Access
HEALTH PROFESSIONALS

Mailing Address: 484 E. Carmel Dr., Ste. 309, Carmel, IN 46032
Telephone: 317.324.8802//Fax: 317.886.8684

Date_____ Primary Phone (___)_____ Secondary Phone (___) _____

PATIENT INFORMATION

Name_____ SS/HIC/Patient ID #_____
Last Name First Name Middle Initial

Address_____ E-mail_____

City _____ State_____ Zip_____

Sex □ M □ F Age_____ Birthdate_____ □ Married □ Widowed □ Single □ Minor

□ Separated □ Divorced □ Partnered for _____years

Patient Employer_____ Occupation_____

Employer Address_____ Employer Phone (____)_____

In case of emergency who should be notified?_____ Phone (____)_____

PRIMARY INSURANCE

Person Responsible for Account_____
Last Name First Name Middle Initial

Relation to Patient_____Birthdate_____ Soc. Sec. #_____

Address (if different from patient's)_____ Phone (____)_____

City_____ State_____ Zip_____

Person Responsible Employed by_____ Occupation_____

Business Address_____ Business Phone (____)_____

Insurance Company_____

Contract #_____ Group #_____ Subscriber #_____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? □ Yes □ No

Subscriber Name_____ Birthdate_____ Relation to Patient_____

Address (if different from patient's)_____ Phone (____)_____

City_____ State_____ Zip_____

Subscriber Employed by_____ Business Phone (____)_____

Business Address_____ Soc. Sec. #_____

Insurance Company_____

Contract #_____ Group #_____ Subscriber #_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to
Name of Insurance Company(ies)

Access Health Professionals all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named doctor(s) may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Guardian, or Personal Representative Date

_____ _____
Please Print Name of Patient, Guardian, or Personal Representative Relationship to Patient

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW "PROTECTED HEALTH INFORMATION" ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Access Health Professionals believes your health information is personal and is committed to protecting the privacy of the health information it creates or receives about you. Access Health Professionals has a professional and legal obligation to respect your confidentiality.

"Protected health information" is your health information or other individually identifiable information, such as demographic data, that may identify you. Protected health information relates to your past, present or future physical or mental health or condition related to healthcare services.

This Notice of Privacy Practices describes how Access Health Professionals may use and disclose your protected health information to carry out treatment, for payment, for healthcare operations and for other purposes permitted or required by law. This Notice also describes certain rights that you may have to access your protected health information. Access Health Professionals is required to abide by the terms of this Notice of Privacy Practices.

The terms of this Notice may change at any time. The new Notice will apply to all protected health information acquired after it goes into effect. Upon your request, Access Health Professionals will provide you with any historical Notice of Privacy Practices.

Uses and disclosures of protected health information that do not require your authorization

Your protected health information may be used and disclosed by Access Health Professionals, its staff and others outside of its offices who are involved in your care and treatment for the purpose of providing healthcare services to you. Your protected health information may also be used and disclosed to pay your healthcare bills and to support the operations of Access Health Professionals. The following list, by way of example rather than limitation, explains certain uses and disclosures of your protected health information that Access Health Professionals is permitted to make.

Treatment

Access Health Professionals will use and disclose your protected health information to provide, coordinate or manage your healthcare and any related services. This includes the coordination or management of your healthcare with another provider. For example, Access Health Professionals may disclose your protected health information, as minimally necessary, to a home health agency that provides care to you.

Access Health Professionals will also disclose health information to physicians or other healthcare providers who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, Access Health Professionals may disclose your protected health information from time to time to another physician or healthcare provider (e.g., specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your healthcare diagnosis or treatment. As another example, a doctor treating you for a broken leg may need to know if you have diabetes, because diabetes may slow the healing process.

Payment

Access Health Professionals may use and disclose your protected health information as necessary to obtain payment for healthcare services. This may include providing it to your health insurance plan before it approves or pays for recommended healthcare services so that it may make a determination of eligibility or coverage for insurance benefits. It may also include supplying the information to review services provided to you for medical necessity and to undertake utilization-review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health insurance plan to obtain prior plan approval.

Healthcare operations

Access Health Professionals may use or disclose your protected health information in order to support its business activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students,

licensing, and conducting or arranging for other business activities. Access Health Professionals may share your protected health information with "business associates," or third-party organizations that perform services such as billing or transcription services on behalf of Access Health Professionals. Access Health Professionals has written contracts with its business associates to protect the privacy of your protected health information, and business associates are also required by law to comply with the same privacy and security requirements that apply to Access Health Professionals.

Access Health Professionals may use and disclose your protected health information to tell you about appointments and other matters related to your care. It may contact you by mail, telephone or email. Access Health Professionals may leave voice messages at the telephone number you provide, and it may respond to your emails.

Access Health Professionals may use and disclose medical information to tell you about possible treatment options, new services or alternatives that may be relevant to your healthcare.

Hospital directory

Access Health Professionals may include limited information about you in the hospital directory while you are a patient. This information may include your name, location in the hospital and your general condition (e.g., fair or stable). This directory information may be released to people who ask for you by name so that they may generally know how you are doing. If you do not want this information shared, please let Access Health Professionals know. Also, your religious affiliation may be given to a member of the clergy even if they do not ask for you by name.

Individuals involved in your care or payment for your care

Unless you indicate otherwise, Access Health Professionals may disclose to a relative, a close friend, or any other person you identify, the portion of your protected health information that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, Access Health Professionals may disclose such information as necessary for your healthcare, if, based on its professional judgment, Access Health Professionals determines it is in your best interest. Access Health Professionals may disclose protected health information to notify or assist in notifying a family member or personal representative (or any other person who is responsible for your care) of your location, general condition or death. Finally, Access Health Professionals may use or disclose your protected health information to an authorized public or private entity to assist in disaster-relief efforts.

To avert a serious threat to health or safety

Access Health Professionals may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety, or the health and safety of another person or the public. However, any disclosure would only be to someone who is able to help prevent the threat.

Organ and tissue donation

Access Health Professionals may release protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ-donation bank as necessary to facilitate organ or tissue donation and transplantation.

Workers' Compensation

Access Health Professionals may release protected health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Public health risks and patient safety issues

Access Health Professionals may disclose protected health information about you for public health activities and purposes to a public health authority that is permitted by law to receive the information. For example, disclosures may be made for the purposes of preventing or controlling disease, injury or disability; to report births and deaths; to report reactions to medications or problems with products; and to notify people of recalls of products that they may be using.

Communicable diseases

Access Health Professionals may disclose or use your protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition, and to comply with state-mandatory disease reporting, such as cancer registries.

Abuse or neglect

Access Health Professionals may disclose your protected health information to a public health authority authorized by law to receive reports of child abuse or neglect, and to notify the appropriate government authority if Access Health Professionals believes a patient

has been the victim of abuse, neglect or domestic violence. Access Health Professionals will only make this disclosure when required or authorized by law.

Health oversight activities

Access Health Professionals may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the healthcare system, government benefit programs and compliance with civil rights laws.

Food and Drug Administration (FDA)

Access Health Professionals may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety or effectiveness of FDA-regulated products or activities, which include: to report adverse events, product defects or problems; biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post-marketing surveillance, as required.

Legal proceedings

Access Health Professionals may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) or, in certain conditions, in response to a subpoena, discovery request or other lawful process.

Law enforcement

Access Health Professionals may disclose protected health information for certain law-enforcement purposes, such as: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness or missing person; about the victim of a crime, if under certain limited circumstances, it is unable to obtain the person's agreement; about a death it believes may be the result of criminal conduct; about criminal conduct at the hospital; and, in emergency circumstances, to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, medical examiners and funeral directors

Access Health Professionals may release protected health information to a coroner or medical examiner, for example, to identify a deceased person or determine the cause of death. It may also release protected health information about patients of the hospital to funeral directors as necessary to carry out their duties.

Military activity and national security

Access Health Professionals may use or disclose the protected health information of individuals who are armed forces personnel for activities deemed necessary by appropriate military-command authorities, for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits or to foreign military authority if you are a member of that foreign military service. It may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the president or others legally authorized.

Inmates

If you are an inmate of a correctional institution or under the custody of a law enforcement official, Access Health Professionals may release protected health information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with healthcare, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

Uses and disclosures of protected health information that do require your authorization

As described above, Access Health Professionals will use your protected health information and disclose it outside of Access Health Professionals for treatment, payment, healthcare operations and when permitted or required by law. Access Health Professionals will not disclose or sell your protected health information for marketing purposes. In addition, certain disclosures of your psychotherapy notes, mental health records, and drug and alcohol abuse treatment records may require your prior written authorization.

Your rights regarding your protected health information

Right to inspect and copy

You have the right to inspect and obtain an electronic or paper copy of your protected health information that may be used to make decisions about your care. This includes medical and billing records, but does not include psychotherapy notes. To inspect and obtain a copy of your protected health information, you must submit your request in writing to the Privacy Officer at Access Health Professionals. If you request a copy of the information, Access Health Professionals may charge a fee for the cost of copying, mailing or other supplies associated with your request.

Access Health Professionals may deny your request to inspect and copy in some limited circumstances. If you are denied access to protected health information, you may request that the denial be reviewed. Another licensed healthcare professional chosen by Access Health Professionals will review your request and the denial. The person conducting the review will not be the person who denied your request. Access Health Professionals will comply with the outcome of the review.

Right to amend

You have a right to request an amendment of the health information that Access Health Professionals has in its records. Your request for an amendment must be made in writing, including a reason for the request, and submitted to the Privacy Office at Access Health Professionals. Access Health Professionals may deny a request for an amendment if it is not in writing and does not include a reason to support the request or requests for amendment of information that: was not created by Access Health Professionals; is not part of the protected health information kept by Access Health Professionals; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

Right to receive notification

An individual will receive a notification if his or her unsecured protected health information is breached.

Right to an accounting of disclosures

You have the right to request an accounting of disclosures. This is a list of disclosures Access Health Professionals has made of your protected health information, excluding disclosures for treatment, payment, healthcare operations or disclosures you authorized in writing. To request an accounting of disclosures, submit your request in writing and include the specific time period to the Privacy Officer at Access Health Professionals. Access Health Professionals will not list disclosures made earlier than six years before your request.

The first accounting of disclosure in a 12-month period is free. Additional accounting of disclosures may cost a fee; you will be notified in advance of any cost involved so that you may choose to withdraw or modify your request before incurring a cost.

Right to request restrictions

You have the right to request a restriction on the ways your protected health information is used or disclosed. To request a restriction, submit your request in writing to the Privacy Officer at Access Health Professionals. The request should include what information you want to limit, whether you want to limit use or disclosure, or both, and to whom you want the limits to apply—for example, disclosures to your spouse. Access Health Professionals is not required to agree to your request. If it does agree, it will comply with your restriction unless the information is needed to provide emergency medical treatment.

Access Health Professionals will agree to restrict disclosures of your health information to your health insurance plan for payment and healthcare operations purposes (not for treatment) if the disclosure pertains solely to a healthcare item or service for which you paid in full.

Right to request confidential communication

You have the right to request that Access Health Professionals communicate with you about healthcare matters in a certain way or at a certain location. For example, you can request that you are only contacted at work or at a specific address. Such requests should be made in writing to the Privacy Officer at Access Health Professionals and should specify how or where you wish to be contacted. Access Health Professionals will accommodate all reasonable requests.

Right to a paper copy of this Notice

You have the right to a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically.

Other uses of protected health information

Other uses and disclosures of your protected health information not covered by this Notice or allowed by law will be made only with your written permission. If you provide permission to use or disclose protected health information, you may revoke that permission, in writing, at any time. If you revoke your permission, Access Health Professionals will no longer use or disclose protected health information about you for the reasons covered by your written authorization. Access Health Professionals is unable to take back any disclosures it may have already made with your permission.

Changes to this privacy Notice

Access Health Professionals reserves the right to change this Notice and to make the revised or changed Notice effective for protected health information it already has about you, as well as any information it receives in the future. The revised Notice of Privacy Practices may be posted on the Access Health Professionals website; you may also request that a revised copy be sent to you in the mail or obtain one at the time of an appointment at Access Health Professionals.

Questions or complaints

If you have questions and would like additional information, you may contact our practice's Privacy Officer at *317.324.8802* or e-mail us at *privacy@accesshealthpros.com*

If you believe that your privacy rights have been violated, you may file a complaint with us. These complaints must be filed in writing. When completed the complaint should be returned to the Business Office, Access Health Professionals, 484 E. Carmel Drive, Suite 309, Carmel, IN, 46032. You may file a complaint with the Secretary of the Federal Department of Health and Human Services. There will be no retaliation for filing a complaint.

I acknowledge receipt of Access Health Professionals Notice of Privacy Practices.

_____
Patient's Name (please print)

_____ _____
Patient's Signature Date

Consent for the Use or Disclosure of Health Information for Treatment, Payment, or Health Care Operations

I understand that as part of my health care, ACCESS HEALTH PROFESSIONALS, and its affiliated companies create and maintain health records containing information about my individual health history, symptoms, examination, and test results, diagnoses, treatments provided to me, plans for future care or treatment and payment for care provided to me. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among many health professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill and seeking payment for the services Access Health Professionals provides to me.
- A means by which a third-party payer, including Medicare and Medicaid, can verify that services billed were actually provided.
- A tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals.
- A purpose of clinical research, where no identifying data will be released. Under conditions where identifying data is required, separate consent will be obtained.

I understand and have been or will be provided with a written Notice of Access Health Professionals Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices prior to signing this Consent. I understand that Access Health Professionals reserves the right to change its Notice of Privacy Practices to reflect changes in the way it handles health records, and that I have a right to request a copy of such new Notice.

I understand I have the right to:

- Request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations. Access Health Professionals is not required to agree to the restrictions requested, but Access Health Professionals will be bound by any restrictions to which it agrees.
- Revoke this consent in writing, except to the extent that Access Health Professionals has already taken action in reliance thereon. I understand that if I revoke my consent, then Access Health Professionals may no longer be able to treat me.

_____

Patient's Name/Patient's Signature/Date

Please list those family members with whom we may discuss your medical condition:

_____

_____

_____

_____

Access HEALTH PROFESSIONALS

HEALTH HISTORY- CONFIDENTIAL

Patient Name: _____ Today's Date:_____

Date of Birth: _____ Date of Last Physical Exam:_____

What is your reason for visit? _____

Please ✓if you have ever had any of the following:

Eyes, Ears, Nose and Throat	
Deafness	
Other Hearing Problems	
Blindness	
Cataract	
Glaucoma	
Other Visual Problems	

Lungs	
Lung Disease	
Asthma	
Emphysema	
Chronic Bronchitis	
COPD	
Tuberculosis	
Cough	
Pneumonia	

Heart	
Heart Disease	
Heart Attack	
Congestive Heart Failure	
Enlarged Heart	
Angina	
High Blood Pressure	
Irregular Heart Beats	
Pacemaker	
AICD	
Cardiac Catheterization	
Angioplasty	
Valvular Disease	
Other Heart Disease	

Kidney and Genital	
Kidney Failure	
Dialysis	
Kidney Stones	
Prostate Problems	
Prostate Cancer	
Venereal Disease	
Other Kidney Disease	
Pregnancy	

Stomach and Bowel	
Stomach Ulcers	
Colon Cancer	
Jaundice	
Liver Disease	
Hepatitis	
Irritable Bowel Syndrome	
Other Stomach Disorder	
Other Bowel Disorder	

Muscles and Bones			
Skin Disorder			
Joint Disease			
Rheumatoid Arthritis			
Osteoarthritis			
Broken Bones			

Nervous System	
Stroke	
Epilepsy or Seizures	
Intellectual Disability	
Brain Injury	
Nerve Injury	
Memory Problems	
Disk Disease	

Endocrine	
Thyroid Disease	
Diabetes	
Adrenal Disease	

Other Problems	
HIV or AIDS	
Psychiatric Disease	

Past Surgeries:

Type/Date

_____

_____

_____

Past Hospitalizations:

Why/When

_____

_____

_____

Any Past Transfusions: (blood, platelets, plasma, albumin)?

_____

_____

Other:

_____

_____

_____

_____

_____

FAMILY HISTORY

Father:	□ Kidney Disease □ Diabetes □ Coronary Artery Disease □ Congestive Heart Failure □ High Blood Pressure □ Stroke
Mother:	□ Kidney Disease □ Diabetes □ Coronary Artery Disease □ Congestive Heart Failure □ High Blood Pressure □ Stroke
Siblings:	□ Kidney Disease □ Diabetes □ Coronary Artery Disease □ Congestive Heart Failure □ High Blood Pressure □ Stroke
Children:	□ Kidney Disease □ Diabetes □ Coronary Artery Disease □ Congestive Heart Failure □ High Blood Pressure □ Stroke

Comments or additional notes:

_____

_____

SOCIAL HISTORY

Marital Status:	□ Married □ Single □ Divorced □ Widowed □ Separated
Living Status:	□ Alone □ With spouse □ With significant other □ With caregiver/family
Residence:	□ Home □ Apartment □ Nursing home □ Assisted living □ Hospice
Occupation:	□ Retired □ Presently employed (list) _____ □ Student □ Disability
Highest Grade Completed:	□ Elementary □ High School □ Some college □ College degree □ Post graduate degree
Tobacco Use:	□ Never □ Quit smoking □ Active smoker Packs per day _____
Alcohol Use:	□ Never □ Quit drinking □ Occasional social drinker □ Regular alcohol
Illicit Drug Use:	□ Never used □ Quit drug use □ Active drug use

Comments or additional notes:

_____

_____

REVIEW OF SYSTEMS

□ Fever □ Chills □Weight gain □ Weight loss □ Weakness □ Cough □ Sore throat
□ Vision problems □ Cataracts □ Eye pain □ Ear pain □ Nose bleeds □ Sinus problems
□ Chest pain □ Irregular heart beat □ Swelling □ Shortness of breath □ Blood in sputum □ Pain with breathing
□ Stomach pain □ Heartburn □ Nausea □ Vomiting □ Diarrhea □ Constipation
□ Urine urgency □ Urine frequency □ Burning with urination □ Difficult urination
□ History of falls □ Arm or leg weakness □ Back pain □ Joint pain
□ Rash □ Bruises or lesions □ Itching □ Seasonal allergies □ Allergic reaction to medications or allergens (list below)
□ Headache □ Dizziness □ Seizures □ Numbness
□ Depression □ Anxiety □ Insomnia
□ Heat/Cold intolerance □ Hair loss □ Bleeding gums □ Anemia □ Easy bruising

Comments or additional notes:

_____

_____

_____

_____

MEDICATION LIST

Please list all medications prescribed by a physician, over-the-counter, and supplements (examples: aspirin, vitamins, fish oil, etc.).

Patient Name: _____ Date: _____

NAME OF MEDICATION	STRENGTH	DIRECTIONS FOR TAKING THIS MEDICATION	ARE YOU TAKING IT AS DIRECTED Y/N

Access
HEALTH PROFESSIONALS

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I (the undersigned) hereby authorize Access Health Professionals to disclose/obtain the following identified information. Please check all that apply. **NOTE: ITEMS WITH * ARE REQUIRED FIELDS.**

***Name of Patient**	***Date of Birth**
Other Names used during treatment (if applicable)	Social Security Number
***Address**	***City, State, Zip Code**
***Dates of Treatment Requested** _____	***Purpose of Disclosure**

INFORMATION TO BE RELEASED (limit request to the minimum necessary)

___ ER Report ___ Discharge Summary ___ Operative/Procedure Report ___ History & Physical Assessment

___ Dictated Consults ___ Lab/Pathology Reports ___ Therapy Notes ___ Radiology Reports ___ Other (specify)

RELEASE INFORMATION TO (IF NOT PATIENT):

Name:

_____

Address:

_____

o I understand that the Protected Health Information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

o I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the address below. I understand that a revocation is not effective to the extent that Access Health Professionals has relied on the use of disclosure of the protected health information. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that this authorization will expire in sixty (60) days unless otherwise specified here. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

o I understand that I have the right to refuse to sign this authorization. By signing this authorization, I acknowledge that I have read and understand this authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this authorization. Access Health Professionals will not condition my treatment, payment, enrollment (if applicable) in a health plan, or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I am responsible for paying the applicable fees, if any. I have the right to an estimate of the fees before receiving a copy of the records.

***Signature of Patient, Guardian, Parent, or Health Representative**	***Date Signed**

Relationship to patient (if other than self or your minor child we will require proof of authority to act on behalf of patient)

_____

Please return the completed form to:

Access Health Professionals, 484 E. Carmel Dr., Ste. 309, Carmel, IN 46032 or fax to 317-584-8436.