Patient Information Form Date:

THE KAUFMANN CLINIC, INC.

Thank you for choosing the Kaufmann Clinic. Please completely fill out this form to ensure the fastest and best healthcare service. We may ask you to look over this information from time to time to make sure it stays up-to-date. Please have your insurance card and picture I.D. ready to photo copy.

Patient Name	Social Security Number
Date of Birth	Address
Sex ☐ Male ☐ Female Marital Status ☐ Single ☐ Married ☐ Widowed	City, State, Zip
Home Phone	Work Phone
Mobile phone or pager	Email Address
Employer	Occupation
Insurance company name and policy number/Primary (see your insurance card) _____ _____ Effective Date _____	Insurance company name and policy number/Primary (see your insurance card) _____ _____ Effective Date _____
Emergency Contact Name/Relationship	Phone
If you are covered under the policy of a spouse, partner, parent, or legal guardian, please tell us about them:	
Patient Name	Social Security Number
Date of Birth	Address, City, State, Zip
Home Phone	Work Phone
Mobile phone or pager	Email Address
Employer	Occupation

Medical History *Date:* / /

Name _____ Age _____ Birthdate ___/___/___

Address _____ Sex: ☐ M ☐ F

_____ Home phone _____

_____ Work phone _____

Occupation _____ Emergency contact _____

Phone _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If married, spouse's name _____

Children's names and ages _____

Allergies to Medications, X-Ray Dyes, or Other Substances ☐ No ☐ Yes

(If yes, please list name of medicine and type of reaction):

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Past Medical History & Review of Systems

Please circle if you have had problems with or are presently complaining of any of the following:

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart disease
5. Chest pain/chest tightness
6. Shortness of breath
7. Swollen ankles
8. Palpitations
9. Lightheadedness
10. Frequent urination
11. Rheumatic fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent cough
16. T.B.
17. Hay fever
18. Abdominal discomfort
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23. Diarrhea
24. Blood in stool
25. Ulcers
26. Change in bowel habits
27. Unexplained weight gain/loss
28. Hemorrhoids
29. Gall bladder disease
30. Colitis
31. Hepatitis or jaundice
32. Thyroid disease
33. Head or neck radiation
34. Headache
35. Kidney diseases
36. Kidney stones
37. Difficulty urinating
38. Arthritis
39. Low back problems
40. Skin diseases
41. Blood disorders
42. Venereal diseases
43. Anxiety
44. Depression
45. Anemia
46. Alcohol abuse
47. Drug abuse
48. Gout
49. _____
50. _____

_____

_____

_____

_____

_____

_____

_____

_____

Gynecologic and Obstetric History

Age at onset of periods: _____ Frequency: _____ Length of period: _____

Pregnancies: _____ Births: _____ Miscarriages: _____

Prolonged or abnormal bleeding: ☐ No ☐ Yes (Please describe): _____

Leakage of urine: ☐ No ☐ Yes (Please describe): _____

Pelvic pain: ☐ No ☐ Yes (Please describe): _____

Abnormal discharge: ☐ No ☐ Yes (Please describe): _____

History of abnormal Pap smear: ☐ No ☐ Yes (Type of treatment): _____

Patient Name: *Date:* / /

Please List and Supply the Dates of:

Operations: _____ _____ _____

_____ _____ _____

Hospitalizations other than for surgery: _____ _____

_____ _____ _____

Immunization history—have you had:

Hepatitis B? ☐ No ☐ Yes When? _____

Other? _____ ☐ No ☐ Yes When? _____

Pneumovax immunization? ☐ No ☐ Yes When? _____

Flu immunization? ☐ No ☐ Yes When? _____

Tetanus immunization? ☐ No ☐ Yes When? _____

When was your last:

Pap smear? _____ Breast exam? _____ Stool check for blood? _____

Mammogram? _____ Cholesterol check? _____ Prostate exam? _____

Family History

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?	Approx. age when diagnosed
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart disease		
Diabetes		
Strokes		
Mental disease (anxiety, depression, etc.)		
Drug or alcohol addiction		
Glaucoma		
Bleeding diseases		
Other: _____		

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug name	Dose	Drug name	Dose

Prevention

Do you wear seatbelts?	☐ No	☐ Yes	If no, why not? _____
Do you wear a bike helmet?	☐ No	☐ Yes	☐ N/A
Do you smoke?	☐ No	☐ Yes	If yes, how many packs per day? _____
Do you drink alcoholic beverages?	☐ No	☐ Yes	If yes, how much per week? _____
Do you drink coffee?	☐ No	☐ Yes	If yes, how many cups per day? _____
Do you drink tea?	☐ No	☐ Yes	If yes, how many cups per day? _____
If there is a gun in your home, is it out of children's reach and unloaded?	☐ No	☐ Yes	☐ N/A
Do you use drugs? (marijuana, cocaine, crack, etc.)	☐ No	☐ Yes	If yes, explain: _____
Have you ever engaged in any activity which has put you at risk of getting AIDS?	☐ No	☐ Yes	If yes, explain: _____
Do you wish to be tested for AIDS?	☐ No	☐ Yes	
Have you ever worked with chemicals, paints, asbestos, or other hazardous material?	☐ No	☐ Yes	If yes, explain: _____
Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner?	☐ No	☐ Yes	
Do you ever feel afraid of your partner?	☐ No	☐ Yes	
Do you have a "living will"?	☐ No	☐ Yes	
Do you have a donor card?	☐ No	☐ Yes	

Method of birth control? _____

The Kaufmann Clinic, Inc.

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2001 Professional Way, Suite 220, Woodstock , GA 30188

CONSENT AGREEMENT

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____,
(Please Print Name Clearly)

understand that as part of my healthcare, The Kaufmann Clinic, Inc., originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided,
- A tool for routine healthcare operations such as assessing quality.

I understand and have been provided with a **Notice of Privacy for Protected Health Information** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that The Kaufmann Clinic reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that The Kaufmann Clinic is not required to agree to restrictions requested. I understand that I may revoke this consent in writing, except to the extent that The Kaufmann Clinic has already taken action in reliance thereon.

Consent Agreement (continued)

I wish to have the following restrictions to the use or disclosure of my health information:

I fully understand and **accept** the terms of this consent._____

I fully understand and **decline** the terms of this consent_____

Signature of Patient_____Date_____

Or By_____Date_____
(Patient's Representative)

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AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I authorize **THE KAUFMANN CLINIC, INC.** to use and disclose a copy of the specific health and medical information described below regarding

_____

(Print Name of Patient)

consisting of : (describe information to be used/disclosed here)

Name of
Recipient_____

Or Class of
recipients_____

For the purpose of: (describe purpose of disclosure here)

Authorization to Use and Disclose Health Information (continued)

If we are requesting this Authorization from you for our own use and disclosure or to allow another healthcare provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization;
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on the Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and no longer protected under federal law.

By:_____ Date:_____
(Patient)

Or By:_____ Date:_____
(Patient's Representative)

Description of Representative's Authority_____

_____

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released 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.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/____

Witness:_____ Date: ____/____/____

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Notice of Privacy Practices for Protected Health Information HIPAA Revision 10.350

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.

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which a third-party payer can verify that services billed were actually provided
- a tool in educating health professionals
- a source of data for medical research
- a source of information for public health officials charged with improving the health of the nation
- a source of data for facility planning and marketing
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where, and why others may access your health information
- make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of The Kaufmann Clinic, Inc., the information belongs to you. You have the:

- **right to inspect and copy** your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to the Kaufmann Clinic's designated privacy official in order to inspect and/or copy your health information. If you require a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We have the right to deny your request and/or copy in certain limited circumstances. You may ask that your denial be reviewed, which, in most cases is handled by an outside licensed healthcare professional. We will comply with the outcome of the review.
- **right to amend** your healthcare information if you believe the information is incorrect or incomplete. You have the right to request an amendment as long as your healthcare information is kept by this office. To request an amendment, complete and submit a Medical Record/Correction Form to the Kaufmann Clinic's designated privacy official. This request may be denied if it is not in writing or does not include a reason to support the request, such as the information is accurate and complete, is not part of the health information that we keep, or that the person creating the information is no longer available to make the amendment.
- **right to request restrictions** or limitations on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request if we feel the information is needed to provide you emergency treatment.
- **right to request confidential communications** 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 may complete and submit the Request for Restriction on Use/Disclosure of Medical Information to Kaufmann Clinic's privacy official.

The Kaufmann Clinic's Responsibilities

The Kaufmann Clinic is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable request you may have to communicate health information by alternative means or at alternate locations

The Kaufmann Clinic reserves the right to change our practices and to make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied to us.

The Kaufmann Clinic will not use or disclose your health information without your authorization, except as described in this notice.

Examples of Disclosures for Treatment, Payment and Health Operations

The Kaufmann Clinic will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record the actions taken and observations in how you respond to your treatment.

If your treatment requires you seeing another physician or healthcare provider, we will provide copies of your record that should assist them in providing you treatment.

The Kaufmann Clinic will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, or supplies used.

The Kaufmann Clinic will use your health information for regular health operations.

For example: Information in your health record may be provided to Business Associates such as physicians in the emergency department, radiology, outside reference laboratories, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information so that they can perform the job we have asked them to do and bill you or your third-party payer for the services rendered. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Notification and Communication with family: We may use or disclose information to notify or assist a family member, personal representative, or another person responsible for your care, your location, and general condition. We may, using our best judgment, disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional Institutions: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Other Uses and Disclosures of Health Information

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization.* We must obtain your *Authorization* separate from any *Consent* we may have obtained from you. If you give us this *Authorization* to use or disclose health information about you, you may revoke that *Authorization,* in writing, at any time. If you revoke your *Authorization,* we will no longer use or disclose information about you for the reasons covered by your written *Authorization,* but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the *Authorization* and *Consent* mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or healthcare operations, we will have to have both your *Consent* and a special written Authorization that complies with the law governing HIV or substance abuse records.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

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I, _____
(Please Print)

acknowledge receiving a copy of the **Notice of Privacy for Protected Health Information, HIPAA Revision 10.350.** The purpose of this notice is to inform you about your rights and how protected health information collected about you may be used and disclosed.

Signed _____

Date: _____

Please return upon signing so this copy may be placed in your medical chart.