CARNETT CLINIC LLC

ADULT FAMILY PRACTICE
OCCUPATIONAL MEDICINE
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NEW PATIENT APPLICATION

DEMOGRAPHICS

Last: _____ First: _____ Middle: _____

Date of Birth: _____ Gender: [Male | Female]

Mailing Address: _____

City: _____ State: _____ Zip: _____

Daytime #: _____ Cell #: _____

Email Address: _____

Marital Status: (Married / Single / Divorced / Widowed) Preferred Pharmacy: _____

Employer: _____ Employer's Phone #: _____

Emergency Contact: _____ Relationship: [Parent | Spouse | Sibling | Child | Other]

Emergency #: _____ If Other, Please Specify: _____

INSURANCE

A) Primary: _____

ID# (Required): _____ Group/Policy# _____

Is Patient the Policy Holder? [Yes | No] [If not, please continue to next line.]

Insured Name: _____ Insured DOB: _____

Insured Address: _____

City: _____ State: _____ Zip: _____

Insured Relationship to Patient: _____ Insured SSN: _____

Insured Phone #: _____

B) Secondary: _____

ID# (Required): _____ Group/Policy# _____

Insured Name: _____ Insured DOB: _____

Insured Address: _____

City: _____ State: _____ Zip: _____

Insured Relationship to Patient: _____ Insured SSN: _____

Insured Phone #: _____

Responsible Party Signature: _____ **Date:** _____

PATIENT MEDICAL HISTORY

NAME: _____ DATE OF BIRTH: _____

Previous Surgeries [Include Year]: _____

_____

Allergies & Reactions: _____

Ongoing Medical Problems: _____

_____

Current Medications and Dosages: _____

_____ [Attach additional sheet if necessary]

FATHER: [Good Health] [Deceased] [Undetermined]

Allergies	Hay Fever	Anemia	Bleeding Disorders	Cancer	Diabetes Type I	Diabetes Type II	Gout	Hypercholesterolism
Hypertension	Obesity	Glaucoma	Vision Impairment	Hearing Impairment	Thyroid Disease	Asthma	Emphysema	TB
Heart Disease	Ulcers	Bowel Problems	Gallstones	Prostate	Arthritis	Osteoporosis	Strokes	Epilepsy/Seizures
Migraine	Depression	Suicide	Mental Illness	Alcoholism	Drug Addiction	Alzheimer's	Skin Disease	Birth Defects

Other: _____

MOTHER: [Good Health] [Deceased] [Undetermined]

Allergies	Hay Fever	Anemia	Bleeding Disorders	Cancer	Diabetes Type I	Diabetes Type II	Gout	Hypercholesterolism
Hypertension	Obesity	Glaucoma	Vision Impairment	Hearing Impairment	Thyroid Disease	Asthma	Emphysema	TB
Heart Disease	Ulcers	Bowel Problems	Gallstones	Prostate	Arthritis	Osteoporosis	Strokes	Epilepsy/Seizures
Migraine	Depression	Suicide	Mental Illness	Alcoholism	Drug Addiction	Alzheimer's	Skin Disease	Birth Defects

Other: _____

SIBLINGS: [Good Health] [Deceased] [Undetermined]

Allergies	Hay Fever	Anemia	Bleeding Disorders	Cancer	Diabetes Type I	Diabetes Type II	Gout	Hypercholesterolism
Hypertension	Obesity	Glaucoma	Vision Impairment	Hearing Impairment	Thyroid Disease	Asthma	Emphysema	TB
Heart Disease	Ulcers	Bowel Problems	Gallstones	Prostate	Arthritis	Osteoporosis	Strokes	Epilepsy/Seizures
Migraine	Depression	Suicide	Mental Illness	Alcoholism	Drug Addiction	Alzheimer's	Skin Disease	Birth Defects

Other: _____

DO YOU CURRENTLY SEE ANY SPECIALISTS? IF YES, WHO? _____

_____

TOBACCO USE? [NEVER SMOKER / FORMER SMOKER / CURRENT SMOKER] IF SO, HOW OFTEN?_____

ALCOHOL USE? [YES / NO] HOW OFTEN? _____

ILLICIT DRUG USE? [YES / NO] HOW OFTEN? _____

MARITAL STATUS: [MARRIED / SINGLE / DIVORCED / WIDOWED] NUMBER OF CHILDREN: _____

FEMALES ONLY — NUMBER OF PREGNANCIES: _____ *NUMBER OF LIVE BIRTHS:* _____

OCCUPATION: _____ DO YOU HAVE A LIVING WILL?: [YES / NO]

CARNETT + CLINIC

LABORATORY/RADIOLOGY TESTING POLICY

While efforts are made to contact you regarding the results of your lab/radiology testing (or any test performed outside of the clinic and ordered through us), **we kindly ask that you contact us within a few days of your test to follow up on your results and ensure they have been received.**

Lack of communication from our clinic ***does not imply*** that your results were normal— instead, it may mean that your results were not properly received from the testing facility.

For your convenience, the results of laboratory testing performed through Sonora Quest and LabCorp are also available to view through your Patient Portal on Patient Fusion.

I acknowledge this policy and agree to follow up on my test results within a few days of completing them.

Patient Name: _____ Date of Birth: _____

Signature: _____ Today's Date: _____

NOTICE TO PATIENT

Carnett Clinic, LLC will **not** provide inpatient hospital care or nursing home admissions/care.

Specialist care is intended for patients requiring a specific type of treatment.

In rare instances, where hospitalization is necessary, we will either:

A) Refer you to the appropriate specialist,

Or...

B.) Refer you to the emergency department for immediate evaluation.

In spite of this, our services will continue to provide for you and your family.

☐: **I acknowledge the aforementioned information.**

_____	_____
PRINT NAME	DATE OF BIRTH
_____	_____
RESPONSIBLE PARTY SIGNATURE	DATE

INSURANCE AUTHORIZATION NOTICE

I hereby authorize the release of any information, including specific and detailed medical records, diagnosis, etcetera, acquired in the course of my examination or treatment to my insurance company.

I also authorize the payment of insurance benefits directly to the Carnett Clinic, L.L.C or any of its employed physicians.

I also agree to pay for any coinsurances, copays, and deductibles that may incur with my insurance.

I understand that once my insurance is processed, I am ultimately responsible for charges not covered.

I agree that if I do not have insurance, I must pay for the office visits in full.

I agree, if necessary, to place the account with a collection agency to collect the balance due. An additional 35% of the principle balance due will be added to help defray the cost of collection. Interest will accrue at a rate of 18% per annum on the principle balance. Should legal action be necessary, I understand I am responsible for reasonable attorney fees, interest, and other court costs. I also understand a credit report will be pulled for the sole purpose of collecting delinquent accounts.

_____ _____

PRINT NAME DATE OF BIRTH

_____ _____

RESPONSIBLE PARTY SIGNATURE DATE

RESTRICTION AND SHARING OF MEDICAL INFORMATION

I, _____, request the following restrictions to the use or disclosure of my protected health information, if any: _____

_____

Carnett Clinic, LLC may discuss my medical condition/information with the following:

1) Spouse: [Yes | No]
2) Parents: [Yes | No]
3) Children: [Yes | No]
4) Friends: [Yes | No]

☐ : Do not discuss my medical condition or information with anyone at all.

_____

Please list the names of the individuals we may discuss with concerning your protected health information, if any.

Name of Individual	Relationship with Patient
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

RESPONSIBLE PARTY SIGNATURE DATE

CARNETT CLINIC

PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize Carnett Clinic, LLC to transfer, release, or obtain information on:

_____ _____
PATIENT NAME DATE OF BIRTH

OBTAIN FROM:

_____
PHYSICIAN/INSTITUTION

_____
ADDRESS

_____
CITY, STATE, ZIP

_____
PHONE FAX

SEND OR FAX TO:

_____
PHYSICIAN/INSTITUTION

_____
ADDRESS

_____
CITY, STATE, ZIP

_____
PHONE FAX

FOR THE PURPOSE OF:

_____

PLEASE CHECK SPECIFIC INFORMATION REQUESTED:

_____ ALL MEDICAL RECORDS (to include all listed below except billing records)

_____ BILLING RECORDS _____ MENTAL HEALTH _____ DRUG/ALCOHOL TREATMENT

_____ COMMUNICABLE DISEASE INFO _____ OTHER

This authorization will expire one year from the date of signature. When your information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer by protected by the federal HIPAA Privacy Rule. You have the right to revoke this authorization at any time in writing.

I HAVE READ AND UNDERSTAND THIS AUTHORIZATION:

_____ _____
PATIENT OR LEGAL REPRESENTATIVE DATE

_____ _____
WITNESS DATE

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

A. I hereby acknowledge receipt of Carnett Clinic, LLC's Notice of Privacy Practices.

_____ _____

PRINT NAME DATE OF BIRTH

_____ _____

RESPONSIBLE PARTY SIGNATURE DATE

B. I am the parent or legal guardian of _____.

I hereby acknowledge receipt of Carnett Clinic, LLC's Notice of Privacy Practices with respect to the patient:

_____ _____

MINOR'S PRINTED NAME DATE OF BIRTH

_____ _____

RESPONSIBLE PARTY PRINTED NAME RELATIONSHIP TO PATIENT

_____ _____

RESPONSIBLE PARTY SIGNATURE DATE

[Notice of Privacy Practices is provided on the following page]

CARNETT CLINIC, LLC
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 read the information below carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information (PHI) is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: Treatment, payment, and health care operation:

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this is a primary care doctor referring you to a specialist doctor.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- Healthcare operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure it continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identified information. We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fund raising communications, that may be of interest to you. You do have the right to “opt out” with respect to receiving fund raising communications from us.

The Following Use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you.

- Most uses and disclosure of psychotherapy notes
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations
- Disclosures that constitute a sale of PHI under HIPAA
- Other uses and disclosures not described in this notice

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

[CONTINUED ON NEXT PAGE]

CARNETT CLINIC, LLC
NOTICE OF PRIVACY PRACTICES [CONTINUED]

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or another person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information by alternative means or at alternative locations

- The right to inspect and copy your PHI

- The right to amend your PHI

- The right to receive an accounting of disclosures of your PHI.

- The right to obtain a paper copy of this notice from us upon request.

- The right to be advised of your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket," in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your protected health information and to provide you with a notice of our legal duties and our privacy practice with respect to PHI.

This notice is effect as of September 23, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy practice and to make the new notice provision effective for all PHI that we maintain.

We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with our office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

For more information, please contact the Practice Compliance Manager, Nicholas Powell, at 520-439-5186.