Patient Information Form

Patient Name: _____ Nickname: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Cell Phone Carrier: _____

DOB & Age: _____ Race: _____ Gender: _____

Social Security Number: _____ Email Address: _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

Who is your primary care physician? _____

How did you hear about our office?

☐ www.drbirely.com ☐ Patient Referral: _____ ☐ Magazine: _____

☐ Social Media (i.e. Facebook) ☐ Doctor Referral: _____ ☐ Office Promotion:_____

☐ Other: _____

What is the nature of your visit? _____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Patient/Guardian ☐ Other: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Insurance

Insurance: _____ Policy #: _____ Group ID: _____

Policy Holder Name: _____ Relationship to patient: ☐ Self ☐ Other: _____

Policy Holder Date of Birth: _____ Employer: _____

Secondary Insurance

Insurance: _____ Policy #: _____ Group ID: _____

Policy Holder Name: _____ Relationship to patient: ☐ Self ☐ Other: _____

Assignment and Release

I, _____, have insurance coverage and assign directly all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on
all my insurance submissions.

_____ _____

Signature of Insured/ Guardian Date

Section I : Surgery and Anesthesia History

1. Have you ever had surgery? ☐ No ☐ Yes, please describe:

_____

_____

2. Do you have a blood relative who had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

_____

Section II : Specific Medical History

1. Are you pregnant? ☐ No ☐ Yes
2. Height: _____ Weight: _____ Bra Size: _____

Have you or do you still have:	No	Yes	Description
3. Asthma	☐	☐	
4. Emphysema	☐	☐	
5. High Blood Pressure	☐	☐	
6. Heart Trouble	☐	☐	
7. Hepatitis or Liver Trouble	☐	☐	
8. Kidney Trouble	☐	☐	
9. Diabetes	☐	☐	
10. Epilepsy or Seizures	☐	☐	
11. Stroke	☐	☐	
12. Cancer	☐	☐	
13. Problem Scarring	☐	☐	
14. Have you been advised to or had psychiatric care?	☐	☐	

15. Others Not Listed: _____

Section III : Social History

1. Do you currently smoke or use nicotine products? ☐ No ☐ Yes, how much? _____ # of Years ____

2. Have you used nicotine products in the past? ☐ No ☐ Yes, how much? _____
   # of years _____
   Date stopped: _____

3. Do you encounter second hand smoke? ☐ No ☐ Yes, how much? _____

4. Do you drink? ☐ No ☐ Yes, how much? _____

5. Do you have children? ☐ No ☐ Yes, how many? _____

Section IV: Family History

Have any blood relatives had any of the following?	No	Yes	Description
1. Cancer	☐	☐	_____
2. Bleeding Tendency	☐	☐	_____
3. Severe Allergies	☐	☐	_____

Section V: Medications

1. Are you taking any medications, vitamins or herbal supplements? ☐ No ☐ Yes, please list:

_____

_____

Section VI : Allergies and Sensitivities

1. Do you have a **LATEX** allergy? ☐ No ☐ Yes
2. Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

_____

_____

Section VII: Consent for Photographs

I agree to be photographed before, during and after my treatment by Brent C. Birely, MD and/or Cheryl Sugar PA-C and/or a member of their staff and that these photographs shall be the property of Brent C. Birely, P.A. and may be used as the office deems proper for scientific and educational purposes.

By checking the boxes below, I allow my photographs to be used for:

☒ Medical Chart ☐ In House Office Marketing ☐ Website/Internet Marketing

Section VIII: Consent to Communicate

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Msg w/ Another Person	Preferred Contact Method(s)
☐ Call Work Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐
☐ Call Cell Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐
☐ Call Home Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐
☐ Send Email			☐
☐ Email Appointment Reminders ☐ Email Medical Information ☐ Email Office Discounts, Seminars, and Birthday Offers			
☐ Send Regular Mail to Home Address			☐
☐ Send Text Message – If Ok, please list carrier (e.g., AT&T) :_____			☐
☐ Text Appointment Reminders ☐ Text Office Discounts, Seminars, and Birthday Offers			

If it's ok to leave a message with another person, please list them:

Name: _____ DOB: _____ Relationship: _____ Release Results? ☐ Yes ☐ No

Name: _____ DOB: _____ Relationship: _____ Release Results? ☐ Yes ☐ No

Section IX: Review of Patient Information Form Authorization

I have read the questionnaire and disclosed my medical history to the best of my knowledge.

Patient Name: _____ Date: _____

Patient Signature: _____

HIPAA Information and Consent Form

NEW NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORM ATION ABOUT YOU MA Y BE USED AND DISCLOSED AND HOW YOU CAN G ET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

Uses and Disclosures We May Make Without Written Authorization. We may use or disclose your health information tor certain purposes without your written authorization, including the following:

Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide in format ion about treatment alternatives or services we offer.

Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain pre-authorization or payment for treatment.

Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our state or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR I 64.5 12 or other applicable laws and regulations, including the following:

To avoid a serious threat to your health or safety or the health or safety of others.

As required by state or federal law such as reporting abuse, neglect or certain other events. As allowed by workers compensation laws for use in workers compensation proceedings. For certain public health activities such as reporting certain diseases.

For certain public health oversight activities such as audits, investigations, or licensure actions. In response to a court order, warrant or subpoena in judicial or administrative proceedings.

For certain specialized government functions such as the military or correctional institutions. For research purposes if certain conditions are sat is fled.

In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.

To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

Disclosures We May Make Unless You Object. Unless you instruct us otherwise, we may disclose your information as described below

To a member of your family, relative, friend or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.

Use and Disclosures with Your Written Authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes, for most marketing purposes; or if we seek to sell your information. You may revoke your authorization by submitting written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

Your Rights Concerning Your Protected Health Information. You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

You may request additional restrictions on the use or disclosure of information for treatment, payment, or healthcare operations. We are not required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.

We normally contact you by telephone or mail at your home address, You may request that we contact you by alternative means

or at alternative locations. We will accommodate reasonable requests.

You may inspect and obtain a copy of records that are used to nine decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., it we determine that disclosure may result in harm to you or others.

You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record or if we determine that the record is accurate and complete.

You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that l2-month period.

You may obtain a paper copy of' this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

Changes To This Notice. We reserve the right to change the terms of this Notice at any time, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of current notice the in our reception area. You may obtain a copy of the operative notice from our receptionist or Privacy Officer.

Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying the Privacy Officer. Al I complaints must be in writing. We will not retaliate against you for filing a complaint.

Contact Information. If you have any questions about this Notice, or if you want to object to or complain about use or disclosure or exercise any right as explained above, please contact:
Privacy Officer at Brent C. Birely, P.A.
1300 York Road, Bldg A, Suite 100, Lutherville, MD 21 093, Phone: 410-828-9570, www.Drbirely.com

Effective Date. This Notice is effective September 23, 2013.

Notice of Privacy Practices Signature Form

This signature page is in reference to the **New Notice of Privacy Practices**.

The undersigned certifies that he/she has read the **New Notice of Privacy Practices** and is the patient, or is duly authorized by the patient as the patient's representative. If a more detailed explanation is needed, please refer to www .hhs.Nov/ocr/privacv or call U.S. Department of Health and Human Services Office at 1-877-695-6775.

Patient Name: _____ Date: _____

Patient Signature: _____