POST CLINIC

Patient Registration Form

PATIENT INFORMATION

Full legal name (First, Middle, Last, suffix) _____ Nickname _____ Sex: ❑ Male ❑ Female

Date of birth _____ Social security number _____ Race _____ Preferred language _____

Ethnicity: ❑ Hispanic ❑ Non-Hispanic Marital status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Life partner

Complete mailing address: _____
(Street, city, state, zip code, county)

Home phone number: _____ Cell phone number: _____ Work number: _____

Email: _____

Employment status: ❑ Full-time ❑ Part-time ❑ Active duty ❑ Self-employed ❑ Not employed ❑ Retirement date: _____

Employer name: _____ Employer phone number: _____

Employer complete address: _____
(Street, city, state, zip code)

SPOUSE OR GUARDIAN

❑ Same as patient

Full legal name (First, Middle, Last, suffix) _____ Date of birth _____ Social security number _____

Relation to patient: ❑ Spouse ❑ Mother ❑ Father ❑ Legal guardian ❑ Other: _____ Sex: ❑ Male ❑ Female

Home phone number: _____ Cell phone number: _____ Work number: _____

Complete mailing address – if different from patient: _____
(Street, city, state, zip code, county)

Employment status: ❑ Full-time ❑ Part-time ❑ Active duty ❑ Self-employed ❑ Not employed ❑ Retirement date: _____

Employer name: _____ Employer phone number: _____

Employer complete address: _____
(Street, city, state, zip code)

EMERGENCY CONTACT INFORMATION

Name (First, Last): _____

Relation to patient: ❑ Spouse ❑ Mother ❑ Father ❑ Legal guardian ❑ Other: _____

Home phone number: _____ Cell phone number: _____ Work number: _____

Complete mailing address – if different from patient: _____

INCOME ELIGIBILITY GUIDELINES

Do you fall within the income eligibility guidelines listed below? Yes_____ No_____

Family Size	Monthly Income	Annual Income
1	$2,602.00	$31,225.00
2	$3,523.00	$42,275.00
3	$4,444.00	$53,325.00
4	$5,365.00	$64,375.00
5	$6,285.00	$75,425.00
6	$7,206.00	$84,350.00
7	$8,127.00	$97,525.00
8	$9,048.00	$108,575.00

*(Income levels based on 250% of FPL for 2019) For each additional family member add $921 monthly; $11,050 annual

GENERAL MEDICAL INFORMATION

Describe current medical problem/reason for today's visit: _____

Present medications: _____

Allergies to medication: _____

Allergies (e.g., itchiness or hives) to specific brands of soap/laundry detergent: _____

Other physicians currently treating you: _____

Previous or other medical problems: _____

List any previous surgeries or hospitalizations (include number of miscarriages and live births): _____

_____

Females only: are you pregnant, planning a pregnancy or nursing a child? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Cigarettes ☐ Pipe ☐ Cigars ☐ No. of Years ____ How much? ____ Interested in stopping? ☐

Do you regularly drink alcohol? ☐ Yes ☐ No How many ounces/beers per day? _____

Do you drink coffee? ☐ Yes ☐ No How many cups per day? _____

Are you under a lot of pressure at home or work? ☐ Yes ☐ No

Please describe: _____

PERSONAL MEDICAL HISTORY

Have you ever had any of the following: (Check all that apply)

- ☐ Chest Pain/Pressure/Tightening
- ☐ Hypertension
- ☐ Heart Attack
- ☐ Stroke
- ☐ Headaches
- ☐ Glaucoma
- ☐ Allergies or Eczema
- ☐ Depression
- ☐ Blood in Stool
- ☐ Asthma
- ☐ Dizzy Spells
- ☐ Cancer
- ☐ Diabetes
- ☐ Arthritis
- ☐ Difficulty Hearing
- ☐ Memory Loss
- ☐ Hemorrhoids
- ☐ Kidney Disease
- ☐ Shortness of Breath
- ☐ TB/Lung Disorder
- ☐ Ulcers
- ☐ Skin Disorders
- ☐ Hepatitis
- ☐ Cataracts
- ☐ Digestive Problem
- ☐ Frequent Urinary Infections

Other: _____

IMMUNIZATIONS

Year last received if known

Smallpox: _____

Tetanus: _____

Typhoid: _____

Polio: _____

Influenza: _____

Pneumonia: _____

Rubella: _____

Hepatitis: _____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
High blood pressure	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Eczemza/Psoriasis	☐	☐	☐	☐	☐	☐
Heart Attack/Stroke	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Hay Fever	☐	☐	☐	☐	☐	☐

NAME: _____ **AGE:** _____ **DATE:** _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect 01/01/2019 and will remain in effect until we replace it.

We reserve the right to change our privacy policy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available to you.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of the Notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization : In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for <u>any purpose</u>. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclosed to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick-up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you. You make a request in writing to obtain access to your health records. You may obtain a form to request access by using the contact information listed at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency).

Amendment: You have the right to request that we amend your health information.

Electronic Notice: If you receive this Notice on our website or by email, you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

The Post Clinic and Post Dental Clinic
15 Sterling Avenue
Mt. Sterling, KY 40353
859.498.0231
Privacy Officer: Louise Summers

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

You may refuse to sign this acknowledgement

_____

Print Patient's Name Date

I,_____, acknowledge that I
(Signature of Patient or Parent or Legal Guardian)

Have either received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I,_____, consent to the use and disclosure of
(Signature of Patient or Parent or Legal Guardian)

My personal health information by your office for Treatment, Billing / Payment and Health care Operations as outlined in the NOTICE OF PRIVACY PRACTICES.

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (please specify)_____

_____

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