Patient Profile

First Name: ____________________ Middle Initial ______ Last Name:________________________

Permanent Address:

____

ADDRESS CITY, STATE, ZIP

Home Phone: ____________________________ Cell Phone: __________________________

Date of birth: ___________________ Sex: ( ) M ( ) F Social Security# _______________________

Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Widowed ( ) Domestic Partner

E-mail Address: _______________________________________

Emergency contact: ___________________________________ Relationship:___________________

NAME PHONE NUMBER

Do we have permission to contact this person regarding matters concerning your care? ( ) Yes ( ) No

Guarantor

First Name: _____________________ Middle Initial: ______ Last Name:________________________

Permanent Address:

____

ADDRESS CITY, STATE, ZIP

Home Phone: ____________________________ Cell Phone: __________________________

Date of birth: _____________________ Sex: ( ) M ( ) F Social Security# __________________

Preferred Language (check one): ( ) English ( ) Spanish ( ) Other: ______________________

Primary Care Physician (PCP): ____

Preferred Pharmacy

Name: _____________________Address: ___________________Phone#:____________________

Mail Order? ( ) Yes ( ) No

Electronic Prescriptions: Our electronic medical record program accesses your prescription/medication history in order for us to safely prescribe your medication. By signing this, you authorize us to do so.

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have insurance coverage, I am responsible for payment of services. I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim. I request that payment of authorized Medicare benefits be made on my behalf to the doctor or group indicated on the claim for a service furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

Signature of patient or responsible party: ___________________________ *Date:*________________

PATIENT RECORD OF DISCLOSURES

DR. PAUL R. LUCAS
DR. VINCENZO PALMIERI
DR. AMANDA M. BOZICH

PATIENT NAME: ___________________________ DATE: ___________________

In general, the HIPAA rule gives the right to request a restriction on uses and disclosures of their protected health information (PHI) to the individual. The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

- o PHONE-HOME: ______________________________
- o PHONE-CELL : ______________________________
  - o OK TO LEAVE A MESSAGE WITH DETAILED INFORMATION
  - o LEAVE MESSAGE WITH CALL-BACK PHONE NUMBER ONLY
- o WRITTEN COMMUNICATION
  - o OK TO MAIL MY HOME ADDRESS
  - o OK TO MAIL MY WORK/OFFICE
    - ▪ WORK ADDRESS: ________________________________
      ____
      ____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures. Healthcare entities must keep records of PHI disclosures.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

________________________________ ________________________________
PATIENT SIGNATURE DATE

________________________________ ________________________________
NAME (PRINTED) DATE OF BIRTH