EPIC HEALTH
INFECTIOUS DISEASES

Name_____ **Date of Birth**_____

SS#_____ **Male**_____ **Female** _____ Marital Status: S M D W

Address _____ **City**_____ **ST**_____ **Zip**_____

Home Phone _____ **Work phone**_____ **Cell Phone** _____

Primary number to be contacted: home ____ work ____ cell___Email: _____

Emergency Contact _____ Relationship _____ Phone Number _____

If you have an HMO Insurance it is your responsibility to make sure your primary care doctor has obtained a referral number for your appointment

Primary Insurance _____ ID# _____ group#_____

Insurance Subscriber: _____ Relationship _____ date of birth _____

Employer _____ Phone # _____

Secondary Insurance _____ ID# _____ group#_____

Insurance Subscriber: _____ Relationship _____ date of birth _____

Employer _____ Phone # _____

Guarantor of Account (who is responsible for billing) _____ Relationship _____

Do you have Pharmacy Insurance? Yes___ No___ If yes, Insurance _____ ID# _____

IF YOU HAVE PHARMACY INSURANCE, PLEASE BE SURE WE HAVE A COPY OF YOUR CARD.

Preferred Pharmacy _____ Phone Number _____

Pharmacy Location _____

Who is your Primary Care Doctor? _____ Phone number _____
(First & Last Name)

How did you hear about Epic Health? ☐ TV ☐ Radio ☐ Website ☐ Newspaper
☐ Social Media ☐ Billboard ☐ Health fair Other:_____

Who is your referring Doctor _____ Phone Number _____

We must have your referring Doctor in order to correctly file insurance

ALL LAB WORK WILL BE SENT TO UNIVERSITY HOSPITAL LAB UNLESS OTHERWISE NOTED.

Preferred Lab _____

Print Name _____ **Signature** _____ Date _____

Notice of Privacy Practices / HIPAA

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It applies to all protected health information contained in your health records maintained by us.

Please sign after reading:

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so.

Communicating With You: ***We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. However, if we contact you regarding information from our office and we leave a message we will NOT leave your doctors name, unless you approve. When leaving messages we will state that we are calling from MedEx unless otherwise approved by you.*** You should be aware that we utilize an "open waiting room" in which several people may be waiting at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be talked to in a private room, please let us know and we will do our best to accommodate your wishes.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without you written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Epic Health may communicate with the following individuals regarding my condition and/or course of treatment.
Please list name(s) and phone number(s)

_____

_____

If you have questions regarding the Privacy Practices, please contact any Epic Health employee for further explanation.
By signing below, you are stating that you have read the HIPAA form and understand the Privacy Practices of Epic Health, LLC.

_____ _____

Patient or Guardian Date

_____ _____

Epic Health, LLC Witness Date

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Patient's Bill of Rights and Responsibilities

Each patient receiving service shall have the following rights:

1. To receive appropriate, coordinated and quality primary care and case management services without discrimination because of age, race, religion, sex, handicap, national origin, or sexual orientation.
2. To the extent consistent with appropriate health care, to be informed of treatments, procedures, and those aspects of his/her condition that relate to health services provided, including alternatives, in terms that he/she can understand.
3. To actively participate, where possible, in the planning, evaluation, and revision of his/her plan of care.
4. To be informed and to give consent prior to any treatments that are experimental in nature and prior to participation in any research activities.
5. To be treated with respect, consideration and full recognition of dignity and individuality including privacy in treatment and care.
6. To access information in his/her own clinical record through legal request and in agreement with his/her own health care provider.
7. To voice grievances and recommend changes in plan of care free from restraint, discrimination or coercion.
8. To approve or refuse release of clinical records to outside agencies, insurers or health care providers.

Each patient receiving service shall have the following responsibilities:

1. To provide accurate and complete information necessary for case management, such as information concerning income, housing, social support systems, etc.
2. To provide accurate and complete information necessary of health care, such as information concerning past illnesses, hospitalizations, medications, allergies, etc.
3. To participate in the development of a plan of care and to make best efforts to adhere to the plan.
4. To make all efforts to keep appointments and to inform care providers when unable to keep a scheduled visit.
5. To inform care providers of any changes in care provision, medication changes, housing, income or any other changes regarding health or well-being.
6. To assist care providers in developing and maintaining a safe health care environment.
7. To inform care providers regarding any concerns or problems he/she may have.

Appointments:

1. Please provide us with your current insurance information and notify us immediately if you have any changes.
2. If you do not have insurance, you will be required to pay the estimated office visit fee at the time you check in. This estimate may be lower than your total office visit fee; you will be billed for the remaining amount.
3. Please arrive 15 minutes early for your appointment so we may verify everything necessary for your visit.
4. If you cannot keep your appointment, please call our office at least 24 hours in advance to cancel or reschedule.
5. ***All appointments missed without a 24 hour notice will result in a $25 per visit fee.***
6. If you have an HMO insurance, it is your responsibility to make sure your Primary Care Doctor has obtained a referral/precertification from your insurance company prior to you being seen by a specialist. MedEx Physicians are Specialty Physicians

Medical Records:

1. Epic Health charges a fee of $25 for all medical records. Medical records request MUST be in writing and may take up to 7 days to complete.
2. Fees must be paid at the time of request- records cannot be printed prior to payment

_____ _____

Signature of Patient **Date**

_____

Witness Signature

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Authorization of 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 health information as described below.
2. The following individual or organization is authorized to make the disclosure:
   Name:_____
   Address:_____
   City:_____State:_____Zip:_____
3. The type & amount of information to be used or disclosed is as follows: (dates included)
   ____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 diseases, 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.
5. This information may be disclosed to and used by the following individual or organization:
   Name:_____
   Address:_____
   City:_____ State:_____ Zip:_____
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. 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 the Epic Health Practice Manager, Human Resources Representative or Privacy Official of Epic Health, LLC.
8.

_____ _____

Signature of Patient or legal representative **Signature of witness**

Date:_____ Date:_____

Please note: This information has been disclosed to you from confidential records protected by state & federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORG-3701.243) and federal law 42 CFR, part II