

PROHEALTH PARTNERS PATIENT INFORMATION SHEET

PATIENT INFORMATION (please print)

First Name: _____ Middle Initial: _____ Last Name: _____
Home Address : _____ City: _____ State: _____ Zip Code: _____
Billing Address (if different): _____
Work Address (if different): _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Preferred Contact # _____ Email Address _____
Drivers License # _____ Date of Birth: _____ Social Security # _____
Sex: M F Marital Status: S M D W Other: How did you hear about us? _____
Primary Care Physician: _____ Primary Language: _____
Race: _____ Ethnicity (circle one) Hispanic or Latino Not Hispanic or Latino
Employer: _____ Employer Phone: _____ Occupation: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
GUARANTOR / PARENT / INSURED INFO (SEND BILL TO):
Guardian Last Name (if applicable): _____ First: _____ Initial: _____
Date of Birth: _____ Social Security # _____ Relationship: _____
Employer: _____ Address: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____
Policy Holder Name: _____ DOB: _____ Social Security # _____
Billing Address: _____ City, State, Zip: _____
Group or Policy # _____ Cert. or Member # _____ Local Union # _____
Co-Pay Amount: _____ Policy Effective Dates: From: _____ To: _____
Patient Relation to Policy Holder: Self Spouse Child Other: _____
Secondary Insurance: _____
Policy Holder Name: _____ DOB: _____ Social Security # _____
Billing Address: _____ City, State, Zip: _____
Group or Policy # _____ Cert. or Member # _____ Local Union # _____
Co-Pay Amount: _____ Policy Effective Dates: From: _____ To: _____
Patient Relation to Policy Holder: Self Spouse Child Other: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Address: _____ Phone: _____
Signature (Patient or Parent of Minor): _____ Date: _____

FINANCIAL POLICY

AGREEMENT TO PAYMENT POLICY: I acknowledge that I received a copy of PROHEALTH PARTNERS, INC. financial policy and agree to the terms of payment due.
AUTHORIZATION TO RELEASE INFORMATION: I authorize release of my medical record information, pursuant to applicable federal and state law, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state and local laws. I further authorize any other individual or entity that has provided health care to me to release to PROHEALTH PARTNERS, INC., any and all of my medical records information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

ASSIGNMENT OF BENEFITS: I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to PROHEALTH PARTNERS, INC. for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

GUARANTEE OF PAYMENTS: I agree to pay all applicable charges, which are not paid in full by my insurance. If amounts due to PROHEALTH PARTNERS, INC. are not paid according to this financial policy, the account shall be deemed delinquent. In the event that I default on payment of my account, I understand I am responsible for any and all cost incurred on the collection of my account, including court cost and reasonable attorney's fee. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amount in default.

Patient Signature

Date

Responsible Party

Relationship to Patient

PLEASE MARK THE APPROPRIATE BOX IF YOU HAVE THESE SYMPTOMS

	NEVER	SOMETIMES	FREQUENTLY
1. CHEST PAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. SHORTNESS OF BREATH			
AT REST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WITH EXERCISE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. ANKLE SWELLING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. PALPITATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. SKIPPED HEART BEATS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. COUGH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. PHLEGM (MOCOUS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. COUGH BLOOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. INDIGESTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. VOMITING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. DIARRHEA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. CONSTIPATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. BLOOD IN STOOL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. BLACK STOOL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. PAINFUL OR BLOODY URINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. VAGINAL BLEEDING (FEMALES)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. SLOW URINARY STREAM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. PARALYSIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. TINGLING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. LEG CRAMPS WITH WALKING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. URINARY INCONTINENCE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NAME: _____ DATE: _____ DOB: _____

**PF 5000
AUTHORIZATION TO COMMUNICATE
PATIENT'S MEDICAL INFORMATION**

COMMUNICATION WITH FAMILY & OTHERS INVOLVED IN YOUR CARE

PATIENT IDENTIFICATION
Name: _____
Date of birth: _____
S.S. #: _____
Medical Record/Account #: _____



(Signed original to be placed in the central medical record and copy to patient)

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

Name:	Relationship to Patient:	TYPE OF INFORMATION			
		All	Scheduling/ Appointment	Medical	Billing/ Insurance
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specific instructions or limitations: _____

Validation code: _____ (Please give this to any individual who may be involved in coordinating your care or payment for care. They will be asked to give this code to our staff before we release information over the phone.)

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify your physician's office if you wish to alter the designations above.

AUTHORIZATION TO LEAVE MESSAGE

I give my permission for the staff of ProHealth Partners, Inc. to leave messages on my telephone answering machine regarding my healthcare, test results or for any appointment

Patient's Signature / Representative

Date

Print Name

Date

Acknowledgement of Receipt of Notice of Privacy Practices

The Practice reserves the right to modify the privacy practices outlined in this notice.

I have received a copy of the Notice of Privacy Practices.

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative
(Required if patient is a minor or an adult who is unable to sign this form.)

Relationship of Representative

Documentation of Attempt to Obtain Acknowledgement of Receipt of Privacy Practices

Attempt to Obtain Acknowledgement

An attempt was made to obtain an acknowledgement of the Notice of Privacy Practices on _____ . The acknowledgement was not obtained because:

- The patient was undergoing emergency treatment
- The patient declined to sign the acknowledgement
- Other _____

Signature _____

Name of the Patient (Print or Type) _____

Name of Staff Member _____

Date _____

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This **Notice of Privacy Practices** is being provided to you as a requirement of the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes under what circumstances our medical practice (the "Practice") may use and disclose medical information about you to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control medical information about you. Your medical information (i.e., "protected health information" for purposes of HIPAA) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition. We are required by law to maintain the privacy of your medical information and we must abide by the terms of this notice.

In this notice we provide descriptions of the different ways that we may use and disclose your medical information. In some cases, an example is provided to describe the types of uses and disclosures of your medical information that may be made by us.

In addition to the privacy protections provided under federal law (which are described in more detail below) and except in certain limited circumstances, California law requires us to obtain your written consent (or, under some statutes or rules, written consent from your attorney, guardian, or upon court order) before we can use or disclose your information if you qualify as a patient that:

- Suffers from a sexually transmitted disease;
- Is HIV+ or has Acquired Immune Deficiency Syndrome;
- Suffers from a mental disorder;
- Has a problem with substance abuse;
- Is eligible to receive benefits for the State of California for certain developmental disabilities or mental retardation;
- Receives rehabilitative services through the California MediCal program;
- Is eligible to receive certain other benefits through California's MediCal program

Uses and Disclosures of Protected Health Information

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, residents, or other health care professionals who are involved in taking care of you. For example, we may disclose your medical information to another doctor or health care provider (such as a specialist, your primary care doctor, a pharmacist or clinical laboratory) who, at the direction of your doctor, is involved in your treatment or care. California Law may also limit these uses or disclosures of your medical information.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or others. For example, your insurance company may need to know certain information about the diagnostic test (such as a stress test or electrocardiogram) or procedure (such as a sigmoidoscopy or conization) you received so they will pay us or reimburse you for the test or procedure. We may also use and disclose medical information about you to obtain prior approval or to determine whether your insurance company will cover a proposed treatment. California Law may also limit these uses or disclosures of your medical information.

For Health Care Operations. We may use and disclose medical information about you for health care operations. This is necessary to make sure that all of our patients receive quality care and to support the business operations of our Practices. These uses or disclosures of your medical information may also be limited by California Law.

A few examples of our health care operations are quality improvement, doctor/employee review activities, compliance, and the training of health care professionals. Also included in healthcare operations are the day-to-day tasks that are required to keep our Practice locations functioning and to provide you with quality care. For example, in our waiting rooms we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor or there may be an individual check-in sheet that will ask additional information of you. We may also call you by name in the waiting room when your doctor is ready to see you. In addition, we may contact you (e.g., by telephone or mail or Email) to remind you about an appointment, to provide instructions prior to a diagnostic test or procedure, to provide information about treatment alternatives or other health-related benefits that may be of interest to you, to advise you of normal test

discuss your account. In such cases, we may leave a message on your answering machine, if available. The departments that may have reason to communicate with you regarding your care include the following:

- Reception/Communications (i.e., appointment reminders)
- Diagnostic Testing
- Authorizations
- Research
- Clinical Services
- Business Office
- Quality Improvement (i.e., patient satisfaction)

As another part of health care operations, we may use and disclose medical information about you to our “business associates”. Our business associates, such as transcription services, collection agency, and call answering service, just to name a few, perform services on behalf of the Practice. Whenever an arrangement between our Practices and a business associate involves the use or disclosure of medical information about you, we will have a written contract with that business associate that will require such business associate to agree to protect the privacy of your medical information.

Uses and Disclosures of Protected Health Information Not Discussed in This Notice

Uses and disclosures of your medical information that have not been described in this notice will not be made without your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by such permission. However, you should understand that we are unable to take back any actions we have already taken with your permission, and that we are required to retain our records of the care we provided to you.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Agreement or Opportunity to Object

You have the opportunity to agree or object to the use or disclosure of all or parts of medical information about you in the situations discussed in the following paragraph. If you are not present or able to agree or object to the use or disclosure of your medical information in such instances, then your doctor may, using his or her professional judgment, use or disclose your medical information if believed to be in your best interest. California Law may also limit these uses or disclosures of your medical information.

Individuals Involved in Your Care or Payment for Your Care. Unless you object, in an urgent situation we may release medical information about you to a friend, family member, or any other person you identify who is involved in your medical care. We may also give information to someone who helps pay for your care. We may use or disclose medical information about you 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. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your location, general condition or death.

Research

We may use and disclose medical information about you for research purposes under certain circumstances. However, other than obtaining medical information in preparation for a research program or protocol, your specific permission is generally required if such research will involve the use or disclosure of your medical information.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

Unless California Law requires otherwise, we may use or disclose your protected health information in certain situations without your specific permission or without giving you an opportunity to agree or object. Among these situations are the following:

Required By Law. We are permitted to disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. In certain circumstances, we may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of

the public or another person.

To Notify and Employer of Medical Information Related to an Employee It:

- or to evaluate whether an employee has a work-related injury or illness,
- the use or disclosure of information is related to these purposes,
- the use and disclosure is required for the employer to comply with its legal obligations,
- and the covered entity was providing services at the request of an employer for medical surveillance the employee is given notice that the information will be disclosed (notice can be handed

Military and Veterans. If you are a member of the armed forces, in certain circumstances we may release information about you to an appropriate government body.

Workers' Compensation. We may release medical information about you to comply with workers' compensation (or similar) laws.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may in certain circumstances release medical information about you to the correctional institution or law enforcement official.

Public Health Activities. We may disclose medical information about you for public health activities. These activities generally include, without limitation, the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse and neglect;
- to report animal bites;
- to report reactions to medications or problems with products;
- to notify people of recalls or products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading disease or condition; or
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities related to the monitoring of the health care system, government programs or compliance with civil rights laws. These oversight activities include, for example, audits, investigations, inspections, and licensure.

Lawsuits and Disputes. In certain circumstances, we may disclose medical information about you in response to a subpoena, discovery request, or other lawful order from a court.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official as part of law enforcement activities in certain circumstances.

Coroners, Medical Examiners and Funeral Directors. If authorized by law, we may release medical information to a coroner or medical examiner. We may also release medical information to a funeral director, as consistent with applicable law, in order to permit the funeral director to carry out his or her duties. Also, medical information may be used and disclosed for organ, or tissue donation purposes.

Protective Services for the President, National Security and Intelligence Activities. We may disclose medical information about you to authorized federal officials so they may, without limitation, (i) provide protection to the President; other authorized persons or foreign heads of state or conduct special investigations, or (ii) conduct lawful intelligence, counter-intelligence, or other national security activities authorized by law.

Your Rights Regarding Medical Information We Maintain About You

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that relates to you. To do so, you must submit your request in writing to our Privacy Officer at the address below. If you request a copy of the information, we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain circumstances. If you are denied access to medical information, you may in certain circumstances request that the denial be reviewed. In such cases, another licensed health care professional

We may deny your request to inspect and copy in certain circumstances. If you are denied access to medical information, you may, in certain circumstances, request that the denial be reviewed. In such cases, another licensed health care professional, chosen by ProHealth/Argus, will review your request and the denial. The person conducting the review will not be the person who denied your original request. We will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. In certain circumstances, you have the right to amend your medical information.

To request an amendment, your request must be made in writing and submitted to our Privacy Officer at the address below. In addition, you must provide a reason that supports your request. We may deny your request for an amendment in certain circumstances.

- **Right to an Accounting of Disclosures.** You have the right to receive an accounting of certain disclosures that we have made.

To request an accounting of disclosures, you must submit your request in writing to our Privacy Officer at the address below. Your request must state a time period that may not be longer than six (6) years and may not include dates before April 14, 2003. 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 within a single 12-month period, 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 the right to request a restriction or limitation on how we use or disclose certain medical information about you, including how we use or disclose your medical information for treatment, payment or health care operations.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

To request restrictions, you must make your request in writing to our Privacy Officer at the address below. 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; and 3) to whom you want the limits to apply.

- **Right to Request Confidential Communications.** 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 to our Privacy Officer at the address below. 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 paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice, you can request one in writing from our Privacy Officer at the address below or simply ask for a copy at the reception/check-in desk at your doctor's office.

Changes to This Notice

We reserve the right to change this notice at any time. We reserve the right to 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. We will post a copy of the current notice. The notice will contain, on the first page, the effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint, contact our Privacy Officer at the address below. All complaints must be submitted in writing. You will not be penalized for filing a complaint, and we will seek to deal with all complaints in a reasonable and efficient manner.

Privacy Officer

Linda Grow, HIPAA Compliance Officer



The Physician Practice Management Company

Linda Grow
Director - Contracting
& Risk Management

(562) 299-5203 Phone
(562) 299-5204 Fax
lgrow@argusmso.com

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