Marsh Family Medicine, PLLC Notice of Privacy Practices (NPP)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information. We are required also by law to do this. These laws are complicated, but we must provide you with important information. You may ask to talk to our Privacy Officer (see the end of this notice) about any questions or problems.

We will use the information about your health, which we get from you or from others mainly to provide you with **treatment which includes communication within PRA treatment team,** to arrange **payment** for our services or for some other business activities which are called, in the law, health care **operations.** After you have read this NPP, we will ask you to sign the bottom of our **Consent and Authorization Form** which includes **Consent** to let us use and share your information for the reasons identified above. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes than identified above, we will discuss this with you and ask you to sign an Authorization to allow this.

Of course, we will keep your health information private but there are some times when the laws require us to use or share it such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings. Note: We must have a subpoena ***and*** court order to release your records without your consent. ***In all cases***, we will contact you first to notify you of any requests for your records.
3. If a law enforcement official requires us to do so in cases of an emergency or community security.
4. We have to report suspected child abuse.

There are some other situations like these which don't happen very often.

Your rights regarding your health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for your care. We will not disclose information to family members and friends without your written authorization to do so. We will honor your request except if it is against the law or in an emergency.

3. You have the right to look at the health information we have about you such as your medical and billing records. You can even get a copy of these records but we will charge you administrative and copy fees. Contact our Privacy Officer to arrange how to see your records. Contact information is listed below.

4. If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.

5. You have the right to a copy of this notice. If we change this NPP we will post it in our waiting room and you can always get a new copy of the NPP from the Privacy Officer.

6. When we disclose information in your records, we keep some record of whom we send it to, when we sent it and what was sent. You can get an accounting (a list) of many of these disclosures, however, you would have be informed and would have to authorize any release of your records that do not relate to your treatment, payment or operations as described in the second paragraph of this notice.

7. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer, our Practice Administrator and can be reached by phone at 520-797-5603.

MARSH FAMILY MEDICINE, PLLC 7440 N. Oracle RD. #7 Tucson, AZ 85704 520-797-5603 PLEASE PRINT CLEARLY	**Medical Records Release Form** Authorization to Use/Disclose Healthcare Information
Patient Name:	**MAIL RECORDS TO:**
Date Of Birth:	**Address:**
Phone #:	**Office Phone #:**
Current Provider's Name:	**New Provider's Name:**

By my signature I authorize that my medical records are to be sent from the office of:

The Purpose or Reason for Request: To transfer my medical care

I am requesting the following information for the entire time I have been seen at your office and including any consult or transferred medical information from other physicians or caregivers that is in your possession:

1. __√____Treatment records, including progress notes, lab and test results, history & physical reports, procedure reports, and consult reports or pain management contracts.
2. __√____Include outside records. Records from outside your practice.
3. __√____Other specified information including photos, X-Rays, or digital images.
4. __√____Information related to treatment of HIV or AIDS
5. __√____Information related to treatment of mental health issues.
6. __√____Information related to treatment of substance abuse.

Dates of Service to be released: From: Past 6 years to Date of most recent appointment.

X Signature _____Date_____ POA_____
Relationship if Not the Patient

I understand that if the organization to receive my information is not a health care provider or health care plan; the released information may not be covered by federal privacy regulations. MFM and its providers, administration, and employees are released from any legal liability for disclosure of my protected health information in the extent authorized by this form. I understand MFM will not condition treatment or payment on obtaining this authorization, except where federal law allow such condition.

Medical offices in Arizona are required to provide and forward a copy of your medical records to the doctor of your choice. "When a physician requests a patient's records from another doctor for continuity of care, there is no charge to the Patient" (Arizona State Medical Board Website). Seven to ten business days should be sufficient time to copy and send your records.

This Authorization is valid for 120 days from the signature date. It may be revoked by the patient at any time, except for the action that has already been taken on it.

Revised 6-18-2014

PERSONAL HEALTHCARE INFORMATION NAME _____ DATE OF BIRTH _____

HEART/BLOOD DISORDERS	ENDOCRINE/CANCER	NEUROLOGICAL/PAIN
☐ **NO PROBLEMS**	☐ **NO PROBLEMS**	☐ **NO PROBLEMS**
☐ Anemia ☐ Bleeding	☐ Diabetes Type I ___ Type II ____	☐ Alzheimer's/Dementia
☐ Blood Clots: Lung ____DVT_____	☐ Immune Disorder	☐ Migraines
☐ Cardiomyopathy	☐ Thyroid Disease ☐ Wt. Loss/Gain	☐ Parkinson's Disease
☐ Coronary Artery Disease	☐ Other _____	☐ Seizures ☐ Memory Loss
☐ Heart Attack: #___Year____ ____	☐ CANCER Year Began _____ ____	☐ Stroke ☐ Dizzy ☐ Falling
☐ Heart Failure ☐ Edema	Type _____ _____	☐ Tremors
☐ Irregular Heart Beat	Treatment: ☐ Surgery ☐ Hormones	☐ Restless Leg Syndrome
☐ Hi Cholesterol/Triglycerides	☐ Chemo TX ☐ Radiation:	☐ Pain Location _____
☐ Peripheral Vascular Disease	Completed Treatment: _____	Began ____Pain Scale Level 1-10 _____
LUNG/SLEEP APNEA	**SKIN**	**HEADACHE/EYES/EARS**
☐ **NO PROBLEMS**	☐ **NO PROBLEMS**	☐ **NO PROBLEMS**
☐ Asthma	☐ Open Wound ☐ Ulcer:_____	☐ TMJ ☐ Dry Eyes
☐ Bronchitis	☐ Acne ☐ Moles	☐ Blind ☐ Glaucoma
☐ COPD/Emphysema	☐ Rashes Location _____	☐ Cataract Removed: R____L____
☐ Pneumonia	☐ Skin Disorder: Type _____	☐ Lens Implant: Year ____ ____
☐ Sleep Apnea	☐ Other _____	☐ Hearing Loss ☐ Ringing in Ears
☐ Other _____ _____		☐ Other _____ _____
MUSCULOSKELETAL/BACK	**GENITAL/URINARY**	**PSYCHOLOGICAL/EMOTIONAL**
☐ **NO PROBLEMS**	☐ **NO PROBLEMS**	☐ **NO PROBLEMS**
☐ Arthritis/Osteoporosis	☐ Bladder Problem	☐ Anxiety
☐ Herniated Disc	☐ Kidney Problem	☐ Depression
☐ Spinal Stenosis	☐ Urinary Infection	☐ Mental Disorder
☐ Injury _____ _____	☐ Burning with Urinating	☐ Panic Disorder
☐ Joint Pain	☐ Blood in Urine	☐ Other _____
☐ Gout	☐ Pain in Pelvic Area	
STOMACH/BOWEL/LIVER	**FEMALES ONLY**	**MALES ONLY**
☐ **NO PROBLEMS**	☐ Age of First Period _____	☐ Change in Urine Stream
☐ Ulcers ☐ Hemorrhoids	☐ Last Menstrual Period _____	☐ Lump on Testicles
☐ GERD/Acid Reflux/Heartburn	☐ # of Pregnancy's ____Births____	☐ Prostate Trouble
☐ Hepatitis Type _____	☐ Unusual Vaginal Discharge/Bleed	☐ Penile Drainage/Sores
☐ Hiatal Hernia	☐ Vaginal Dryness/Pain	☐ Trouble with Erection
☐ Liver Disease	☐ Breast Lump/Pain/Rash	☐ Sexually Transmitted Disease
☐ Constipation ___Diarrhea ____	☐ Breast Drainage	☐ Muscle Loss
☐ Nausea/Vomiting	☐ Hot Flashes/ Night Sweats	☐ Increased Tiredness
☐ Black Stools/Rectal Bleeding	☐ Hormone Replacement	☐ Other _____
☐ Swallowing Difficulty	☐ Sexually Transmitted Disease	☐ Other _____
MEDICAL DEVICES/IMPLANTS/HOME	**BLOOD TRANSFUSION/ANESTHESIA**	**INFECTION HISTORY/TB SCREEN**
☐ **NONE**	☐ **NO PROBLEMS**	☐ **NO PROBLEMS**
☐ Heart Valve		☐ TB Positive Test? Year _____
☐ Implantable Defibrillator	☐ No Prior Blood Transfusion	Last Tested _____ _____
☐ Pacemaker	☐ Prior Transfusion no Reaction	☐ MRSA YES _____ No _____
☐ Stents	☐ Prior Transfusion with Reaction	☐ VRE YES _____ No _____
☐ Stimulator	☐ Prior Anesthesia no Problems	☐ Recent Infections? _____
☐ Implantable Pump	☐ Prior Anesthesia with Problems	☐ Other _____
☐ Implants	Cardiac Arrest _____	☐ Wound Care Now _____
☐ Orthopedic Hardware _____	Allergic Reaction _____	Where _____
☐ Other _____		

PERSONAL HEALTH HISTORY QUESTIONNAIRE DATE: _____ Health Care Provider: _____

Patient Name:	**Date Of Birth**	**Age:**
Occupation:	**Employer:**	
With Whom Do You Live?	**On Whom Do You Depend On For Transportation?**	
Partner Status: Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner ☐		

FAMILY HISTORY

If any blood relative has suffered from any of the following, please check and indicate which relative in the space provided:

*Please List **ALL** Blood Relatives - GP= Grandparent, S= Sibling, M= Mother, F= Father*

☐ Alcoholism _____
☐ Allergy _____
☐ Anemia _____
☐ Arthritis _____
☐ Asthma _____
☐ Clotting Disorders _____
☐ Diabetes _____
☐ Dementia _____
☐ Glaucoma _____
☐ Heart Disease _____
☐ High Cholesterol _____
☐ Hypertension _____
☐ Mental Illness _____
☐ Migraine _____
☐ Osteoporosis _____
☐ Seizures _____
☐ Stroke _____
☐ Stomach Problems _____
☐ Tuberculosis _____
☐ Breast Cancer _____
☐ Colon Cancer _____
☐ Other Cancer _____

If Mother Deceased, Age & Cause of Death: _____

If Father Deceased, Age & Cause of Death: _____

HOSPITAL ADMISSIONS (Please Include **Pregnancies** & **Past Illnesses**)	**YEAR**	**ILLNESS/OPERATION**	**YEAR**	**ILLNESS/OPERATION**

List Name & Dosage of All Medications That You Are Taking Please Include: Prescriptions, Supplements, & Non-Prescription Drugs

1.	4.	7.
2.	5.	8.
3.	6.	9.

ALLERGIES Please List All Known Allergies, Especially to Medicines or Anesthesia:

Please List The Month & Year Of Your Most Recent: Tests, Exams and Immunizations

Eye Exam:	Stool Card:	Pneumonia Vaccine (65 yrs. and older):
Diabetic Foot Exam:	PAP Smear:	Shingles Vaccine (50 yrs. and older):
Dental Exam:	Cholesterol Screen:	Hepatitis Vaccine:
Mammogram:	Other Labs:	HPV:
Colonoscopy:	Tetanus Shot (every 10 years):	TB Skin Test:
Sigmoidoscopy:	Flu Shot:	

List Health Care Providers
That You See Currently (Or Have Seen)
For Your Major Medical Problems

Habits

☐ Smoking; #Cig/Day For Yrs. ☐ Alcohol; #Drinks/Day #Drinks/Mo. ☐ Caffeine; #Cups/Day

☐ Exercise; #Times/Week ☐ Other Drugs (I.E. Chew Or Illegal Drugs)

WHAT QUESTIONS MAY I ANSWER FOR YOU CONCERNING YOUR HEALTH?

Marsh Family Medicine, PLLC (MFM)

Financial Policy

Thank you for choosing us for your healthcare needs. Our goal is to provide and maintain a good physician-patient relationship. The following is our Financial Policy, which we ask you to review and sign prior to your first visit.

General Information

Your co-payment, deductible, coinsurance, or balance due is due at time of service. We accept cash, check, American Express, Discover, MasterCard, and Visa. **Initial**_____

Regarding Insurance

Our providers participate in a wide variety of Insurance & managed care plans. We are happy to bill your health insurance carrier as a courtesy to you. We suggest that all patients review their health coverage with their carrier prior to receiving services or treatment. It is the responsibility of the patient to notify us of any changes in the insurance policy. Your insurance policy is a contract between you and your insurance company and the staff will not know all the terms of your insurance policy. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances. The patient/financial guardian will be responsible for any remaining balances. Additionally, it is your responsibility to obtain and track referrals for your visits.

Initial_____

Self-Pay Patients

Patients without health insurance are expected to pay at time of service. As a courtesy to these patients, we offer a 20% discount to most of the services rendered. If you are unable to pay the full balance at time of service the remaining balance is expected upon receipt of your first statement. **Initial**_____

Payment Arrangements

MFM has a plan for outstanding balances owed under certain circumstances of financial hardship. We are willing to meet with you to discuss your situation and try to work out a plan that will meet both your needs and the needs of the Medical Group. Please consult with one of our billing staff for further information.

Initial_____

Worker's Compensation

We will bill your employer's worker's compensation insurance carrier and follow all other procedures as required by the states workers compensation laws. As the patient, it is your responsibility to notify us prior to the visit that it is a work related case and to provide us with the appropriate worker's compensation policy information.

Initial_____

Automobile and Other Liability Cases

Due to State laws surrounding auto insurance payments, as well as payment delays, We regrets that it may not be able to bill third party administrators in liability cases. In addition, we cannot suspend our normal billing and collection process when services are rendered. Your health insurance carrier or the guarantor will be billed for services. **Initial**_____

Returned Checks

There will be a $25 returned check fee on all returned checks. In the event that a check is returned for insufficient funds, we reserve the right to call your bank to verify funds for any future checks that are presented for payment on your account.

Initial_____

Missed Appointments

Unless cancelled at least 24 hours in advance your appointment could be considered a no-show. Our policy allows us to charge up to $40 for these types of missed appointments. Please help us serve you better by keeping your scheduled appointments.

Initial_____

Thank you for understanding our Financial Policy and just like any other business, we need to have one. Please let us know if you have any questions or concerns. I have read, understand, and agree to this Financial Policy:

Patient Name _____ **Date** _____

Patient/Responsible Party Member's Signature _____

Responsible Party Member's Name _____ **Relationship**_____

Marsh Family Medicine PLLC Patient Registration & Demographic Form

PatientInformation

Name (Last, First, MI)				Today's Date	
Street Address		City		State	Zip
Home Phone ( ) Preferred		Work Phone ( ) Preferred		Cell Phone ( ) Preferred	
SSN	Date of Birth	Gender Male Female	Marital Status Single Married Divorced Widowed Separated Single Other		
Race	Ethnicity	Preferred Language	Email address		

FinanciallyResponsible Party

Is patient responsible party/guarantor? Yes No (If you are over the age of 18 and not in the care of an institution you are the guarantor as you are the person financially responsible for any charges you may incur during your visit.

Name	Address	City/ State/ Zip	Relationship to Patient
Occupation	Employer	Email address	Date of Birth
Home Phone ( ) Preferred	Work Phone ( ) Preferred	Cell Phone ( ) Preferred	

Emergency Contact

Name	Relationship to Patient Phone:	Is this person approved by you to give your health care Information to in the event of an emergency? If Not, Who? Name: Phone:
Home Phone ( ) Preferred	Work Phone ( ) Preferred	Cell Phone ( ) Preferred

Referral

Referring Physician's Name	Physician Phone/Fax (if known)
Physician Address	

PHARM LAB

Preferred Pharmacy:	Pharmacy Phone/Fax
Preferred Laboratory:	

InsuranceInformation

Primary Insurance Co.			Policy #	Group #
Patient's Relationship to Insured q Self q Spouse q Child q Other _____			Name of Subscriber (if other than patient)	
Subscriber's Social Security #	Gender q Male q Female	Date of Birth	Employer of Subscriber	Work Phone ( )
Secondary Insurance Co.			Policy #	Group #
Patient's Relationship to Insured q Self q Spouse q Child q Other _____			Name of Subscriber (if other than patient)	
Subscriber's Social Security #	Gender q Male q Female	Date of Birth	Employer of Subscriber	Work Phone ( )

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature: _____ Date: _____/_____/_____

Guarantor Signature (if other than patient) _____ Date: _____/_____/_____