



PATIENT INFORMATION

Thank you for choosing our practice! In order to provide you with your medical care and to comply with Federal HIPPA laws, we need the following information.

Please print. Make sure you read the reverse side about our Privacy Practices or ask for a copy to take with you.

Patient Name: (First) _____ (Middle Initial) _____ (Last) _____ SSN: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone #: _____ Cell Phone #: _____ Birth date: _____ [] Male [] Female
 E-mail Address: _____
 Please check one: [] Single [] Married [] Divorced [] Widowed [] Separated
 Patient Employer: _____ Occupation: _____ Work Phone #: _____
 Work Address: _____ City: _____ State: _____ Zip: _____
 Spouse or Parent/Guardian Name: _____ Employer: _____ Work Phone #: _____
 If patient is a student, name of school/college: _____ City: _____ State: _____
 Person to contact in case of an emergency: _____ Phone #: _____
 Whom may we thank for referring you?: _____

RESPONSIBLE PARTY

Name of person responsible for this account: _____ Relationship to patient: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone #: _____ SSN: _____ Birth date: _____
 Employer: _____ Work Phone: _____

INSURANCE INFORMATION

Name of Insured (Subscriber): _____ Relationship to Patient: _____
 SSN: _____ Home Phone #: _____ Birth date: _____
 Employer: _____ Work Phone #: _____
 Work Address: _____ City: _____ State: _____ Zip: _____
 Insurance Company: _____ ID or Insurance #: _____ Group # (if any): _____
 Insurance Company Address: _____ City: _____ State: _____ Zip: _____

Do you have any additional insurance? [] Yes [] No If yes, please complete the following information.

(2nd) Name of Insured (Subscriber): _____ Relationship to patient: _____
 Insurance Company: _____ ID or Insurance #: _____ Group #: _____
 Insurance Company Address: _____ City: _____ State: _____ Zip: _____

(3rd) Name of Insured (Subscriber): _____ Relationship to patient: _____
 Insurance Company: _____ ID or Insurance #: _____ Group #: _____
 Insurance Company Address: _____ City: _____ State: _____ Zip: _____

Authorization, Release and HIPAA Notice of Privacy Practices Certification

I hereby authorize release of any information concerning my, my child's, or my legal guardianship's healthcare pursuant to the terms of the "Notice of Privacy Practices" on the reverse side. I consent to the release of my prescription history from any pharmacy or drug monitoring agency. I hereby assign to MMCFP any and all health care benefits to which I am entitled under any insurance policy and authorize, to the extent permitted by law, payment of those benefits directly to MMCFP, only up to the amount of any balance due for services. Any co-pays, deductibles, co-insurance, or charges not covered by insurance that I agree to have performed in advance will be paid at the time of service. If any collection activities are pursued, all costs associated with this will be borne by me. By signing below I certify that I have either read the "Notice of Privacy Practices" on the reverse side and/or I have requested and been given a copy.

X _____
 Signature of Patient, Parent/Guardian of Patient, if a minor

 Date

_____ Please initial if you **DO NOT** want us to leave information on your answering machine.

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 IT CAREFULLY

We understand that medical information about you and your health is personal and we are committed to protecting that information. We create a confidential record of the care and services you receive at the Mechanicsville Medical Center Family Physicians (MMCFP) in order to provide you with quality care and to comply with certain legal requirements. Certain information must be shared with other entities who participate in your medical care. Should you require any special considerations regarding the handling of your medical records you may contact our Privacy Officer. If we are unable to accommodate your needs or if by your refusal we are prevented from transmitting your medical information we will be required to determine our ability to properly care for your medical needs in the future.

Protected Health Information: (includes but not limited to)

Identifying information: Name, address, names of relatives and/or employers, birth date, telephone and fax numbers, social security number, medical record number(s), e-mail address, health plan beneficiary number, account number, certificate/license number, photographic images, and/or any other unique identifying number or code.

Health information: Any past, present, or future physical or mental condition relating to diagnosis or procedures in written or codified formats, medication use, substance use/abuse, allergies, social and family history, "review of systems". Operative reports, laboratory and radiographic findings and reports, and physical examination finding.

Methods of Transmission: any form of communication including, but not limited to oral, paper, or electronic (i.e. phone, fax, and/or via the internet).

Institutions and Individuals receiving protected health information includes, but are not limited to:

Members of your family

Employees of MMCFP

Other physicians active in your medical care, their staff and vendors

Insurance Companies and Worker's Compensation Agencies

Government Agencies involved in health care administration or regulation

Hospitals including affiliated laboratories and radiology departments

Non-hospital affiliated Laboratories and Radiology facilities

Pharmacies

Residents and other health care professionals in training

Business associates or vendors employed by MMCFP for billing, transcription and other medical/business related services

Appointment reminders and/or referral information, our message will include all pertinent information required in order to give you all necessary information that we would give you in person

Research

Food and Drug Administration

Local/State/Federal Health or Legal Agency as required by law

Your Rights:

You have the right to inspect and copy your medical information.

You have the right to request a restriction of your medical information.

You have the right to request that we accommodate you in communicating confidential medical information.

You may have the right to ask us to amend your medical information.

You have the right to receive an accounting of certain disclosures we have made, if any, of your medical information.

You have the right to obtain a paper copy of this notice from us.

Privacy Contact:

If you have any questions about this Notice or require additional information, please contact our Privacy Officer, Ronald R. Eagle, at (804) 746-9055, e-mail at MMCFP@aol.com, or at 7571 Cold Harbor Road, Mechanicsville, VA 23111. Our Privacy Officer is available during normal business hours to discuss your privacy questions, concerns or complaints.

Effective Date: This notice becomes effective on April 14, 2003