Patient Demographics & Medical History

Carnett Clinic, L.L.C

▪ Family Practice ▪ Occupational Medicine
▪ FAA Examiner ▪ CDL Medical Examiner

▪ Mark C. Carnett, D.O. ▪ Laura Goethe, FNP ▪ Lorena Warren, FNP

Phone: 520-439-5186 Fax: 520-439-4466
Email: forms@carnettclinic.com

Demographics

Last: First: Middle:

DOB: 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# (Mandatory): 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# (Mandatory): Group/Policy#

Insured Name: Insured DOB:

Insured Address:

City: State: Zip:

Insured Relationship to Patient: Insured SSN:

Insured Phone #:

Responsible Party Signature: **Date:**

Name: _____ *DOB*: _____

List Previous Surgeries for Patient [Include Year]: _____

_____

Allergies & Reactions: _____

_____

Ongoing Medical Problems: _____

_____

Current Medications: _____

_____ [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: _____

Tobacco Use: [Yes | No] If yes, How often?: _____

Alcohol Use: [Yes | No] If yes, How often?: _____

Illicit Drugs: [Yes | No] If yes, How often?: _____

Marital Status: [Married | Single | Divorced | Widowed]

# of Children: _____ *Females Only*→ # of Pregnancies: _____ # of Live Births: _____

Occupation: _____ Do You have a Living Will: [Yes | No]

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Notice to our Patients

The Carnett Clinic 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.

Printed Patient Name: _____ DOB: _____ Date: _____

Responsible Party Signature: _____ Relation to Patient: _____

Carnett Clinic, L.L.C.

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 understand that in the event, it is 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.

Printed Name: _____

Signature of Responsible Party: _____

Date: _____

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Request for Restriction and Sharing of Medical Information

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

The Carnett Clinic 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]

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

Name of Individual	Relationship with Patient

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

Patient Signature: _____ Date: _____

Receipt of Notice of Privacy Practices Written Acknowledgement Form

A.

I am a patient of Carnett Clinic, L.L.C. I hereby acknowledge receipt of Carnett Clinic's Notice of Privacy Practices

Printed Name: _____

Signature of Responsible Party: _____

Date: _____

B.

I am a parent or legal guardian of _____. I hereby acknowledge receipt of Carnett Clinic's Notice of Privacy Practices with respect to the patient:

Minor's Name: _____

Relationship to patient: [Parent | Legal Guardian]

Signature of Responsible Party: _____

Date: _____

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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.

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.

Feel free to contact the Practice Compliance Manager Nicholas Powell at 520-439-5186 for more information.