

New Patient Information Form

Name _____ Today's Date _____ Birthdate _____
 Gender _____ Age _____

Personal Information

Address _____ City _____ State _____ Zip _____

Email _____

Cell Phone (_____) _____ Home Phone (_____) _____

Best Way to Contact You? Cell Phone Home Phone Email Text

Occupation _____ Employer/School _____

Business Address _____ Work Phone (_____) _____

Emergency Contact _____ Phone Number (_____) _____

Primary Physician _____ Phone Number (_____) _____

Who can we thank for referring you? _____

What is their address or business name? _____

Office Policies

- Visit time for the initial appointment is approximately 1 to 2 hours and follow up visits 30 to 60minutes.
- Payment is due at time of visit, with cash, check, or credit card. This office does not accept any insurance plans. At each appointment, you will receive a "super bill" that you can mail into your health insurance provider. Typical reimbursement of some PPO policies is 20-60% once the deductible has been met. You may contact your health insurance provider directly if you have any questions about payment.
- This office sees Medicare patients independently of Medicare coverage. Medicare patients will need to sign an agreement to not seek reimbursement from Medicare for these services and waive entitlement to Medicare benefits for the services provided in this office.
- We do not take patients under Worker Compensation at this time.
- Wearing loose clothing is preferred.
- There is a full charge for appointments if notice is not given at least one full day (24 HOURS) before the scheduled appointment time.

TREATMENT AUTHORIZATION and FINANCIAL RESPONSIBILITY

I hereby authorize Jason Comfort, D.O. to provide osteopathic medical services deemed necessary for the treatment of any condition, illness or injury. I also understand that I, the undersigned, am financially responsible for all services provided to the above named patient and hereby agree that in the event of default in payment of any amount due, to pay an additional reasonable charge covering the expense of collection including collection agency, attorney or court fees.

SIGNED _____
 (Patient or Parent/Guardian if patient is a minor or Healthcare Proxy)

DATE _____

PRINTED NAME _____

Notice of Privacy Practices

The 1996 Health Information Portability and Accountability Act (HIPAA), established a "Privacy Rule" to help insure that personal information is protected and to set a standard for certain health care providers to obtain patient consent for the use and disclosure of health information to carry out treatment, payment, or health care operations. As our patient, we want you to know that we respect the privacy of your personal medical records. Our goal is to protect your privacy.

You have the right:

- to inspect and obtain a copy of the individually identifiable health information (IIHI). Please submit a request in writing. A fee will be charged for the costs of copying and incidentals. To request a restriction of your IIHI for treatment, payment or health care operations, please make a request in writing.
- to receive a paper copy of our notice of privacy practices.
- to request an "accounting" of disclosures of your IIHI.
- to request that our practice communicate with you about your health/related issues in a particular manner or at a certain location. Our practice will accommodate reasonable requests.
- to amend your health information if you believe it is incorrect or incomplete, and to request an amendment for as long as the information is kept by or our practice.
- to file a complaint with our practice if you believe your privacy rights have been violated.

We may disclose your IIHI for the following reasons. Let us know if you want restrictions.

- to contact you regarding appointments or other items (email/voicemail/postal service).
- to treat you, or disclose your IIHI to other health care providers for treatment or educational purposes.
- to bill and collect payment for the services and items you may receive from us.
- to inform you of health-related benefits or services that may be of interest to you.
- to a medical examiner, coroner or funeral director if necessary to perform their job.
- to family/friends to reduce or prevent a serious threat to your health and safety. With your permission, our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you.

When necessary or required to do so by federal, state or local law including the following:

- to reduce or prevent a serious threat to the health and safety of your self or others.
- in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding.
- if you are a veteran/member of US or foreign military forces, in prison or legal care and if required by the appropriate authorities.

We reserve the right to change this Notice and to make the revised or changed Notice effective for Health Information we already have as well as any information we receive in the future.

I, the undersigned, acknowledge the above is an abbreviated version of the full Privacy Practices, and that I have been given access to a copy of the full Privacy Practices of this office, and I agree to the terms of the full Privacy Practices document.

SIGNED _____
(Patient or Parent/Guardian if patient is a minor or Healthcare Proxy)

DATE _____

PRINTED NAME _____