Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE SUMMARIZES YOUR RIGHTS AND HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. A COPY OF THE FULL NOTICE OF PRIVACY PRACTICE IS ON FILE AND AVAILABLE UPON REQUEST.

PLEASE REVIEW THIS NOTICE CAREFULLY

1. We value your privacy and rights about your health information. Your rights as prescribed by the Health Insurance Portability and Accountability Act (HIPAA) include the right to:
   a. Confidential communications about your Protected Health Information (PHI) and how communication should be directed;
   b. Individual access to your PHI and Individually Identifiable Health Information (IIHI);
   c. Restricted or limited access to your PHI;
   d. Amend your PHI;
   e. Request an accounting of who has access to your PHI;
   f. A copy of the Notice of Privacy Practices;
   g. Complain to the Department of Health and Human Services; and,
   h. Provide an Authorization for Other Uses and Disclosures of your PHI.

2. We routinely use and disclose some of your individually identifiable health information in the following ways:
   a. Medical Care and Treatment - Information about you may be shared during the course of routine medical care and treatment. Consultants, labs, x-rays, hospitals, emergency rooms, pharmacies, etc. all will receive some information about your PHI as we care for your medical needs.
   b. Payment for Medical Care - Information about you may be shared during the course of billing and payment for medical services. Insurance companies, billing services, etc. all require some information for payment processes.
   c. Health Care Operations - Information about you may be shared during the course of required audits of quality of care, management of care, and utilization of resources.
   d. Appointment Reminders - Information about you may be shared during the course of appointment reminders.
   e. Release of Information to Family/Friends - Information about you may be shared with designated friends and family during the course of medical care. You may grant permission to release your medical care information to (check all that applies):
      i. Spouse / Partner □ No □ Yes, Specify name: ________________________________
      ii. Children □ No □ Yes, Specify name: ________________________________
      iii. Mother □ No □ Yes, Specify name: ________________________________
      iv. Father □ No □ Yes, Specify name: ________________________________
      v. Friend □ No □ Yes, Specify name: ________________________________
      vi. My Voicemail □ No □ Yes, Specify best time: ________________________________
      vii. Doctor □ No □ Yes, Specify name: ________________________________
      □ NONE of the above. You may only release information to me in person or via telephone.

f. Disclosures Required by Law Officials

*** SECRET 4 DIGITS: _____ _____ _____ _____ This code will be used to verify identity of person listed on this form, including yourself.

I have read the above summary and am aware of my rights under HIPAA and how information about me is routinely used during the course of providing medical services.

_________________________________________________                    ________________________________
Patient / Guardian Signature                        Date

_________________________________________________                    ________
Printed Name                      Witness

Name: «LastName», «FirstName» «MiddleInitial» DOB: «DOB» Age: «Age» eCW: «PatientAccountNumber» MRN: «MRNNo»
Please Tell Us About Your Medical History:

### MEDICAL HISTORY: I Currently Have or Had In The Past

<table>
<thead>
<tr>
<th>Condition</th>
<th>Psychiatric Disorder</th>
<th>Cancer of</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>ADHD</td>
<td>Esophagus</td>
</tr>
<tr>
<td>Allergies</td>
<td>Migraine Headaches</td>
<td>Stomach</td>
</tr>
<tr>
<td>Asthma Atrial Fibrillation</td>
<td>Adjustment Disorder</td>
<td>Colon</td>
</tr>
<tr>
<td>Back Pain (lower)</td>
<td>Kidney Stones</td>
<td>Bipolar</td>
</tr>
<tr>
<td>Blood Clot</td>
<td>Heart Disease</td>
<td>Thyroid</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>Heart Attack</td>
<td>Bulimia</td>
</tr>
<tr>
<td>Diabetes Type I</td>
<td>Heart Disease</td>
<td>Lungs</td>
</tr>
<tr>
<td>Diabetes Type II</td>
<td>Kidney Stones</td>
<td>Obese</td>
</tr>
<tr>
<td>Ear Infection (recurring)</td>
<td>Stroke</td>
<td>Obsessive Compulsive</td>
</tr>
<tr>
<td>Emphysema / COPD</td>
<td>Kidney Infection</td>
<td>Breast</td>
</tr>
</tbody>
</table>

Others:

### SURGICAL HISTORY: I Had The Following Surgeries

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Psychiatric Disorder</th>
<th>Cancer of</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix Removal</td>
<td>Colon Resection</td>
<td>Thyroid Removal</td>
</tr>
<tr>
<td>Adenoid Removal</td>
<td>C-Section</td>
<td>Tonsils Removal</td>
</tr>
<tr>
<td>Bariatric Surgery</td>
<td>Ear Tube Placement</td>
<td>Tubal Ligation</td>
</tr>
<tr>
<td>Breast Resection</td>
<td>Gallbladder Removal</td>
<td>Prostate Removal</td>
</tr>
<tr>
<td>Breast Augmentation</td>
<td>Knee Replacement</td>
<td>Vasectomy</td>
</tr>
</tbody>
</table>

Others:

### SOCIAL HISTORY: My Social Life / Habits Include

Cigarette / Tobacco: ___________ pack(s) per day
Marital Status: □ Single □ Married □ Divorced □ Widowed
Alcohol / Beer: ___________ drink(s) per week
Recreational Drug Use:
Occupation:

### ALLERGIES: I Am Allergic To

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Psychiatric Disorder</th>
<th>Cancer of</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latex</td>
<td>ADHD</td>
<td>Esophagus</td>
</tr>
<tr>
<td>Iodine</td>
<td>Migraine Headaches</td>
<td>Stomach</td>
</tr>
<tr>
<td>Penicillin</td>
<td>Aspirin</td>
<td>Adjustment Disorder</td>
</tr>
<tr>
<td>Codeine</td>
<td>Kidney Stones</td>
<td>Bipolar</td>
</tr>
<tr>
<td>Tape</td>
<td>Heart Disease</td>
<td>Thyroid</td>
</tr>
</tbody>
</table>

Others:

### VACCINATIONS:

Childhood Vaccinations: □ Up-To-Date □ Unknown
Year of Last Tetanus(Adult): ___________
Year of Last Pneumonia Shot (Adult > 50): ___________
Year of Last Flu Shot: ___________

### MEDICATIONS: My Current Medications Include (Prescribed and OTC)

□ NONE
**Patient Registration**

**Name:** «Last Name», «First Name» «Middle Initial»

**DOB:** «DOB»

**Age:** «Age»

**ecW:** «Patient Account Number»

**MRN:** «MRN No»

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**Patient Name:**

**Address:** (H) __________________________________________________

**DOB:** _____________

**Age:** _____________

**Gender:**

**City:** ____________________________________ **State:** ______ **Zip:** _____________

**Address:** _____________________________________________________________

**If Other Subscriber Address, Same as:**

**Relationship to patient:**

**Subscriber Name:** ___________________________________________________

**SSN:** _______________________ **DOB:** ___________________

**Relationship to patient:**

**Insurance A:** __________________________________________________

**Policy #** ______________________________ **Group #**

**Subscriber Name:** ________________________________________________

**SSN:** _______________________ **DOB:** ___________________

**Relationship to patient:**

**Secondary Insurance Information**

**Insurance A:** __________________________________________________

**Policy #** ______________________________ **Group #**

**Subscriber Name:** ________________________________________________

**SSN:** _______________________ **DOB:** ___________________

**Relationship to patient:**

**If Other Subscriber Address, Same as:**

**If Other Address:**

**City:** ____________________________________ **State:** ______ **Zip:** _____________

**Emergency Contacts**

**Name 1:**

**Address (if Same as patient) __________________________________________**

**City:** ____________________________________ **State:** ______ **Zip:** _____________

**Home Phone:** ______________________________

**Cell Phone:** ______________________________

**Name 2:**

**Address (if Same as patient) __________________________________________**

**City:** ____________________________________ **State:** ______ **Zip:** _____________

**Home Phone:** ______________________________

**Cell Phone:** ______________________________

**Nearest Person (Not Living With You): **

**Address (if Same as patient) __________________________________________**

**City:** ____________________________________ **State:** ______ **Zip:** _____________

**Home Phone:** ______________________________

**Cell Phone:** ______________________________

**Financial Agreement**

I understand and agree that Sendas Northwest Urgent Care will bill my insurance as a courtesy.

* If verification of my medical insurance coverage cannot be made at this time, I will receive services today with the understanding that in the event coverage is NOT in effect, I am responsible for any balance on my account.

* If I do not have insurance coverage, I am required to pay for all services rendered to me today; this does not guarantee payment in full and I may still receive a bill for labs and other services provided to me.

I have read and agree to the financial statement, and certify that the above information is correct to the best of my knowledge.

**Parent/Guardian Signature:** ______________________________ **Date:** ____________________________

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**RESPONSIBLE PARTY**

**□ Self** □ Mother □ Father □ Guardian

**Address (if different from patient) __________________________________________**

**Zip:** __________________ **Phone:** __________________

**□ Mother** □ Father □ Guardian

**Address (if different from patient) __________________________________________**

**Zip:** __________________ **Phone:** __________________

**EMERGENCY CONTACTS**

**INSURANCE INFORMATION**