Patient Information

Patient Information

Last Name_____ First Name_____MI____

Address_____City_____ State_____Zip_____

Home Phone_____ Cell_____ Work_____

Email_____ Date of Birth_____ Gender_____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Race: ☐ American Indian ☐ Asian ☐ Black or African American ☐ Native Hawaiian ☐ White ☐ Other

Ethnicity: ☐ Cambodian _____Filipino _____Hispanic/Latin _____Non-Hispanic

Preferred Language: _____

Dependent?_____ If yes, Guardian's Name_____

Address_____ Phone_____

Relationship to Patient _____

Primary Insurance holders name: _____ Primary Insurance holders date of birth: _____

Employer

Employment Status ☐ Employed ☐ Self-employed ☐ Retired ☐ On active military duty ☐ Unknown

Employer Name_____

Emergency Contact Information

Name_____ Relationship to Patient_____

Home or Work Phone_____ Cell Number_____

Preferred Method of Contact

Phone Number to leave messages_____ Phone Number to text_____

Do we have your permission to leave a detailed message including test results? ☐ Yes ☐ No

Is it okay to text with your healthcare team to your cell phone number? ____Yes _____No

I consent and state my preference to have my One to One Health providers communicate with me by standard SMS and MMS text messaging regarding various aspects of my medical care, which may include, but shall not be limited to, scheduling, test results, prescriptions, and referrals.

I understand that SMS and MMS text messaging are not confidential methods of communication and may be unsecure. I further understand that, because of this, there is a risk that messaging regarding my medical care might be intercepted and read by a third party.

_____ _____

Patient Signature (or Parent/Guardian if a minor) Date

Authorization to Release Medical Information

Please check one

____ I authorize One to One to release my medical information including the diagnosis, examination rendered to me and treatment to:

____ Spouse_____ Child(ren)_____Other_____

____ Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

General Consent

I consent to treatment by One to One Physicians and staff for my healthcare, including but not limited to exams, testing, medications, and minor procedures. I acknowledge and agree no guarantees have been made to me as the results or outcome of my care. I understand that State Law requires physicians to report certain communicable diseases to the Health Department.

If at any time I have questions about my examination, diagnosis, or treatment, I will not proceed until my questions have been answered to that I am fully informed. I understand that giving the providers and nurses all relevant information is important to my proper diagnosis and treatment. I understand complete compliance with my provider's instructions is critical to the success of any treatment prescribed.

I authorize one to one Health to release my health information to my health plan or to a health and wellness provider approved by my health plan for purposes of advising me concerning appropriate measures to maintain or improve my health or any condition reflected in my records. I authorize One to One Health to release information to my designated insurance plan for the purpose of health plan administration, including receiving or making payment for services rendered on my behalf. I understand a patient is responsible for all charges incurred, subject to contract and program rules, regardless of my insurance status. If it becomes necessary to send this account to collections, the patient will be responsible for all additional charges.

I verify that the above information is factual and true to the best of my knowledge. I understand that proof of insurance and/or copay, if applicable, is due at the time of service.

_____ _____

Patient Signature (or Parent/Guardian if a minor) Date

NEW PATIENT HEALTH HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICTLY

CONFIDENTIAL AND WILL REMAIN PART OF YOUR MEDICAL RECORD.

Name (Last, First, Middle)	DOB:
PCP:	Date of last physical:

ALLERGIES

Please list all allergies and the reactions below.

MEDICATION NAME OR ALLERGEN	REACTION

MEDICATIONS

Please list all medications that you are currently taking, including any over the counter medicines.

PHARMACY NAME: _____**PHONE:** _____

MEDICATION NAME	STRENGTH	FREQUENCY

MEDICAL HISTORY PLEASE LIST ANY MEDICAL PROBLEMS THAT YOU HAVE PREVIOUSLY BEEN DIAGNOSED WITH	
CONDITION	HOW LONG

SURGICAL HISTORY PLEASE LIST ALL SURGERIES WITH DATES	
DATE OF SURGERY	TYPE OF SURGERY

Family History: Put a ✓ in the "yes" or "no" or "don't know" box for any health conditions a first- or second-degree family member may have or had. Do not include family members who are adopted or part of your stepfamily.

	Yes	No	Do Not Know	Please state relationship to you and the person's age when the condition started, please note if living or deceased.
Example: Diabetes	☑	☐	☐	**My dad was diagnosed at age 50, living**
Autism	☐	☐	☐	
Birth Defects, including heart defects or spina bifida	☐	☐	☐	
Blindness from birth or before age 40	☐	☐	☐	
Blood Clots or deep vein thrombosis (DVT)	☐	☐	☐	
Cancer, such as breast, ovarian or colon	☐	☐	☐	
Cystic fibrosis (CF)	☐	☐	☐	
Deafness from birth or before age 40	☐	☐	☐	
Diabetes	☐	☐	☐	
Early Menopause (before age 40)	☐	☐	☐	
Heart disease, including heart attack	☐	☐	☐	
Hemophilia	☐	☐	☐	
High blood pressure	☐	☐	☐	
Intellectual disabilities or learning disabilities	☐	☐	☐	
Mental illness, such as anxiety or depression	☐	☐	☐	
Pulmonary edema (PE)	☐	☐	☐	
Repeat Pregnancy losses (miscarriage, stillbirth)	☐	☐	☐	
Sickle cell disease	☐	☐	☐	
Spinal muscular atrophy	☐	☐	☐	
Stroke	☐	☐	☐	
Sudden, unexpected death as an adult or child	☐	☐	☐	
Tay-Sachs	☐	☐	☐	
Thalassemia	☐	☐	☐	
Von Willebrand disease	☐	☐	☐	

Signature: _____ **Date:** _____

HIPAA Information and Patient Privacy Consent

Patient's Name: _____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change, and if so, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- All other disclosures by the practice will require specific authorization by you unless required by law.
- The Practice has a Notice of Privacy Practices and that the patient can review this Notice and receive a copy.
- The Practice reserves the right to change the Notice of Privacy Policies. The new policy will be posted in the lobby and on the web site.
- The patient has the right to restrict the uses of their information used for treatment, payment, or operations, but the Practice does not have to agree to those restrictions.

_____ _____

Patient Signature **Date**

_____ _____

Parent/Guardian Signature if Minor **Date**

_____ _____

Witness/Practice Staff Member Signature **Date**

ONE TO ONE 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 review this notice carefully.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related healthcare services is referred to as Protected Health Information("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics.* It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your healthcare treatment and related services. This includes consultation with clinical supervisions or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.
As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect/ Disabled Adult/Elder Abuse. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena, court order, administrative order or similar process.

Medical Emergencies. We may use or disclose your PHI in a medical emergency to medical personnel only in order to prevent serious harm. Including suicidal ideation or homicidal ideation.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or a necessity to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena(with your written consent),court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Public Health. If required, we may use or disclose your PHI for mandatory public health activates to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary, to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization:(i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record;(ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request to the Center for Healthy Living.

- **Rights of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI, we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement or disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy.
- **Right to an Accounting of Disclosures.** You have the right to request a restriction or limitation on the use of disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our The Center for Healthy Living or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619O 0257. **We will not retaliate against you for filing a complaint.**

The effective date of this notice is September 2013

Notice of Privacy Practices

Receipt and Acknowledgement of Privacy Practice Notices

Patient Name/Client:_____

DOB:_____

SSN:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the One to One's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my Privacy Rights, I can contact One to One.

_____ _____

Signature of Patient/Client Date

_____. _____

Signature or Parent, Guardian or Personal Representative* Date

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

☐ Patient/Client Refuses to Acknowledge Receipt:

_____ _____

Signature of One to One Staff Member Date

PERMISSION TO ACCOMPANY A MINOR

I, _____ being the parent/legal guardian of_____
(Name of minor child)
born_____, hereby authorize _____ to accompany
(Date of birth) (Name of adult to be accompanying child)
and authorize treatment for my child. This includes bringing the child into the office of One to One Health, providing a history of present illness, disclosing protected health information, accompanying consented research study procedures, and witnessing any physical exam completed by the provider.

This adult has the responsibility to relay any diagnosis, treatment plan or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all copays and coinsurance.

This consent will remain in effect until terminated by me in writing, or the minor reaches legal age.

Emergency Contact Information for Parents/Guardians:

Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____

Comments: _____
_____

_____ _____
Parent or Legal Guardian's Signature Date

Consent to Treat a Minor

We are required to obtain a parent's consent to treat a child (unless a matter of life or death). It is requested that you complete the information below so that if your child presents to a One to One Health Clinic either alone or in the company of an adult (not a legal guardian) for an office visit, our staff can assess and treat the child as necessary. A Permission to Accompany a Minor form will need to be completed and on file for someone other than the parent bringing the child in for treatment.

MINOR INFORMATION

Minor's Full Name:_____ DOB: _____ Gender:☐M ☐F

PARENT/GUARDIAN INFORMATION

Mother's Name:_____ DOB:_____

Address: _____

Home Phone:_____ Cell: _____ Work: _____

Father's Name:_____ DOB:_____

Address: _____

Home Phone:_____ Cell: _____ Work: _____

Guardian's Name:_____ DOB:_____

Address: _____

Home Phone:_____ Cell: _____ Work: _____

EMERGENCY CONTACT (other than parent or guardian):

Name:_____ Relationship to Minor:_____

Home Phone:_____ Cell: _____ Work: _____

Consent Statement Authorizing Treatment:

I,_____, parent or legal guardian of _____, a minor, do hereby consent to and authorize any and all medical care deemed necessary by a One to One physician to be rendered to the above named minor without me being present.

_____ _____

Parent/Guardian Signature Date

_____ _____

Minor Signature: to allow parent to discuss details of the office visit Date

This consent to treat will remain in effect until terminated by me in writing, or the minor reaches legal age.