Patient Information

Thank you for choosing our office!
In order to serve you properly, we need the following information.

Please print.
All information will be confidential.

Date_____ Patient name_____ (FIRST MI LAST) Patient #_____

SS#/SIN _____ ☐ Male ☐ Female Birthdate_____ Home Phone _____

Address_____ City _____ State/Prov._____ Zip/P.C. _____

Email _____ Cell Phone_____

Do you prefer to recieve calls at your: ☐ Home ☐ Work ☐ Cell Phone

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient or parent/guardian's employer _____ Work Phone _____

Business address _____ City _____ State/Prov._____ Zip/P.C. _____

Spouse or parent/guardian's name_____ Employer_____ Work Phone _____

If patient is a student, name of school/college _____ City_____ State/Prov._____

Whom may we thank for referring you? _____

Person to contact in case of emergency_____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient_____

Address _____ Home Phone _____

Email _____ Cell Phone_____

Driver's license # _____ Birthdate_____ Financial Institution _____

Employer _____ Work Phone _____

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Name of insured _____ Relationship to patient_____

Birthdate_____ SS#/SIN _____ Date employed _____

Name of employer_____ Work Phone _____

Address of employer _____ City _____ State/Prov._____ Zip/P.C. _____

Insurance company _____ Group #_____ Union or local # _____

Insurance co. address _____ City _____ State/Prov._____ Zip/P.C. _____

How much is your deductible?_____ How much have you used? _____ Max. annual benefit?_____

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured _____ Relationship to patient_____

Birthdate_____ SS#/SIN _____ Date employed _____

Name of employer _____ Work Phone _____

Address of employer _____ City _____ State/Prov._____ Zip/P.C. _____

Insurance company _____ Group # _____ Union or local # _____

Insurance co. address _____ City _____ State/Prov._____ Zip/P.C. _____

How much is your deductible?_____ How much have you used? _____

Max. annual benefit? _____

Authorization & Release

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X _____ _____

Signature of patient (or parent/guardian if minor) Date

ITEM 064-4682/17001

Jan Miller Schwartz, M.D., P.A.
902 Frostwood drive, #153
Houston, Texas 77024

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Jan Schwartz, MD, PA

Notice of Privacy Practices

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.

The Health Insurance Portability and Accountability Act of 1996 ("Hipaa") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. " HIPAA" provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on yur authorization.

Jan Miller Schwartz, M.D., PA

Patient Name:_____ Date of Birth: _____

Date you received your privacy notice? _____

Signature: _____

Do you want your Health Information to be **RESTRICTED** or limited? (For example, this is used to authorize release of information to anyone else such as a spouse, caregiver, etc.)

NO **YES**

If you answered "Yes" to the above question, please indicate how you would like your PHI restricted. (For example, exactly what kind of information do you want released and to whom.) Additionally, please indicate if there are any restrictions where we can mail information or leave voice messages. Provide ANY special instructions regarding your PHI in the space below.

_____

_____

_____

_____

If you have a RESTRICTION request, please indicate type of Protected Health Information to be LIMITED or RESTRICTED:

☐ Home phone #	☐ Spouse's name	☐ Other _____
☐ Home address	☐ Spouse's office phone #	☐ Other _____
☐ Occupation	☐ Patient history	☐ Other _____
☐ Employer Name	☐ Office visit notes	
☐ Office address	☐ Hospital notes	
☐ Office phone #	☐ Prescription information	

(PATIENT PLEASE NOTE: The practice is not required to agree to your request, but we will honor it when possible)

FOR OFFICE USE ONLY: (DO NOT FILL IN BELOW)

Log to Track Disclosures of PHI

	Date	Description	Who Requested	Who got the PHI?
1.				
2.				
3.				
4.				
5.				