____ Phone: _____

Other: _____ Phone: _____

Other: _____ Phone: _____

Any Current Concerns? _____

Allergies and sensitivities to medications, food, animals, other. Please include the reactions:

_____

_____

_____

❑ No known allergies

Medication Name	Frequency	As of	Prescriber

ALL current medications (List all prescription and non-prescription medications, contraceptives, vitamins, and supplements):

❑ Not taking medications

PAST MEDICAL HISTORY	YES	NO	PAST MEDICAL HISTORY	YES	NO
Anemia	☐	☐	HIV/AIDS/Hepatitis	☐	☐
Asthma	☐	☐	Hypo/Hyperthyroidism	☐	☐
Blood Clot/DVT	☐	☐	Lyme Disease	☐	☐
Cancer:	☐	☐	Osteoporosis/Osteopenia	☐	☐
COPD	☐	☐	Peripheral Vascular Disease	☐	☐
Diabetes Type I/Type II	☐	☐	Psoriasis	☐	☐
Gout	☐	☐	Renal Failure/Kidney Disease	☐	☐
Heart Attack/Angina	☐	☐	Rheumatoid Arthritis/Lupus	☐	☐
Heart Disease/Pacemaker	☐	☐	Stroke	☐	☐
High Blood Pressure	☐	☐	Tuberculosis	☐	☐
History of Blood Transfusion	☐	☐	Ulcer/Acid Reflux/GERD	☐	☐
History of Prednisone or Steroid Medication	☐	☐	Other:	☐	☐

PAST SURGERIES	REASON	SURGEON	DATE

PAST HOSPITALIZATIONS	REASON	DATE

Preventative Care

Please list the date of your most recent, if unknown please check unknown:

Complete Physical:	Date:	❒Unknown
Colonoscopy:	Date:	❒Unknown
Dental Cleaning:	Date:	❒Unknown
Eye Exam:	Date:	❒Unknown
COVID Vaccine:	Date:	❒Unknown
COVID Booster:	Date:	❒Unknown
Tuberculosis Test:	Date:	❒Unknown
Tetanus Immunization:	Date:	❒Unknown
Prevnar 13:	Date:	❒Unknown
Pneumovax 23:	Date:	❒Unknown
Shingles:	Date:	❒Unknown
HPV:	Date:	❒Unknown
Meningitis:	Date:	❒Unknown
TDAP:	Date:	❒Unknown
Influenza Vaccination:	Date:	❒Unknown
Measles Immunization:	Date:	❒Unknown
Hepatitis A Immunization:	Date:	❒Unknown
Hepatitis B Immunization:	Date:	❒Unknown

Family History

Relationship	Living or Deceased?	Please list any inherited diseases, chronic illness or cause of death
Mother		
Father		
Paternal Grandfather		
Paternal Grandmother		
Maternal Grandfather		
Maternal Grandmother		
Brothers		
Sisters		
Sons		
Daughters		

Social History

Marital Status: ❒Single ❒Married ❒Divorced ❒Widowed

What do you consider your stress level is? ❒Low ❒Medium ❒High

Do you have a family history of medical, mental, or hereditary problems? ❒Yes ❒No
Please list:_____

_____

_____

Travel Outside the U.S within the past three years? ❒Yes ❒No

Where and when?_____

_____

Do you have a living will? ❒Yes ❒No

Is your time well balanced between your jobs, family and hobbies? ❒Yes ❒No

Do you wear seat belts? ❒Always ❒Usually ❒Occasionally ❒Never

If you ride a bicycle or motorcycle, do you wear a bike helmet? ❒Yes ❒No

Do you have frequent falls? ❒Yes ❒No

If there is a gun in your home, is it out of children's reach and unloaded? ❒Yes ❒No

If you are a female, do you do a monthly self-breast exam? ❒Yes ❒No

If you are a male, do you do a monthly self-testicular exam? ❒Yes ❒No

Do you practice "safe sex"? ❒Yes ❒No

Have you used illegal drugs? ❒Yes ❒No

How would you describe your dietary intake? _____
_____

How many cups of coffee or caffeinated drinks do you drink daily? _____

What (if any) physical activity/exercise do you engage in and how often?_____
_____
_____

Do you smoke? ❒Now ❒Past ❒Never
If so, how many per day and for how long? _____

How much alcohol do you drink? _____per day _____per week
If yes, how many times in the past month have you had more than 4 alcoholic drinks in one day?
_____

Are you currently experiencing any of the following? Please circle all that apply:

Loss of interest in things you used to enjoy
Chronic sadness
Problems concentrating/decision making
Restlessness, inability to sit still
Hopelessness
Thought of death/suicide.
Feelings of worthlessness, guilt.
Loss of energy/exhaustion.
Changes in appetite.
Other: _____

For Females Only

Last Menstrual Period: _____ Length of Period: _____

Form of Birth Control: _____

Last Pap Smear: _____

Provider: _____ Phone # _____

Last Mammogram: _____

Ordering Provider: _____ Phone #: _____

Are you experiencing or actively in menopause? Yes or No (circle one)

Last Pregnancy: _____

Have you ever had any miscarriages? Yes or No (circle one) If yes, how many_____.

Live Births? Yes or No If yes, how many _____.

Terminations? Yes or No (circle one) If yes, how many_____.

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT FORM

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

_____

Signature

_____

Print Name

_____

Date

OFFICE USE ONLY

Unable to obtain patient's written acknowledgement because:

- ☐ Patient refused to sign
- ☐ Patient is incapacitated and no responsible party is available prior to discharge
- ☐ Other:

_____

_____

NOTICE OF PRIVACY PRACTICES

Your rights under the Health Insurance Portability & Accountability Act of 1996 (HIPPA)

How Your Medical Information May Be Used and Disclosed &

How You Can Get Access to This Information

PLEASE REVIEW CAREFULLY.

If you have any questions about this notice, please contact the Facility Privacy Officer by dialing the main facility member.

Who Will Follow This Notice: This notice describes the facility's practices and that of:

- Any healthcare professional authorized to enter information into your facility chart
- All departments and units of the facility
- Any member of a volunteer group allowed to help you while you are receiving services from the facility
- All employees, staff, agents and other facility personnel
- All entities, sites and locations within this facility's system will follow the terms of this notice. They may also share medical information with each other for treatment, payment and healthcare operations purposes.

Our Pledge Regarding Medical Information: We understand that medical information about you and your healthcare is personal. We are committed to protecting medical information about you. A record is created of the care and services you receive at this facility. This record is needed to provide the necessary care and to comply with legal requirements. This notice applies to all the records of your care generated by the facility. Your personal physician may have different policies or notices regarding the physician's use and disclosure of your medical information in the physician's office or clinic.

This notice will tell about the ways in which the facility may use and disclose medical information about you. Also described are your rights and certain obligations we have regarding the use and disclosure of medical information.

The law requires the facility to:

- Make sure that medical information that identifies you is kept private;
- Inform you of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

HOW THE FACILITY MAY USE and DISCLOSE YOUR MEDICAL INFORMATION:

The following categories describe different ways the facility uses and discloses medical information. Each category will be explained. Not every possible use or disclosure will be listed; however, all the different ways the facility is permitted to use and disclose information will fall within one of these categories.

- **Treatment:** Your medical information may be used to provide you with medical treatment or services. This medical information may be disclosed to physicians, nurses, technicians, or other agents of the facility who are involved in your care at the facility. Your medical information may also be disclosed to healthcare students, interns and residents.
    - For example: A doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. The doctor may need to tell the dietitian about the diabetes so appropriate meals can be arranged. Different departments of the facility may also share medical information about you to coordinate your different needs, such as prescriptions, lab work and x-rays. The facility may also disclose medical information about you to people outside the facility who may be involved in your medical care after you leave the facility, such as family members, home health agencies, or others used to provide services that are part of your care.

- **Payment:** Your medical information may be used and disclosed so that the treatment and services received at the facility may be billed and payment may be collected from you, the insurance company and/or a third party.
    - For example: The health plan or insurance company may need information about the care you received from the facility, so they can provide payment for the surgery. Information may also be given to someone who helps pay for your care. Your health plan or insurance company may also need information about a treatment you are going to receive to obtain prior approval or to determine whether they will cover the treatment.

- **Health Care Operations:** Your medical information may be used and disclosed for purposes of furthering day-to-day facility operations. These uses and disclosures are necessary to run the facility and to monitor the quality of care our patients receive.
    - For example: Your medical information may be:
        1. Reviewed to evaluate the treatment and services performed by our staff in caring for you.
        2. Combined with that of other facility patients to decide what additional services the facility should offer, what services are not needed, and whether certain new treatments are effective.
        3. Disclosed to doctors, nurses, technicians, and other agents of the facility for review and learning purposes.
        4. Disclosed to healthcare students, interns, and residents.
        5. Combined with information from other facilities to compare how we are doing and see where we can improve the care and services offered. Information that identifies you in this set of medical information may be removed so others may use it to study healthcare and healthcare delivery without knowing who the specific patients are.

- **Business Associates:** There are some services provided in our organization through contracts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can preform the job we've asked the, to do and bill you or your third-party payer for services rendered. To protect your health information, however, business associates are required by federal law to appropriately safeguard your information.

- **Directory:** We may include certain limited information about you in the facility directory while you are a patient at the facility. The information may include your name, location in the facility, your general condition (e.g. good, fair) and your religious affiliation. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. If you would like to opt out of being in the facility directory, please request the Opt Out Form from the admission staff or Facility Privacy Official.

- **Census Information:** Limited information about you may be used in the census report while you are a patient of the facility. This information may include your name, location of the facility, admission date and address.

- **Clergy Members:** While you are a patient in the facility, upon written consent, information about you may be disclosed to your specific clergy. This information may include your name, address, and admission date.

- **Appointment Reminders:** Your medical information may be used to contact you as a reminder of a appointment you have for treatment or medical care from the facility.

- **Future Communications:** We may communicate to you via newsletters, mail outs or other mean regarding treatment options., health related information, disease-management programs, wellness programs, or other community-based initiatives or activities our facility is participating in.

- **Organized Health Care Arrangement:** This facility and its medical staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment, and healthcare operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

- **Affiliated Covered Entity:** Protected health information will be made available to facility personnel at local affiliated facilities as necessary to carry out treatment, payment, and health care operations. Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the Facility Privacy Official for further information on the specific sites included in the affiliated covered entity.

- **Individuals Involved in Your Care:** With your permission, your medical information may be released to a family member, guardian or other individuals involved in your care. They may also be told about your condition unless you have requested additional restrictions. In addition, your medical information may be disclosed to an entity assisting in a disaster relief effort, so your family can be notified about your condition, status, and location.

- **Research:** Under certain circumstances, your medical information may be used and disclosed for research purposes.

    - For example: A research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same conditions. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, balancing the research needs with the patients' need for privacy of their medical information. Your medical information may be disclosed to people preparing to conduct a research project; for example, helping them look for patients with specific medical needs, so long as the medical information they review does not leave the facility. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care.

- **As Required by Law:** Your medical information will be disclosed when required to do so by federal, state, or local authorities, laws, rules and/or regulations.
    - *Lawsuits and Disputes:* If you are involved in a lawsuit or dispute, your medical information will be disclosed in response to a court or administration order, subpoena, discovery request or other lawful process by someone else involved in the dispute when we are legally required to respond.
    - *Law Enforcement:* Your medical information will be released if requested by a law enforcement official:
        1. In response to a court order, subpoena, warrant, summons or similar process;
        2. To identify or locate a suspect, fugitive, material witness, or missing person;

3. About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
4. About a death we believe may be the result of criminal conduct;
5. In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- *National Security and Intelligence Activities:* Your medical information will be released to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.
- *Protective Services for the President and Others:* Your medical information may be disclosed to authorized federal officials, so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
- *To Alert a Serious Threat to Health or Safety:* Your medical information may be used and disclosed when necessary to prevent a serious threat to your health and safety and that of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- *Health Oversight Activities:* Your medical information may be disclosed to a health oversight facility for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Private Accreditation Organizations:** Your medical information may be used to fulfill this facility's requirements to meet the guidelines of private facility accreditation organizations such as JC, NCQA, etc.

SPECIAL SITUATIONS:

- **Organ and Tissue Donation:** If you are an organ or tissue donor, your medical information maty be released to organizations that handle organ procurement or organ, eye and tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Medical Devices:** Your social security number and other required information will be released in accordance with federal laws and regulations to the manufacturer of any many device(s) you have implanted or explanted during a hospitalization and to the Food and Drug Administration, if applicable. This information may be used to locate you should there be a need with regard to such medical device(s).

- **Military and Veterans:** If you are a member of the armed forces, your medical information may be released as required by military command authorities. If you are a member of the foreign military personnel, your medical information may be released to the appropriate foreign military authority.

- **Workers' Compensation:** If you seek treatment for a work-related illness or injury, we must provide full information in accordance with state-specific laws regarding workers' compensation claims. Once state-specific requirements are met and an appropriate written request is received, only the records pertaining to the work-related illness or injury may be disclosed.

- **Public Health Risk:** Your medical information may be used and disclosed for public health activities. These activities generally include the following:
    1. To prevent or control disease, injury or disability;
    2. To report births and deaths;
    3. To report child abuse or neglect;
    4. To report reactions to medications or problems with products;
    5. To notify people of recalls of products they may be using;
    6. To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
    7. To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- **Coroners, Medical Examiners, and Funeral Directors:** Your medical information may be released to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We may also release medical information about patients of the facility to funeral directors as necessary to carry out their duties.

- **Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the following reasons:
    1. For the institution to provide you with healthcare;
    2. To protect the health and safety of you and others;
    3. For the safety and security of the correctional institution.

ADDITIONAL SITUATIONS:

- **Other Uses of Medical Information:** Other uses and disclosures of medical information not covered by this notice or the laws that apply to this facility will be made only with your written permission. If you provide the facility permission to use or disclose your medical information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your medical information for the reasons covered in your written authorization. You understand that we are unable to take back any disclosures already made with your permission, and that we are required to retain our records of the care that the facility provided to you.

ADDITIONAL INFORMATION CONCERNING THIS NOTICE:

- **Changes to This Notice:** We reserve the right to change this notice and make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. The facility will post a current copy of the notice with the effective date. In addition, each time you are admitted to the facility for care/services, as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

- **Complaints:** You will not be penalized for filing a complaint. If you believe your privacy rights have been violated, you may file a complaint with the facility or with the Secretary of the Department of Health and Human Services. To file a complaint with the facility, contact the system Privacy Officer. All complaints must be submitted in writing.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:

You have the following rights regarding medical information the facility maintains about you:

**NOTE: All Requests must be submitted in writing to the Facility Medical Records Department.*

- **Right to Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care. To inspect and copy medical information or to receive an electronic copy of the medical information that may be used to make decisions about you, you must submit a written request. If you request a paper copy of information, we may charge a fee for the cost of copying, mailing, or other supplies associated with your request.

  If the facility uses or maintains an electronic health record with respect to your medical information, you have the right to obtain an electronic copy of the information if you so choose.
    1. You may direct the facility to transmit the copy to another entity or person that you designate provided the choice is clear, conspicuous, and specific.
    2. The facility may charge a fee equal to its labor cost in providing the electronic copy.

We may deny your request to inspect and copy in some limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed healthcare professional, other than the person who denied your request, will be chosen by the facility to review your request and the denial. The facility will comply with the outcome of the review:

1. A licensed healthcare professional has determined, in the exercise of professional judgement, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person.
2. The protected health information makes reference to another person (unless such other person is a healthcare provider) and a licensed healthcare professional has determined, in the exercise of professional judgement, that the access requested is reasonably likely to cause substantial harm to such other person.
3. The request for access is made by the individual's personal representative, and a licensed healthcare professional has determined, in the exercise of professional judgement, that the provision of access to such personal representative is reasonable likely to cause substantial harm to the individual or another person.

- **Right to Amend:** If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment to information kept by or for the facility. To request an amendment, you must submit a written request. You must also provide a reason that supports your request. Your request for an amendment may be denied if:
    1. Your request is not in writing or does not include a reason to support the request;
    2. The medical information was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
    3. The medical information is not part of the medical information kept by or for the facility;
    4. The medical information is not part of the information you would be permitted to inspect and copy;
    5. The medical information is accurate and complete.

- **Right to an Accounting of Disclosures:** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of your medical information for purposes other than treatment, payment, and health care operations. To request this list or accounting of disclosures:
    1. You must submit your request in writing;
    2. Your request must state a time period, which may not be longer than 6 (six) years and may not include dates before April 14, 2012;
    3. Your request should indicate in what form you want the list (for example, on paper or electronically).

  The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions:** You have a right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member.

  To request restrictions, you must make your request in writing. In your request, you must tell us:
    1. What information you want to limit;
    2. Whether you want to limit our use, disclosure, or both;
    3. To whom you want the limits to apply, for example, disclosures to your spouse.

  You also have the right to request that a healthcare item or service not be disclosed to your health plan for payment purposes or healthcare operations. We are required to honor your request if the health care item or service is paid out of pocket and in full. This restriction does not apply to use or disclose your medical information related to your treatment.

- **Right to Request Confidential Communication:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

- For example: You can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of this Notice:** You have the right to a copy of this notice. You may ask us to give you a copy at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Last modified: 06.26.2018

CareMedica Policies

Arrivals:

Please arrive 15 minutes prior to your scheduled appointment.

Please always keep all personal belongings with you.

All Patients please bring in the following to your appointment:

- Active insurance and Prescription card*
- Photo ID
- Payment of co-payment and/or deductible that is set forth by your insurance carrier
  We accept Cash, MasterCard, Visa, Discover, and American Express
- Current list of medication(s)/and or supplement(s)

If insurance eligibility cannot be obtained at the time of your appointment, you will be asked to pay for your visit or procedure. If you are not able to pay at time of service, you will be asked to reschedule.

New Patient Required Information:

- Active insurance and Prescription card*
- Photo ID
- Payment of co-payment and/or deductible that is set forth by your insurance carrier
  We accept Cash, MasterCard, Visa, Discover, and American Express
- Current list of medication(s)/and or supplement(s)
- Completed Registration Form
- Completed New Patient Medical History Intake Form
- Signed Payment/Collection Policy
- Completed Authorization to Release Form
- Signed Notice of Privacy Practices Acknowledgement Form

Established Patient Required Information

- Active insurance and Prescription card*
- Photo ID
- Payment of co-payment and/or deductible that is set forth by your insurance carrier
  We accept Cash, MasterCard, Visa, Discover, and American Express
- Current list of medication(s)/and or supplement(s)
- Annual updated Registration Form even if there are no changes from the previous year

Auto Accident Required Information

- Auto Policy Declaration page defining themedical provision coverage (Med Pay)
- Date of Accident

- Auto Insurance Carrier Card listing their contact info, and address
- Adjuster's name and contact info
- Claim Number
- We do not accept Letter of Protection (LOP)
- If your policy does not have Med Pay, you will be responsible to pay your copayment and/deductible set forth in your health insurance policy.

Workers CompensationRequired Information:

- Name of employer, and their contact information
- Date of Injury
- Adjuster's name and contact info
- Claim Number
- If your WC claim is denied, our billing office will be your health insurance carrier and you will be responsible to pay your copayment and/deductible set forth in your health insurance policy as we will

Late Arrivals:

Arriving late for your scheduled appointments may result in having to reschedule your appointment.

Per Your Insurance:

Please note that your insurance carrier may require you to pay an additional copayment and/or deductible for the following:

- Chronic and/or new conditions addressed during an annual physical exam.
- EKG, diagnostic in house procedures, and injections.

Cancellations and No-Show Policy

When we make your appointment, we are reserving a room for your healthcare needs. If you must change and/or cancel your appointment, please give us 24-hours' notice. Your courtesy will make it possible to give your reserved spot to another patient who needs to be seen.

All cancellations and no shows cancelled less than 24-hours' notice will be subjected to a $25.00 fee for Routine Office Visits and $50.00 for New Patients Visits, Physicals or Pre-Surgical Exams and In-Office Procedures.

Repeated missed or cancelled appointments will result in the loss of future appointment privileges. The fees are the sole responsibility of the patient and must be paid in full prior to the next appointment.

I, _____ acknowledge the terms of this policy.
Print Name

Signature: _____

Date Signed: _____

Payment/Collection Policy

We will file a claim to your insurance company; however, all the insurance co-payments/co-insurance and/or deductible amounts are due at the time of service. Any outstanding patient balances or uncovered amounts are to be paid prior to being seen. Failure on our part to collect co-payments and deductibles from patients can be considered *fraud*. Please help us in upholding the law by paying your co-payment at each visit.

Please be aware that some, if not all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You will be billed for these services. If your insurer changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in **45 days**, the balance will automatically be billed to you.

Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We cannot guarantee payment of your claims. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.

The practice will send out a maximum of 3 bills. If an account is not paid in full or payment arrangements have not been made, the account will go to collection. Once an account is in collections, it must be paid in full in order to schedule future appointments. There will be no exceptions made.

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

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

SEXUAL ORIENTATION GENDER IDENTITY (SOGI)

PATIENT NAME: _____ DOB: _____ DATE: _____

SEX ASSIGNED AT BIRTH	☐ Male	☐ Female	☐ Unknown

PRONOUNS

☐	he/him/his/his/himself	☐	co/co/cos/cos/cos
☐	she/her/her/hers/herself	☐	en/en/ens/ens/enself
☐	they/them/their/theirs/themselves	☐	ey/em/eir/eirs/emself
☐	ze/zir/zir/zirs/zirself	☐	yo/yo/yos/yos/yoself
☐	Xie/hir (“here”)/hir/hirs/hirself	☐	ve/vis/ver/ver/verself

☐ Another Pronoun, please specify: _____

SEXUAL ORIENTATION

☐	Lesbian, gay, or homosexual
☐	Straight or heterosexual
☐	Bisexual
☐	Do not know
☐	Choose not to disclose

☐ Something else, please describe: _____

GENDER IDENTITY

☐	Male
☐	Female
☐	Female-to-Male (FTM) Transgender Male/Trans Man
☐	Male-to-Female (MTF)/ Transgender Female/Trans Woman
☐	Genderqueer, neither exclusively male nor female
☐	Choose not to disclose

☐ Additional gender category or other, please specify: _____