HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a “friendly” version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ____date______________do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward

Stacey Foshee, MD | **Patient Information** | ***Please complete all information**

Name ______________________________ M F ___/___/___ ______
First Middle Last Sex DOB Age

Address ______________________________
Street Address City State Zip

Home Phone ( ) - ________ Cell Phone ( ) - ________ Email address ________

Patient Employer ________________ SS# ________

Employer's Address ________________ Employer Phone ( ) -
Street Address City, State Zip

If Patient is a Minor, Responsible Party

Name ________________ Social Security # - -

Address ________________ Phone ( ) -
Street Address City, State Zip

Employer ________________ Occupation ________

Employer Address ________________ Employer Phone ( ) -
Street Address City, State Zip

Health Insurance Information

Insurance: ________________ Policy Holder : ________________
Policy Holder Name **Soc Sec #** **Date of Birth**

Insurance Address: ________________ Phone ( ) -
Street Address City, State Zip

Policy # ________________ Group # ________

Were you referred to our office? ☐ Yes ☐ No By whom: ________

If not, how did you learn about us? ________________

Who should we contact in case of an emergency? ________________

________________ Phone ( ) -
Address City, State Zip

Required Authorizations

***Please take a moment to complete all of the following required consents**

Benefits to Physician: I hereby authorize payments directly to Stacey Foshee, MD of the surgical and/or medical benefits. I understand that I am responsible for any portion of my bill not covered by my insurance company within the terms of its contract.

Signed (patient or parent of minor) ________________

Release of Information: I hereby authorize release of information necessary for filing my insurance claim or filing a payment review.

Signed (patient or parent of minor) ________________

I have received a Notice of Privacy Practices from the office of Stacey Foshee, MD.

Signed ________________ Date ________

I have signed the patient consent for use and disclosure of protected health information from the office of Stacey Foshee, MD.

Signed ________________ Date ________

HIPAA) I authorize practice/billing company to contact me about my bill by reaching me via (Note: If all boxes are checked "no" we will require prepayment on all services)
Phone: yes ☐ no ☐ Cell phone: yes ☐ no ☐ Work phone: yes ☐ no ☐ Mail: yes☐ no ☐

You may speak with the following person/s about my bill regarding medical services provided:

Name ________________ Relationship ________________ Phone ( ) -

You may not speak with the following person/s about my bill regarding medical services provided:

Name ________________ Relationship ________________

Name: ________________________________ DOB: _________________ Date: ______________

Pharmacy Name: ___________________________________ Phone #:______________________

Allergies: ____

MEDICATION LIST

MEDICINE	DOSE	FREQUENCY

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Stacey Foshee, MD may use and disclose **protected health information** about me to carry out **treatment, payment and healthcare operations.** Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Foshee reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Privacy Officer at:

Stacey Foshee, M.D.	Stacey L. Foshee, MD, PLLC
Name of Privacy Officer	Practice
PO Box 720631	Norman, OK 73070
Address	City, State, Zip

Telephone
With my consent, Stacey Foshee, MD may call my home or another designated location and leave a message (on voice mail, answering machine or in person) in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory and other results.

Mail
With my consent, Stacey Foshee, MD may mail to my home or another designated location any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminder cards, correspondence and billing statements.

Email
With my consent, Stacey Foshee, MD may e-mail to my home or another designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards, correspondence and billing statements.

I have the right to request that Stacey Foshee, MD restrict the use or disclosure of my protected health information to carry out treatment, payment and healthcare operations. (Please request form.)

I authorize the following individual(s) to call the office on my behalf to verify the status of appointments, treatment plan, medications (as well as pick up prescriptions or drug samples that I have requested) and/or account information. (Please leave blank if you do not authorize another party to access your protected health information.

Name: ______________________________ Relation: ______________

Name: ______________________________ Relation: ______________

I understand that the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I consent to the use and disclosure of my protected health information to carry out treatment, payment and healthcare operations by Stacey Foshee, MD.

I may revoke my consent in writing except to the extent that the practice has already made disclosures based upon my prior consent. If I do not sign this consent, Stacey Foshee, MD may decline to provide treatment to me.

______________________ ______________________ ______________

Print Patient's Name — Signature of Patient **or Legal Guardian* — Date

©

FEMALE SYMPTOM CHECKLIST

Name:______________________ E-Mail: ____________________________ Date:__________________

Symptoms (please check mark)	Never	Mild	Moderate	Severe
Fatigue				
Memory Loss				
Mental Confusion				
Decreased Sex Drive or Libido				
Sleep Problems				
Mood Changes or Irritability				
Tension				
Migraines or Severe Headaches				
Difficult to Climax Sexually				
Bloating				
Weight Gain				
Breast Tenderness				
Vaginal Dryness				
Hot Flashes				
Night Sweats				
Dry or Wrinkled Skin				
Hair Falling Out				
Cold All The Time				
Swelling All Over The Body				
Joint Pain				

History of Breast Cancer: Self (Y/N):______Family Member:____

Have You Ever Had Any Issues With Anesthesia (Y/N):____ Explain:______________________________

Current Hormone Replacement Therapy:____

Past Hormone Replacement Therapy:____

Nutritional Supplements or Vitamins:____

Last Menstrual Period (estimate year if known):____

Birth Control Method:____

Date of Last Mammogram:____

Date of Last Pap Smear:____

I Want to Be Sexually Active (Y/N):___________

I Have Completed My Family (Y/N):___________

History of Heart Disease (Y/N):______________

History of Diabetes (Y/N):__________________

History of Osteoporosis (Y/N):______________

History of Alzheimer's Disease (Y/N):_________