# ROSE INTERNAL MEDICINE
## Patient Registration

Name_____ Birth date ____/_____/_____

Address_____

City _____ State_____ Zip_____

Phone: Home _____Work _____Cell_____

Email _____

Emergency Contact _____ Relationship_____

Phone Number _____ Preferred Pharmacy_____
Please indicate what best describes your Race:
__White (including White of Latino/Hispanic Descent)
__ Black/African American (including Black/African of Latino/Hispanic Descent)
__Asian __Native Indian __Pacific Islander __ Multiple/Other
Do you consider yourself to be of Latino/Hispanic origin: Yes____ No____
What is your preferred language?

**IS IT OK TO LEAVE A MESSAGE ON YOUR ANSWERING MACHINE, VOICEMAIL OR EMAIL FOR US TO:**

| | | |
|---|---|---|
| Remind you of an appointment | ____Yes | ____ No |
| Tell you a medication has been refilled | ____Yes | ____ No |
| Leave Lab or test results | ____Yes | ____ No |
| Respond to your question | ____Yes | ____ No |

If you are unavailable, can we leave responses to the above messages with whoever answers your telephone? ____Yes ____ No

**Rose Internal Medicine will share your medical information ONLY with individuals and entities directly involved with your healthcare as outlined in the Notice of Privacy Practices.**
Is there anyone we **cannot** discuss your health and/or health conditions with on the phone or in person? ____Yes ____ No

If the answer is yes to the above questions, please list the name(s) or entities of the unauthorized person(s)/organization(s):

I understand that a scanned copy of this consent shall have the same force as the original.

**X**_____ _____
SIGNATURE OF THE PATIENT, PARENT OR LEGAL GUARDIAN DATE

# ROSE INTERNAL MEDICINE

## Insurance Information and Authorization

Patient Name _____ Birth date _____

**Is someone else responsible for this patient's bill? If yes, list their info:**

Relationship to Patient: _____
Name_____ Birth date _____
Address_____
City _____ State_____ Zip_____
Home Phone _____ Work Phone_____
Cell Phone _____ Email _____

| ***INSURANCE INFO*** | **PRIMARY INSURANCE** | **2nd INSURANCE** | **3rd INSURANCE** |
|---|---|---|---|
| Insurance Name | | | |
| **Birth date of Policy Holder (REQUIRED)** | | | |
| Relationship of Patient to Insured | | | |

I authorize the release of medical information to my primary care or referring physician, to consultants, and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to Rose Internal Medicine, P.C. I understand that if I do not supply Rose Internal Medicine, P.C. with my current insurance information, I may be liable for payment.

If covered by Medicare, I authorize any personal medical information needed to determine benefits payable to be released to the Centers for Medicare and Medicaid Services and its agents. I authorize Medicare to furnish to Rose Internal Medicine, P.C. any information regarding my Medicare claims under Title XVIII of the Social Security Act.

**I understand that I am responsible for co-pays and deductibles at the time of service. If I do not have insurance, I understand that payment in full is expected at the time of service.**

**I, the undersigned, understand that if my account is delinquent, it will be referred to a collection agency for collection procedure, and I am responsible for all costs including fees, attorney fees, and court costs.**

**I have received a copy of the Notice of Privacy Practices for Rose Internal Medicine, P.C. I understand that Rose Internal medicine, P.C. reserves the right to modify the privacy practices outlined in this notice. I understand that a scanned copy of this consent shall have the same force as the original.**

**X**_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE

# Notice of Privacy Practices

## Rose Internal Medicine, P.C.

**This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.**

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

**Your Rights Under The Privacy Rule**

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

**You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices** - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

**You have the right to authorize other use and disclosure** - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**You have the right to request an alternative means of confidential communication** – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

**You have the right to inspect and copy your PHI** - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

**You have the right to request a restriction of your PHI** - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

**You may have the right to request an amendment to your protected health information** - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

**You have the right to request a disclosure accountability** - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

**You have the right to receive a privacy breach notice** - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided at right, under Privacy Complaints.

**How We May Use or Disclose Protected Health Information**

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

**Treatment** - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

**Special Notices** - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

**Payment** - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

**Healthcare Operations** - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

**Health Information Organization** - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

**To Others Involved in Your Healthcare -** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as neceesary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

**Other Permitted and Required Uses and Disclosures** - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

**Privacy Complaints**

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

Rose Internal Medicine, 2205 W Sudbury Dr. Suite A, Bloomington, IN 47403

We will not retaliate against you for filing a complaint.

Effective Date 1/1/2013

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