HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary 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 our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____

Stephan A. Silva, D.P.M.
6971 N. Federal Hwy, Suite 306
Boca Raton, FL 33487
(561)241-9447
(561)241-4324 Fax

First Name _____ M.I. _____ Last Name _____ DOB _____

Age _____ Height _____ Weight _____ Shoe Size _____ Reason for visit _____

How long has this been a problem? _____ When does it occur? Morning Afternoon Evening Off and On All Day

TREATMENTS: Please list previous treatments (either prescribed or home remedies):

_____

_____

Is this visit related to an accident/injury? Y N If yes, date of injury _____

LIST CURRENT SPORTS/ACTIVITIES: _____

MEDICATIONS: Please list (or attach a list) of your current medications and their dosages:

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES: Do you have a history of allergies/skin reaction/sickness following the administration of any of the following:

	Y	N	** If yes, list REACTION		Y	N	** If yes, list REACTION
Adhesive tape	__	__	_____	Foods	__	__	_____
Anesthesia	__	__	_____	Iodine	__	__	_____
Aspirin	__	__	_____	Latex	__	__	_____
Caffeine	__	__	_____	Local Anesthetics	__	__	_____
Codeine	__	__	_____	Penicillin	__	__	_____
Cortisone	__	__	_____	Sulfa Drugs	__	__	_____
Demerol	__	__	_____	Other, please list:	_____		

MEDICAL HISTORY:

____Alcohol/Drug addiction/dependency
____Alzheimer's/Dementia
____Anemia – type_____
____Arrhythmias – type _____
____Arthritis - type_____
____Asthma circle (adult or childhood)
____Bleeding/Clotting Problems – type_____
____Cancer - type_____
____Depression/Anxiety disorder/Bipolar depression/other
____ Diabetes (how long? _____)
____Emphysema/COPD
____Glaucoma
____Gout
____GERD (Reflux)/GI ulcers (circle)
____Headaches / Migraines
____Hearing Problems
____Heart Disease
____Hepatitis A B C/Liver Disease _____
____High Blood Pressure
____High Cholesterol
____ HIV/ Aids/ARC
____Kidney/ Renal Disease
____Lung Disease/Pulmonary Embolus
____Lyme's Disease
____Nervous Condition (type?)_____
____Osteoporosis/Osteopenia (circle)
____Phlebitis (blood clots in legs)
____Pregnancy: are you currently pregnant? Due date: _____
____Poor Circulation/PVD
____Rheumatic Fever/Scarlet Fever
____Schizophrenia
____Seizures/Epilepsy
____STD's (sexually transmitted ds.)
____Sickle Cell Trait/Disease
____Stroke/TIA's
____Thyroid Problems (Hyper__ Hypo__)
____Tuberculosis
____Other, Please Specify _____
____Other, Please Specify _____
____ NONE of the above

PLEASE FILL OUT COMPLETELY

SMOKING:
Do you or have you ever smoked? Y N
If yes, how many years? _____How long ago did you quit? _____

RECREATIONAL DRUG USE:
Do you or have you ever used illicit/recreational drugs? YES NO
If yes, which ones? _____
How long ago did you quit? _____

ALCOHOL USE:
Do you or did you ever drink alcoholic beverages? Y N
How many drinks will you consume in a day? _____ Week? _____
How long ago did you quit? _____

HOSPITALIZATION: Y N If yes, please list: _____

SURGICAL HISTORY: Y N If yes, please list the surgeries you have had in the past 7 years:

PEASE READ AND SIGN: The information on y intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (*Assignment of Benefits*): I authorize payment of medical benefits to the practice named above. (*Release of Information*): I authorize the release of any medical information necessary to process this claim. (*HIPAA Privacy*): I acknowledge that I received my HIPAA Privacy Practices Notice. (*Medication History*): I authorize the Doctor's office to retrieve my medication history.

Signature of Responsible Party _____ Date _____

Relationship (if not patient) _____

PATIENT INFORMATION SHEET

First Name_____ MI_____ Last_____

Social Security #_____ Date of Birth ____/____/____Email address: _____

** **Primary Care Dr.** _____ ** **Date Last Seen by Primary Care** _____

Gender: M/F Ethnicity_____ Marital Status Div/M/S/Wid

Mailing Address:_____ City _____ State_____ Zip _____

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

Work Phone# ( ) _____ Best Way to Reach You: _____

Employer_____ Phone# ( )_____

Emergency Contact: _____ Phone#_____

Pharmacy Name_____ Phone#_____

How did you learn about our office? Referral from: Physician's name/Friend/Yellowpages/internet)

_____

----------**Patient's Insurance Information**----------

Primary Insurance Company Information

Company Name_____

Address_____

Insurance_____

Group#_____

Effective Date_____

Do you have a Specialist Copay? Yes Amt$ ____ No

Policy Holder's Name_____

Policy Holder's SS#_____

Policy Holder's Date of Birth_____

Secondary Insurance Company Information

Company_____

Address_____

Insurance_____

Group#_____

Effective Date_____

Do you have a Specialist Copay? Yes Amt$___ No

Policy Holder's Name_____

Policy Holder's SS#_____

Policy Holder's Date of Birth_____

HIPAA DISCLOSURE/AUTHORIZATION TO RELEASE INFORMATION: My signature below denotes my acceptance of podiatric medical care. I authorize release of information to my referring physician or other providers as a necessary part of the course of medical diagnosis and treatment. Authorization is also given to release information to insurance companies necessary to the completion of insurance claims, review of services or receipt of benefits.

Today's Date: _____ Patient's Signature _____