

**PATIENT INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient Name: | | Date of Birth: | | Male Female |
| Address | | Social Security #: | | |
| City: | | ZIP code: | Own Rent | |
| Phone: | How long have you lived at your current address? | | | |
| Work phone: | Best time to contact you? morning afternoon evening | | | |
| Preferred Pharmacy: | May we leave a message with information on your answering machine?  Yes No | | | |

|  |  |
| --- | --- |
| Emergency Contact: | Emergency Contact's phone number\*: |
| Relationship: | *\*number must be different from patient's* |

**Marital Status:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Single: | Married: | Divorced: | Widowed: | Separated: | Partnered: |

**Race:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Black/ African American |  | White/ Caucasian |  | Hispanic | Asian/ Pacific Islander |  | Native American/ Eskimo |  | Other |

**Employment status:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Full time: | Part time: | Student: | Self-employed: | Unemployed: | Retired: |

Total household members:

How many members between 0-21 years old? between 21-45 years old?

between 45-65 years old? over 65 years old?

Average monthly household income $

Source of income, if not employed:

Do you currently have any health insurance? Yes No Prescription coverage? Yes No

If Yes, what type?

|  |  |  |  |
| --- | --- | --- | --- |
| Medicare | Medicaid | Private Insurance | Veteran's Benefits |
| Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy # \_\_\_\_\_\_\_\_\_\_\_\_  Group # \_\_\_\_\_\_\_\_\_\_\_\_ | Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy # \_\_\_\_\_\_\_\_\_\_\_\_  Group # \_\_\_\_\_\_\_\_\_\_\_\_ | Name of Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_  Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy # \_\_\_\_\_\_\_\_\_\_\_\_  Group # \_\_\_\_\_\_\_\_\_\_\_\_ | Name of Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_  Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy # \_\_\_\_\_\_\_\_\_\_\_\_  Group # \_\_\_\_\_\_\_\_\_\_\_ |

If No, when was it terminated?

Have you had any health insurance in the past? Yes No

Last seen by doctor: When?

Are you a military veteran? Yes No Are you a U.S. Citizen? Yes No

Occupation/Employer: Highest Education completed:

**NEOMED Clinical Services**

**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.

The privacy practices described in this Notice will be followed by health care professionals, employees, medical staff, trainees, students, contracted service providers, and volunteers in the **NEOMED Clinical Services, LLC.**

NEOMED Clinical Services is required by law to maintain the privacy of our patient’s personal protected health information and to provide patients with notice of our legal duties and privacy practices with respect to personal protected health information.  We are required to abide by the terms of this Notice so long as it remains in effect.  We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all personal protected health information maintained by us. You may receive a copy of any revised Notice upon request.

**Uses and Disclosures of Your Personal Protected Health Information**

**Your Authorization.**Except as outlined below, we will not use or disclose your personal protected health information for any purpose unless you have signed a form authorizing the use or disclosure.  You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

**Uses and Disclosures for Treatment.**  We use and disclose your personal protected health information as necessary for your treatment.  For instance, doctors, nurses, and other professionals involved in your care will use information in your medical record to plan a course of treatment for you.  We may also release your personal protected health information to another health care facility or professional who is not affiliated with our organization but who is or will be providing treatment to you.

**Uses and Disclosures for Payment.**  We will use and disclose your personal protected health information as necessary for the payment purposes of those health professionals and facilities that have treated you or provided services to you.

**Uses and Disclosures for Health Care Operations.**  We will use and disclose your personal protected health information as necessary and as permitted by law, for our health care operations.

**Family and Friends Involved in Your Care.**  With your approval, we may disclose your personal protected health information to those specific family, friends, and others (each designated by you in a separate document), in order to facilitate that person’s involvement in caring for you or paying for your care.

**Business Associates.**  Certain components of our services may be performed through contracts with outside persons or organizations.  At times, it may be necessary for us to provide some of your personal protected health information to one or more of these outside persons or organizations who assist us with our healthcare operations.  In all cases, we require these business associates to appropriately safeguard the privacy of your information.

**Appointments and Services.** We may contact you with appointment reminders or information about treatment alternatives or other health–related benefits and services that may be of interest to you.  You have the right to request (and we accommodate reasonable requests) to receive communications regarding your personal protected health information by alternative means or at alternative locations.

**Other Uses and Disclosures.**  We are permitted or required by law to make certain other uses and disclosures of your personal protected health information without your authorization. We may release your personal protected health information:

- For any purpose required by law or the judicial system.

- For public health activities as required by law including reportable illnesses i.e. COVID, certain sexually transmitted infections, etc.

- Under specific circumstances, to government agencies; and

- In the event of medical emergencies or disaster situations.

**Your Rights**

**Notice of Breach.**  You will receive notification if there has been an impermissible use or disclosure resulting in the compromise of your personal health information.

**Notice of Nondiscrimination:** Discrimination is against the law. NEOMED CLINICAL SERVICES complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. NEOMED CLINICAL SERVICES does not exclude people or treat them differently because of the race, color, national origin, age, disability, or sex.

**Notice of Privacy Practices Acknowledgment**

**I hereby acknowledge that I have received, or have been given the opportunity to receive, a copy of the NEOMED Clinical Services Notice of Privacy Practices.  By signing below, I *ONLY* acknowledge that I have received or have had the opportunity to receive the Notice of Privacy Practices.**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Print Name)**

**Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Print Name)**

**Patient/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Signature)**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INFORMED CONSENT AND WAIVER**

***I have been informed and I understand*** that the medical personnel of the NEOMED Clinical Services, in exchange for providing free care, cannot be sued or held liable unless their action, failure to act, or omission, constitutes willful misconduct.

***I hereby release*** the treating practitioners, clinic healthcare workers, and other persons or organizations associated with this clinic from any and all liabilities resulting from:

1.  Any injury directly or indirectly caused by the medical care and treatment provided to me.

2.  Any injury that may directly or indirectly result from my failure to arrange or delay in arranging for a consultation recommended by the professional personnel of this clinic.

***I hereby give permission and consent*** to all diagnostic and medical procedures determined to be necessary for me. I acknowledge that the professional personnel of this clinic have informed me of the nature and purpose of medical care and treatment to be provided to me, and I have carefully considered this. This includes finger sticks for blood sample testing used in diagnostic or screening purposes and any other blood draws.

***I give consent*** to release my medical records to a subsequently treating practitioner, when requested, to ensure continuity of care, to establish statistical data (without disclosing my identity) or to facilitate reimbursement, if any, for the above services.

***I certify that I have read and fully understand*** the above paragraphs and that the explanations provided to me were clear and understandable.  I have been able to ask further questions regarding these matters and have no further questions currently.  I certify that I am mentally competent to give this informed consent.

**I sign this form on my own free will and without being subject to any undue influence.**

 (Initals)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (print) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Parent/Guardian/Legal Rep.           Name of Parent/Guardian/Legal Rep. (print)   *Signature*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness *Signature* Witness Name (print)

**CONFIDENTIALITY OF PATIENT RECORDS**

United States government laws and regulations protect all information in your medical records.  NEOMED Clinical Services may not give out any information about you or the services they receive here unless:

* You provide written consent,
* There is a court order to release the records,
* The information is given to physicians, pharmacists, or nurses in a medical emergency, or
* The information is given to qualified people for research, auditing purposes, or program  after any identifying information has been removed.

United States laws and regulations require that we report any information about a crime committed by a patient, either at NEOMED Clinical Services, or against any person who works or volunteers for NEOMED Clinical Services, or about any threat to commit a crime against aforementioned entities.

These laws also require that we report any information about suspected child and elder abuse or neglect to state and local authorities.

*I have read the above information and understand the laws and regulations about patient records.  I understand and accept both my responsibilities and the responsibility of NEOMED Clinical Services over the confidentiality of patient records.*

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Patient Name (print) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NEOMED Clinical Services Signature