BROWN ROAD FAMILY MEDICINE

Welcome to our office. Please fill out the information requested as completely as possible. A copy of your driver's license or a photo ID <u>And</u> your insurance card is required for identification.

Name: Please print clearly your First, Middle	Date of birth:		
Please print clearly your First, Middle	e and Last Name		
Street Address:		Apt/Unit#	
City: State: _	Zip	code:	
Home Phone: Cel May we leave a message? YES NO	l:	Email:	
Gender: Male Female Marital Status	: Married Divorced Widowed Single	e Life Partner	
Is Patient a Minor: YES NO If yes, you	r first & last name, relationship		
Emergency Contact	Phone	Relationship	
Pharmacy:	Crossroads:	/	
Mail order:	Phone:		
Disclosure of Your Health Care Informa	tion- Please select one:		
representatives of Brown Road Family Med I grant Brown Road Family Medicine Financial Billing with the individual(s) liste Name	permission to discuss Health Care Ir		
Name	Relationship	Phone Number	
Check here if you do not have medica	linsurance		
Primary Insurance		ance	
Group#			
Policy Holder Name		Policy Holder Name	
Policy Holder Date of birth		e of birth	
Relationship		Relationship	

Insurance Authorization: I hereby authorize Brown Road Family Medicine to furnish information to insurance carriers regarding my illness and treatments and also assign to the medical providers payments for medical services for myself or dependents. I understand that I am responsible for any copayments, coinsurance and deductibles.

No-Show/Late Cancellation Policy: I understand that in the event I am unable to keep my scheduled appointment, I must give 24 hours notice and that failure to do so will result in a \$25.00 fee.

ADULT HEALTH HISTORY FORM

Name: _____

PERSONAL MEDICAL HISTORY: (Check all that apply)

Allergies	Diabetes	Hypothyroid
Anemia	Enlarged Prostate	Lung Cancer
Arthritis	Fractures	Obesity
Asthma	Gallstones	Osteoporosis
Blood clots	GERD	Pancreatitis
Cancer-type	Graves' disease	Peptic Ulcer Disease
Carotid Artery Blockage	Headache-Migraines	Prostate Cancer
Colon Cancer	Heart Attack	Seizures
Coronary Artery Disease	Heart Palpatations	Skin Cancer
Congestive Heart Failure	Hepatitis STD's	
COPD	High Cholesterol Stroke	
Depression	Hypertension	Urinary Tract Infections- Frequent

FAMILY MEDICAL HISTORY: (Check all that apply for immediate family)

__Adopted __ Unknown

Allergies	Heart attack	Renal Failure
Alzheimer's Disease	High blood pressure	Seizure
Arthritis	High cholesterol	Sleep Apnea
Asthma	Hypertension	Stroke
Cancer-type	Leukemia	Sudden Death
Congestive heart failure	Loss of vision	Suicide
Coronary artery disease	Lymphoma	Thyroid disorder
COPD	Malignant melanoma	Ulcerative colitis
Depression	Obesity	Varicose veins
Diabetes	Osteoporosis	Vision problems
Hearing loss	Pancreatitis	Other:

<u>SURGERIES:</u> (Check and write year)

Abortion	Gall Bladder	Shoulder
Adenoids	Gastric Bypass	Sinus
Appendix	Heart Bypass	Tonsils
Ankle	Heart Stent	Tubal Ligation
Breast	Hernia	Vasectomy
C-Section	Hysterectomy	Other:
Ear tubes	Joints	Other:

HOSPITALIZATIONS/INJURIES: (Not including above surgeries)

MEDICATIONS: (List all medications/doses)

MEDICAL ALLERGIES: (Include reaction)

PREVENTATIVE EXAMS:

When was your last colonoscopy? Month/Year	When was your last EKG? Month/Year
When was your last DEXA? Month/Year	When was your last cholesterol test? Month/Year
When was your last Physical? Month/Day/Year	When was your last eye exam? Month/Year

MEN ONLY:

When was your last PSA blood test?

FEMALE ONLY:

When was your last pap smear?	When was your last mammogram? Month/Year
Current method of birth control?	Number of pregnancies Number of births
Number of miscarriages	Number of abortions

SOCIAL HISTORY: Married Single Divorce	ed	Widow	ved
What is your occupation?			Employer:
Do you exercise regularly?	Y	Ν	Type/Frequency:
Do you currently smoke tobacco?	Y	Ν	If yes, how much per day?
How long have you smoked?		_	Do you vape? Y N
If no, have you ever smoked tobacco?	Y	Ν	How long did you smoke?
Do you drink alcohol?	Y	Ν	If yes, how often do you drink?
If no, are you a recovering alcoholic?	Y	Ν	How long ago did you quit?
Do you have a Power of Attorny?	Y	Ν	Do you have a living will? Y N

Do you have a signed 'do not resuscitate'? Y N

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

PLEASE READ CAREFULLY

This notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care options and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any of your written and oral health information, including demographic data that can be used to identify you. This health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

Uses and disclosures of your protected health information:

- Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual.
- Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person.
- Protected health information contains specific information that identifies a person or can be used to identify a person. Protected health information is health information created or received by health care provider, health plan, employer, or health care clearinghouse. Brown Road Family Medicine, can act as each of the above business types. This medical information is used by Brown Road Family Medicine, in many ways while performing normal business activities.
- Your protected health information may be used or disclosed by Brown Road Family Medicine, for purposes of treatment, payment, and health care operations. Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. Brown Road Family Medicine, may use or disclose your health information for case agreement and services. Brown Road Family Medicine may send the medical information to insurance companies, Medicaid, or community agencies to pay for services provided to you.
- Your information may be used by certain department personnel to improve the department's health care operations. The department also may send you appointment reminders, information about treatment options or other health-related benefits and services.
- Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:
- > Reporting abuse of children, adults, or disabled persons.
- > Investigations related to a missing child.
- > Internal investigations and audits by the department's divisions, bureaus, and offices.
- Investigations and audits by the state are inspector General and Auditor General and the legislature's Office of Program Policy Analysis and government Accountability.
- > Public health purposes including vital statistics, disease reporting, public health surveillance, investigations, interventions and regulation of health professionals.
- > District medical examiner investigations.
- \succ Research approved by the department.
- > Court orders, warrants, or subpoenas.
- > Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.

Individual Rights

You have the right to request Brown Road Family Medicine, to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The BRFM privacy department is not required to agree to any restriction.

You have the right to inspect and receive a copy of your protected health information. Brown Road Family Medicine may mail or call you with health care appointment reminders. We will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

You have the right to inspect and receive a copy of your protected health information. Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law. If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to dent access. This licensed health care professional will be designated by BRFM privacy department.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. Brown Road Family Medicine may deny your request, in whole or part, if it finds the protected health information:

- Was not created by the department,
- Is not protected health information,
- Is by law not available for your inspection, or
- Is accurate and complete.

If your correction is accepted, the department will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The department will respond to your letter in writing. You also may file a complaint, as described below in section titled Complaints.

You have the right to receive a summary of certain disclosures Brown Road Family Medicine, may have made of your protected health information. The summary does **not** include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payments, and health care operations.
- Disclosures for public health.
- Disclosures for health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled.
- Disclosures prior to [Practice decides date here].

This summary does include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than 6-year period from the date of your request if you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

Complaints

You have the right to express complaints to the provider and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the provider by contacting the provider's Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person

The provider's contact person for all issues regarding privacy and your rights under the Federal privacy standards is the Privacy Officer. Information regarding matters covered by this notice can be requested by contacting the Privacy Officer. Complaints against the provider can be mailed to the Privacy Officer by sending it to: **2310 E. Brown Rd. Mesa, AZ 85213**

Effective Date

This Notice of Privacy Practices is effective beginning March 28, 2011, and shall be in effect until a new Notice of Privacy Practices is approved and posted.

By signing below you acknowledge that you have read and understand the privacy practices of Brown Road Family Medicine.

Patient Printed Name:

Patient Date of Birth:

Patient/Guardian Signature:

Today's Date: _____