

Ardent Administrative Policies

Thank you for choosing Ardent for your healthcare needs. We are committed to high quality, personalized and comprehensive care. We ask that you carefully read the following administrative policies so that the expectations of our organization are understood and we may care for you in the most efficient manner. Please initial underneath each policy acknowledging you have read, understood and agreed to these policies.

Patient / Guarantors Initials: _____

Consent for treatment:

I hereby authorize and acknowledge to work with physicians and other clinicians at Ardent to administer such medications and treatments as may be deemed necessary for the interest and care of me / and/or the child for whom I acknowledge that I am the official legal guardian.

Patient / Guarantors Initials: _____

Guarantee of payment:

I understand that I will solely be responsible to pay the charges of the scheduled visit time. I understand insurance will not cover the cost of the visit.

I understand that I am responsible for the charge of the time of the visit which I scheduled even if I shorten my visit time.

I understand and agree to pay for the visit in full at a time of the appointment. Patient / Guarantors Initials: _____

Delinquent Accounts:

I give permission to charge my credit card for any delinquent payments which are due. All outstanding balances are due in full at the time the services are provided.

I understand if I have a delinquent account over 60 days that my account will be sent to a collection agency with a 30% Collection fee added to the outstanding balance. In the event that services are not paid in full and we must pursue legal action, all attorney fees, court costs and filing fees will be the responsibility of the patient/guarantor.

I understand that late payment or nonpayment of account balances may be grounds for termination of services rendered by Ardent.

Patient / Guarantors Initials: _____

Cancellations:

All appointments must be canceled 24 hours in advance of the appointment time. If an appointment is canceled less than 24 hours in advance, I understand that I will be responsible for the charge of the scheduled visit.

Please be advised that your clinician does not have the ability to waive this fee. If there is a circumstance that is out of the patient's control that caused him/her to miss his/her appointment, then appropriate documentation must be submitted for administrative review. The administrative director will have the sole discretion of whether this fee may be waived.

Patient / Guarantors Initials: _____

Phone consultations:

Phone consultations will be charged at the normal hourly rates. Phone calls without a scheduled appointment will be charged in five minute increments. All phone consultations will be the patient's responsibility. Charges for phone consultation will be due before, but no later than, at the time of the next scheduled visit.

Patient / Guarantors Initials: _____

Medical records charges:

We take time and consideration to ensure your records are kept confidential. There is a standard \$30 fee per medical records that are released outside of physician offices. Please note that all medical record fees must be paid in full before any medical records will be released.

Patient / Guarantors Initials: _____

Completion of forms and letters:

There is no additional charge for forms and letters which are completed during the office visit. However, any forms or letters completed outside the normal visit hours may be charged starting at a thirty dollar service fee. More complex paperwork, such as FMLA, require an appointment to discuss such circumstances.

Patient / Guarantors Initials: _____

Because insurance companies do not honor the time necessary for physicians to spend the necessary time involved in excellent patient care, Ardent has decided not to accept insurance. In order to provide specialty care, this requires your physician to spend sufficient time with you to accurately diagnosis, treat and educate our patients. Our hourly rates are as follows:

Rates:

<p><u>Dr. Sarah Zielsdorf, MD, MS in person or on phone</u> Initial Eval - 2 hours 500.00 Follow up - 1 hour 425.00 Follow up - 30 mins 275.00 <u>Roxana Calafos, FNP in person or on phone</u> Initial Eval 2 hours - 375.00 Follow up - 1 hour 300.00 Follow up- 45 minutes 250.00 Follow up - 30mins 200.00</p>	<p><u>Jennifer Peterson, FNP in person or on phone</u> Initial Eval 2 hours - 375.00 Follow up - 1 hour 300.00 Follow up- 45 minutes 250.00 Follow up - 30mins 200.00 <u>Kelly Johnson, LCPC Health Coach in person or on phone</u> Initial Eval 1 hours- 140.00 Follow up - 1 hour 140.00 Follow up - 30mins 95.00 <u>Phone calls with Dr. Zielsdorf Assistants</u> \$60 per hour (<i>discretionary</i>)</p>
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**Phone consultations are not covered by insurance. The rates for phone calls will be charged the same as the rates for self-pay patients.
**Appointments will be charged the amount of time that the appointment is scheduled for. To make sure everyone receives an appropriate amount of time with their provider, appointments will not go over in time. Appointments that require extra time will need to book an additional follow-up appointment shortly after (this can be in the form of an in person visit or phone consultation).

Please Sign Below to Authorize treatment that you acknowledge your full financial responsibility for services rendered at the time of the visit:

_____	_____
Printed name of the patient	date
_____	_____
Signature of the patient	date
_____	_____
Signature of the guarantor	date
_____	_____
Signature of Ardent staff	date

If the patient is unable to sign please state the reason below:



New Patient Information Sheet

Personal Information (must be filled out completely)

Doctor you are seeing today			Today's Date		
Patient Name					
Home Address					
Street		City		State	Zip
E-Mail Address					
Home Telephone		Work Telephone			
Cell Telephone		Other Telephone			
Patient Date of Birth		Patient Social Security Number			
Driver's License # of the Responsible Party					
Employer					
Employer's Address					
Street		City		State	Zip
Employer's Phone					
Spouse's Name			Spouse's Work Phone		
Referral Source (i.e.: Doctor, phone book, etc)					
Referral Address					
Street		City		State	Zip
Referral Phone Number					
Reason For Your Visit					
Family Physician			Telephone Number		
Whom may we contact in an emergency?					
Telephone number		Relationship			

FINANCIAL AGREEMENT

I, _____ understand that I am being accepted as a cash only patient and that Ardent is a concierge service. I understand services are to be paid in full** at the time of service by cash/ credit or debit card/ or check and that Ardent is not contracted with any insurance company.

Signature of Patient (or Legal Guardian)

Date

Witness (Ardent Staff Member)

Date

**In the event that services are not paid in full and we must pursue legal action, all attorneys' fees, court costs and filing fees will be the responsibility of the patient/guarantor.

Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

INSTRUCTIONS:

Please fill out this form completely. If you are the parent/guardian of the patient, please ask the patient any questions that he/she is able to answer according to his/her age. Otherwise, answer the questions below to the best of your knowledge of the patient. The answers to these questions are very important in allowing us to care for the patient. Some of these questions we ask may seem silly or that they don't apply to you. Regardless, answer all questions to the best of your ability.

Date: _____

Name: _____

Age: _____

Sex: Male/Female Date of birth: _____

If you are the parent/guardian of the patient and completing this form for the patient listed above, please write your name:

_____ Relation to Patient: _____

Who is your primary care physician? _____

May we contact your primary care physician with our initial findings? Yes No

In the event that you request us to contact your primary care physician to coordinate your care, please provide his or her:

Address _____

Phone Number(_____) Fax number _____

*Please make sure to sign an IPD Release of Information Form

Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Previous or referring doctor: _____ Date of last physical exam: _____

PERSONAL HEALTH HISTORY

Childhood illness: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio		
Immunizations and dates or ~year of infection:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital



Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion? Yes No

Allergies/ medication reactions	
Name the Drug	Reaction You Had

Food sensitivities	
Name the Food	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY					
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.					
Exercise	<input type="checkbox"/> Sedentary (No exercise)				
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30min.)				
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30minutes)				
Other Modalities (ex: massage, yoga, meditation, etc)			<input type="checkbox"/> Yes, please list: _____	<input type="checkbox"/> No	
Diet	Are you dieting?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	# of meals you eat in an average day?				
	Rank salt intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low	
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola	
	# Of cups/cans per day?				
Alcohol	Do you drink alcohol?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you considered stopping?			<input type="checkbox"/> Yes	<input type="checkbox"/> No

	Are you prone to "binge" drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you drive after drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tobacco	Do you use tobacco?	<input type="checkbox"/> Yes	
	<input type="checkbox"/> Cigarettes – pks/day	<input type="checkbox"/> Chew -#/day	<input type="checkbox"/> Pipe -#/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	<input type="checkbox"/> Cigars -#/day
Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY					
	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Do you have any children?	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Mother			Yes: [] # _____	<input type="checkbox"/> M	
			No: []	<input type="checkbox"/> F	
Siblings	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
Where are you in your family's birth order?	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
# _____ of _____ children	<input type="checkbox"/> M		Grandmother		
	<input type="checkbox"/> F		<i>Maternal</i>		
	<input type="checkbox"/> M		Grandfather		
	<input type="checkbox"/> F		<i>Maternal</i>		
	<input type="checkbox"/> M		Grandmother		
	<input type="checkbox"/> F		<i>Paternal</i>		
	<input type="checkbox"/> M		Grandfather		
	<input type="checkbox"/> F		<i>Paternal</i>		



MENTAL HEALTH		
Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

WOMEN ONLY		
Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?		

MEN ONLY		
Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times _____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Metabolic Assessment Form

Name: _____ Age: _____ Sex: _____ Date: _____

PART I

Please list the 5 major health concern in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART II

Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea Constipation	0	1	2	3
Hard dry or small stool	0	1	2	3
Coated tongue of "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul smelling gas	0	1	2	3
Category II				
Excessive belching burping or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2	3
Category III				
Stomach pain, burning or aching 1- 4 hours after eating	0	1	2	3
Do you frequently use antacids	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	0	1	2	3

Category IV				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage bloated	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Excessive passage of gas	0	1	2	3
Stool undigested, foul smelling, mucous-like, greasy or poorly formed	0	1	2	3
Frequent urination	0	1	2	
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3
Category V				
Greasy or high fat foods cause distress	0	1	2	3
Lower bowel gas and or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unexplained itchy skin Yellowish cast to eyes	0	1	2	4
Stool color alternates for clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones Have you had your gallbladder removed	0	1	2	3

Category VI				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or started	0	1	2	3
Get lightheaded and if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful	0	1	2	3
Blurred vision	0	1	2	3
Category VII				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst & appetite	0	1	2	3
Difficulty losing weight	0	1	2	3
Category VIII				
Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3
Category IX				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category X				
Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3
Category XI				
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervousness and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats				
Difficulty gaining weight	0	1	2	3
Category XII				
Diminished sex drive	0	1	2	3
Menstrual disorders of lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3
Category XIII				
Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
“Splitting” type headaches	0	1	2	3
Category XIV				
Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males Only)				
Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintain morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional then in the past	0	1	2	3
Category XVI (Menstruating Females Only)				
Are you a menopausal	0	1	2	3
Alternating menstrual cycle lengths	0	1	2	3
Extended menstrual cycle, greater than 32 days	0	1	2	3
Shortened menses, less than every 24 days	0	1	2	3
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne break outs	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XVII (Menopausal Females only)				
How many years have you been menopausal?	0	1	2	3
Do you ever have uterine bleeding since menopause?	0	1	2	3
Hot flashes	0	1	2	3
Mental foginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breast	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal, pain, dryness or itching	0	1	2	3

Authorization to Release Information

_____ I authorize Ardent to request records from the following office:

_____ I authorize Ardent to release records to the following office:

_____ I give ardent permission to speak verbally with the following individual/office:

(Name of Facility or Clinician)/Nature or Relationship to Patient

(Address)

(City, State, Zip)

(Phone Number)

(Fax Number)

The following information on _____

(Patient's Name)

(Date of Birth)

Please release the following information (or specify):

_____ Verbal Information

_____ ALL INFORMATION

_____ Medical Records

_____ Medical History/Physical

_____ Psychologist Evaluation

_____ Social History

Lab Results

Treatment Plan/Patient Progress Discharge Summary

Results of Drug and Alcohol Treatment or Testing

Other (specify) _____

For the Purpose of: _____

Approximate Dates of Service: _____

Release Expiration Date: _____ **Not to exceed 90 days** (Consent subject to revocation at anytime.)

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information used or disclosed pursuant to this authorization may be subject to re disclosure by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosed.
- I will receive a copy of this completed authorization form showing when my records have been sent.

Signature of Patient / Responsible Party if Minor

Date

Signature of Witness

Date

Signature of Clinician#1

Date

Signature of Clinician#2

Date

Signature of Clinician#3

Date

Date Records Sent:

Initials of Records Keeper

*** There is a standard processing fee of \$30.00 for any medical records that are released outside of physician offices. Also, all patient responsibility balances must be paid in full before any medical records are released. ***

Notice of Privacy Practices Patient Acknowledgement

Patient Name: _____ **Date of Birth:** _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Type of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
 - The rights to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
 - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
 - The right to receive confidential communications of protected health information.
 - The right to inspect and copy protected health information.
 - The right to amend protected health information
 - The right to receive an accounting of disclosures of protected health information
 - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ **Date:** _____

Relationship to patient (if signed by a personal representative of patient): _____

PATIENT COPY

Notice of Privacy Practices Patient Acknowledgement

Patient Name: _____ **Date of Birth:** _____

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- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
 - The rights to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
 - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
 - The right to receive confidential communications of protected health information.
 - The right to inspect and copy protected health information.
 - The right to amend protected health information
 - The right to receive an accounting of disclosures of protected health information
 - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ **Date:** _____

Relationship to patient (if signed by a personal representative of patient): _____