Authorization to Disclose Protected Health Information

(Copy of records takes 7 to 14 business days to process)

PLEASE PRINT CLEARLY- You must provide full mailing address or this form will be returned to you

Patient Name: ______________________________ SSN: ______________ Medical Record # ________________
Address: ______________________________________ City: ___________________ State: ________ Zip: _____
Phone (home): _________________________(work)________________________ DOB: ___________________

1. I authorize the use or disclosure of the above named individual's Protected Health Information as described below.
2. Omni Helathcare is authorized to ___________ make the disclosure to _________ receive the disclosure from the following individual or organization.

Omni Healthcare

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

☐ Progress Notes ☐ Medication List ☐ Immunization Record

☐ Labortatory Results from (date) ________________ to (date) ___________________

☐ X-Ray and Diagnostic Reports from (date) ________________ to (date) ________________

☐ Entire Record ☐ Other ____

4. REASON FOR REQUEST: (PLEASE CHECK ONE)

☐ Medical Care ☐ Insurance ☐ Personal ☐ Attorney ☐ Clinical Research ☐ Marketing

5. Medical records are to include any and all of Federal and State protected information to include diagnosis, treatment and/or examination related to mental health related care, drug and/or abuse, HIV testing/AIDS, and sexually transmitted-diseases.
6. I hereby release OMNI and its employees from any and all liability that may arise from the release of information as I have directed.
7. 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 Medical Records Department. I understand that the revocation will not apply to insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ___________________. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.
8. 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 obtain a copy of 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 re disclosure and the information may not be protected by the federal confidentiality rules. If I have questions about disclose of my health information, I can contact the Medical Records Department and obtain a copy of the Privacy Notice.

Printed Name of Patient :____ Date: ______________________

Signature of Patient: ____

Witness Name: ____ Date: ______________________

Consent Agreement

- **Consent for Treatment:** I give consent to my physician, other attending physicians and their assistants and designees, to provide me with such medical, surgical, diagnostic, or other treatment services judged necessary and/or appropriate. This consent includes my consent for diagnostic procedures and all medical treatment rendered at my physician's office under his/her instruction; including x-ray, laboratory procedures and other tests, treatments or medication, monitoring, and all other procedures or treatments that do not require my specific informed consent. I understand that in the course of diagnosis and treatment, cells, tissues, and/or parts may be removed from my body. I authorize my physician and his/her personnel to preserve or use such cells, tissues, or parts for teaching purposes and/or to dispose of any cells, tissues, or parts that are removed.

- **General Acknowledgments:** I understand that the practice of medicine and surgery is not an exact science. I understand that medical and surgical treatment and diagnosis may involve risks of injury and even death. No guarantees have been made to me with respect to the results of my examinations or treatments. I understand and agree that I may be observed and/or receive care from medical, nursing, and other health care students in training at my physician's office. I understand that it is my responsibility to follow instructions about and make arrangements for follow-up care as directed by my physician. I understand that I may review and obtain a copy of my medical record, at my own expense, and that this review shall take place during regular business hours.

____

Patient Name

____ ______________

Patient Signature/Guardian/Legal Representative Date

____

Witness Name

____ ______________

Witness Signature Date

Designation of Health Care Surrogate

Name: ____

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name ____
Street Address ____
City ___________________________ State ___________
Phone _________________________________

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name ____
Street Address ____
City ___________________________ State ___________
Phone _________________________________

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility. Additional instructions (optional):

____
____
____
____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name ____

Signature _______________________________ Date ______________________

Witness _________________________________
Street Address ____________________________
City ________________________ State _______
Phone __________________________________
Date ____________________________________

Witness _________________________________
Street Address ____________________________
City ________________________ State _______
Phone __________________________________
Date ____________________________________

Consent for communication and/or disclosure

I request the following alternatives or limitations relating to communications directed to me by my healthcare provider or employee of Omni Healthcare.

Do we have your permission to:

Call you at home? _____Yes _____ No
If yes may we leave the following information on your answering machine/voice mail?
Appointment information _____Yes _____ No
Billing information _____Yes _____ No
Medical information _____Yes _____ No
Labs/Prescriptions _____Yes _____ No

Call you at work? _____Yes _____ No
If yes may we leave the following information on your answering machine/voice mail?
Appointment information _____Yes _____ No
Billing information _____Yes _____ No
Medical information _____Yes _____ No
Labs/Prescriptions _____Yes _____ No

Call you on your cell? _____Yes _____ No
If yes may we leave the following information on your answering machine/voice mail?
Appointment information _____Yes _____ No
Billing information _____Yes _____ No
Medical information _____Yes _____ No
Labs/Prescriptions _____Yes _____ No

I give my permission to share the following information with the person(s) listed below:

Primary Care Physician: ____
(Name) (City/State)

Other Person:

____
(Name) (Relationship)
Appointment Information: Yes/No Medical: Yes/No Billing: Yes/No

____
(Name) (Relationship)
Appointment Information: Yes/No Medical: Yes/No Billing: Yes/No

____
(Name) (Relationship)
Appointment Information: Yes/No Medical: Yes/No Billing: Yes/No

______________________________________ ______________
Patient Name Date

____
Patient Signature/Guardian/Legal Representative

______________________________________ ______________
Witness Name Date

____
Witness Signature

Living Will

Declaration made this _____ day of ________________, 2____, I, ____________________________, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and

_____(initial) I have a terminal condition,
or _____(initial) I have an end-stage condition,
or _____(initial) I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I do ___, I do not ___ desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name ____
Street Address ____
City _______________________ State _____________ Phone ___________

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional): ____
____
____
____
____

Signature _______________________________ Date ______________________

Witness _________________________________
Street Address ___________________________
City ________________________ State _______
Phone __________________________________
Date ____________________________________

Witness _________________________________
Street Address ___________________________
City ________________________ State _______
Phone __________________________________
Date ____________________________________

Notice of Privacy Practices Acknowledgment Form

The Health Insurance Portability and Accountability Act (HIPPA) provides a safeguards to protect your privacy. Implementation of HIPPA requirements officially began April 14, 2003. Many of the policies have been *our* practice for years. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services- www.hhs.gov.

OMNI Healthcare has adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handles appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for handling of charts, patient records, PHI (Protective Health Information) and other documents or information.
2. It is the policy of this office to remind patients of their appointments/ We do this by telephone, e-mail, U.S. Mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable and informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPPA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws,
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

The undersigned certifies that he/she read the forgoing, received a copy of the Notice of Privacy Practice and is the patient, patients guardian, or legal representative.

____ __________________
Patient Name Date

____
Patient Signature/Guardian/Legal Representative

____ __________________
Witness Name Date

____

Office Policy

- **Late Arrivals:** After 15 minutes the patient will be considered late, and the appointment will be rescheduled. _______ Initials

- **Broken appointment:** Patients must call office with at least 24 hours advance notice of the appointment to cancel or reschedule. If not there will be a $25.00 charge added to your account. Patients with 3 or more broken appointments without good reason could result in dismissal. ______ Initials

- **Confirming appointments:** It is our policy to confirm all appointments. It is the patient's responsibility to remember their own appointment. If the patient does not call or show for their appointment this is considered a broken appointment. _______Initials

- **Personal information changes**: It is the patients responsibility to notify our office of changes such as insurance, address, phone number and health history. Our office will update patient's history once a year. ______Initials

Thank you for your cooperation.

____

Patient Name

____ _________________

Patient Signature/Guardian/Legal Representative Date

____

Witness Name

____ _________________

Witness Signature Date

Patient Information Sheet

PATIENT INFORMATION		
Patient Last Name:	First:	Middle:
Social Security #		
Street Address:		
City:	State:	Zip:
Home #:	Work#:	Cell #:
Sex: ___Male ___Female	Date of Birth:	Age:
Are you Military? If so: ___Active Duty or ___Retired		
Employer:	Occupation:	
Employer Street Address:		
Employer City:	State:	Zip:
Employer Phone #:	Marital Status: ___Single ___Married ___Divorced ___Widowed ___Separated	
Email Address:		
Employment Status: ___Full Time ___Part Time ___Not Employed ___Self Employed ___Retired ___Military		
Are You A Student: ___Yes ___No	Student Status: ___Full Time ___Part Time	

REFERRING & PRIMARY PHYSICIAN INFORMATION		
Referring Physician Name:		
Street Address:		
City:	State:	Zip:
Phone Number:	Specialty:	
Primary Care Physician Name:		
Street Address:		
City:	State:	Zip:

GUARANTOR INFORMATION (Who is responsible for you financially)		
Name:	Relationship to Patient:	
Street Address:		
City:	State:	Zip:
Home Phone#:	Work#:	Cell #:
Sex: ___Male ___Female	Date of Birth:	
Social Security #:		
Please list other family members that Guarantor is responsible for that are Omni patients:		
Employer Name:		
E-Mail Address:		

EMERGENCY CONTACT INFORMATION		
Name:	Relationship to Patient:	
Street Address:		
City:	State:	Zip:
Home Phone#:	Work#:	Cell #:

INSURANCE INFORMATION		
Is Your Visit Related To: ___Auto Accident ___Workers Compensation		
PRIMARY Insurance Company Name:		
Policy #:		
Group Name:	Group #:	
Claims Street Address:		
City:	State:	Zip:
Effective Date of Insurance:		
Insurance Phone #:		
Policy Holder Name:	Relationship to Patient:	
Policy Holder Employer:		
Policy Holder Social Security #:	Sex: ___Male ___Female	
SECONDARY Insurance Company Name:		
Policy #:		
Group Name:	Group #:	
Claims Street Address:		
City:	State:	Zip:
Effective Date of Insurance:		
Insurance Phone #:		
Policy Holder Name:	Relationship to Patient:	
Policy Holder Employer:		
Policy Holder Social Security #:	Sex: ___Male ___Female	

RACE, ETHNICITY & LANGUAGE INFORMATION
(The government asks OMNI Healthcare and all healthcare providers to collect the information below.)
Race: ___White ___Black/African American ___Hispanic ___Asian ___American Indian/Alaska Native ___Native Hawaiian ___Other___________________
Ethnicity: ___Hispanic/Latino ___Not Hispanic/Latino ___Other____________________
Primary Language Spoken: _English ___Spanish ___Creole ___Other:______________________

PHARMACY INFORMATION		
Pharmacy Name:		
Street Address:		
City:	State:	Zip:
Pharmacy Phone#:	Pharmacy Fax#:	

Patient Financial Policy

Thank you for choosing OMNI Healthcare as your healthcare provider. We are committed to building a successful physician- patient relationship with you and your family. Please understand that payment for services is a part of that relationship. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

Patient Information:
A fully completed, current patient registration will be on file in the patient chart during the time in which the patient is considered an active patient. Patient registration will be updated by the patient yearly or as changes in the demographic information occurs and will include where the patient can be reached by phone. A signature by the responsible party is required.

Insurance Claims:
Primary Insurance: OMNI Healthcare will file claims with the patient's insurance upon the patient's submission of proof of insurance; (insurance card indicating coverage, identification number, and group number). In the event the patient has insurance coverage but cannot provide documentation, payment is due at the time of service. Upon receipt of the insurance card, OMNI Healthcare will submit the health insurance claim form indicating patient payment at the time of service.

Secondary Insurance: Claims will be filed with secondary insurance if adequate information is received at the time of service. However, if payment is not received in our office within 45 days after filing, the responsibility will be transferred to the patient and due upon receipt.

Patient Financial Responsibility:
If no insurance is to be filed by OMNI Healthcare, or if OMNI Healthcare is not a participating provider, **full payment is due** at the time services are rendered. We are willing to work with you to develop a payment schedule to meet your needs and ours. Co-payments, deductibles, co-insurance, and non-covered services are due at time of service. Payment arrangements will be made with a signed Payment Agreement and the approval of the office manager.

Minors/ Dependents:
Children under the age of 18 will require the signature of a responsible adult party on the registration form.

Worker's Compensation:
Worker's compensation will be filed if the patient notifies OMNI Healthcare upon scheduling an appointment and supplies billing information upon arrival. Details of the accident will be required and a worker's compensation form will be completed.

Motor Vehicle Accidents:
Payment of visits for auto accidents will be due at time of service. OMNI Healthcare will provide a health insurance claim form and details of examination upon patient signature for release of records.

Method of Payment:

- Acceptable methods of payments are cash, check, Visa, MasterCard, Discover, and American Express.
- Credit Cards mentioned above will be accepted by phone or fax.

Accounts Past Due:

- Payment from statement is due upon receipt.
- Delinquent accounts may result in small claims court, a collection agency, credit bureau reporting and/or possible discharge from the practice.
- After 90 days an account will be turned over to collections. The person financially responsible for the account will be responsible for all collection costs including reasonable attorney fees of not less that 30% and court costs.
- A patient may remit in full for all outstanding charges owed on account and include amounts previously placed with the collection service. Under these circumstances, a physician may reserve the right to re-establish the patient to active status in the practice.

Missed Appointments:

- OMNI Healthcare requires 24 hour notice of appointment cancellation. Consecutive appointments missed and not previously canceled will be documented and excessive abuse could result in a possible discharge from the practice.
- Interpreter fees incurred as a result of a missed appointment or an appointment not canceled within 24 hours of the appointment time will be billed to the patient.

Account Consultation:

Physicians do not discuss financial issues. Our billing staff member is trained to discuss your account and make payment arrangements. They will be happy to help you, but if you need further assistance, our Billing Director may be consulted as well.

Medical Records:

If you require us to transfer your records to another physician, other than your primary care physician, there will be a fee. This fee must be paid prior to the transfer of the records. There is no cost to provide to your primary care physician.

I have received a copy of the OMNI Healthcare financial policy.

____

Patient Name

____ _______________

Patient Signature/Guardian/Legal Representative Date

____

Witness Name

____ _______________

Witness Signature Date

NEW PATIENT HISTORY FORM

Date: ________________
Name: __________________________ Age: __________________

List previous surgical procedures.

Name of Procedure	Date of Procedure

List all current prescribed, over the counter medications, and herbal remedies

Medication Name	Dosage	Frequency

Health Maintenance	
Colonoscopy	Date of Exam:
Pap Smear	Date of Exam:
Mammogram	Date of Exam:
Dexa Scan	Date of Exam:
Annual Eye Exam	Date of Exam:
Annual Dental Exam	Date of Exam:

List any allergies to medicine or dyes ____
List all other allergies ____
Do you currently use smokeless tobacco/cigarettes/cigars? Yes __________ No__________
If yes, which one and quantity/day ____
Do you drink alcohol? Yes__________ No__________
If yes, indicate beverage and quantity/day______________________________
Daily caffeine intake: coffee _______ tea __________ soda ________

Other Medical History:

Mark (x) if you are currently experiencing or recently experienced any of the following:

______Weight loss/gain
______Heart palpitation
______Blood in urine
______Headaches
______Anemia
______Vision problems
______Shortness of breath
______Joint pain/swelling
______Sleeping problems
______Immune problems
______Difficulty swallowing
______Appetite problems
______Rashes on skin
______Thyroid problems

Date: ________________
Name: __________________________ Age: __________________

Have you ever been treated for any of the following? Mark (x) if Yes

______Heart disease ______Vein/artery disease ______High blood pressure
______Kidney disease ______Liver disease ______Epilepsy
______Depression ______Diabetes ______Thyroid disease
______Migraine headaches ______Stroke ______Elev. Cholesterol/Tri
______Cancer: (Type) ____

List Other Diseases:____

____

Family History: Please indicate all conditions that apply to family members (brother, sister, father, mother, aunt, uncle, grandparent) and NOTE RELATIONSHIP or additional concerns below:

___High blood pressure ___________ ____Thyroid disorder ____________
___Asthma/allergies ______________ ____Heart disease______________________
___Headaches____________________ ____Diabetes__________________________
___Stroke_______________________ ____Chronic lung disease_________
___Seizures/epilepsy_____________ ____Alcoholism/substance abuse_________
___Kidney problems______________ ____Bleeding/clotting disorder___________
___High cholesterol______________ ____Ulcers____________________________
____Mental illness___________________

Emergency Contact Information:
Name:____
Relationship: __________________________________
Address: _____________________________________
____
Phone: _______________________________________

____
Patient Name

____ __________________
Patient Signature/Guardian/Legal Representative Date

____
Witness Name

____ __________________
Witness Signature Date

“Effective Immediately”

We will require 48-72 hours for all prescription refills.

This will include:

- Patient phone in requests
- Pharmacy refill faxes
- Patient walk in requests
- Internet requests

All pain medications must be picked up as they can no longer be called into the pharmacy.

____
Patient Name

______________________________ ______________
Patient Signature/Guardian/Legal Representative Date

____
Witness Name

______________________________ ______________
Witness Signature Date

Understanding Your Healthcare Records/Information

This notice is to inform you how information about you may be used and disclosed and how you can get access to it. Please review this carefully.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnosis, and plans for future care and treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication among the many professionals who contribute to your care.
- Legal document which you or a third-party payer can verify that services billed were actually provided.

Understanding what is in your medical records and how it is used helps to;

- Ensure it's accuracy.
- Better understand who, what, when, where, and why others may access your health information.
- Make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your records are the physical property of your healthcare provider that complied it, the information contained belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45CFR 164.522.
- Obtain a paper copy of the notice practices upon request.
- Request a copy of your health records as provided for in 45CFR 164.522.

I have read and understand the above:

____________________________________ ________________
Patient Name Date

____
Patient Signature/Guardian/Legal Representative

____________________________________ ________________
Witness Name Date

____
Witness Signature