HUNTERDON INTEGRATIVE PHYSICIANS
A common sense approach to your health care

Patient Information

First Name _____ Last Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone_____ Cell _____

Social Security # _____

Insurance Information

Primary Carrier Name _____ Primary Insured Name _____

ID # _____ Group Name _____ Group # _____

Secondary Carrier Name _____ Secondary Insured Name _____

ID # _____ Group Name _____ Group # _____

I hereby authorize my insurance benefits to be paid directly to Hunterdon Integrative Physicians. I understand that I am responsible for verifying insurance participation and treatment coverage. I agree that I am financially responsible for any unpaid balances including non-covered services. In the event that Hunterdon Integrative Physicians is not a provider of my insurance carrier, I understand that I am responsible to pay any charges incurred at the time of service. I authorize Hunterdon Integrative Physicians to release any information to my insurance company as needed when processing claims.

I am aware that new patient missed appointments and appointments cancelled with less than 24 hours notice are subject to a $150 fee.

_____ _____

Patient Signature Date

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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 6 February 2013.

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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 _____

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Patient Name: _____ Date of Birth: _____

How did you hear about us? _____

Please explain why you are visiting us today:

_____

_____

_____

List any other medical problems:

1. _____
2. _____
3. _____
4. _____

List any other clinicians (name and type), therapists, etc. who are currently treating you and for what:

1. _____
2. _____
3. _____

List any vitamins, supplements, prescriptions or over-the-counter medications you are currently taking:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

What is your Pharmacy preference? (please provide phone #): _____

Social History:

Drug Allergies/Sensitivities: _____

Smoking History: Never smoked_____ Currently smoke _____ Use to smoke(amt and date quit) _____

Alcohol History: Never/rarely _____ Currently drink (average drinks per week)_____

Drug Use: Never _____ Past use of _____ Current use of _____

Education / Occupation (Current or Retired): _____

Marital Status: Single ____ Married ____ Separated ____ Divorced ____ Widowed _____

History of Surgeries/Hospitalization (Include dates):

_____

_____

_____

_____

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Family Medical History (please list who):

Abuse_____ Eczema_____

Alcoholism_____ Epilepsy/Seizures_____

Allergies_____ Gastrointestinal Disease_____

Arthritis_____ Hearing Loss_____

Autoimmune Disease_____ Heart Disease _____

Birth Defects_____ High Cholesterol_____

Bleeding Disorder_____ Migraines_____

Cancer_____ Psychological Illnesses_____

Diabetes _____ Smoking_____

Drug Abuse_____ Other_____

Father's Blood Type_____RH_____ Mother's Blood Type_____RH_____

Children Only

Prenatal History:

Pregnancy Complications:_____

Medications:_____ Illnesses:_____

Trauma: _____ Location of birth:_____

Duration of Pregnancy (# of weeks): _____

Birth Weight _____ Birth Length_____ Apgar Scores _____ / _____

Health issues: _____

Feeding: Breast_____ Formula_____

Developmental Landmarks (age):

_____Sat up _____Started speaking _____Bladder Training

_____Stood _____First Tooth _____Bowel Training

_____Rolled Over _____Walked

School History:

Special Education Needs: _____

Behavior Problems:_____

Sports/Recreational Activities:_____

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Medical History (Please list explanation to any problems)

Constitutional:

___Significant weight change (10lbs or more)_____

___Appetite problems _____

___Low/High energy _____

___Change in stress/mood _____

___Unexplained fever_____

___Heat/cold intolerance_____

___Unusual thirst_____

___Sleep problems _____

Eyes/Ears/Nose/Throat:

___Hearing loss_____

___Ringing in ears_____

___Nasal congestion_____

___Nose bleeding_____

___Bleeding gums/mouth sores_____

___Impaired taste _____

___Visual Problems _____

Neurological:

___Dizziness/Vertigo/Fainting_____

___Balance / Coordination problems_____

Cardiovascular:

___Chest Pain _____

___Palpitations_____

___Shortness of Breath _____

___Swollen legs _____

___Unusual cough_____

Gastrointestinal:

___Nausea/vomiting_____

___Diarrhea/constipation_____

___Change in stool_____

___Rectal bleeding_____

___Abdominal pain_____

___Gas/bloating_____

___Heartburn_____

___Trouble swallowing _____

Genitourinary:

___Painful Urination_____

___Blood in urine_____

___Sexual difficulty_____

___Difficulty controlling urine/bowels_____

Musculoskeletal:

___Muscle cramps/pains/fatigue_____

___Joint stiffness/swelling/pain_____

Skin:

___Rashes/sores/lesions_____

___Bruising_____

Breasts:

___Pain/Discharge_____

___Lumps in breasts_____

Infectious Diseases:

___Parasites_____

___HIV_____

___Chicken Pox_____

___Hepatitis_____

___Tick Diseases_____

___COVID_____

___Whooping Cough_____

___Diphtheria_____

___TB_____

___Rheumatic Fever_____

___Meningitis_____

___STI_____

Women Only:

Age of menstrual onset:_____

Regular: Y___ N ___ _____

Cycle: (# of days) _____

Flow: Heavy____ Medium_____ Light_____

Clots? _____

Cramps? _____

Premenstrual symptoms _____

Date of last period _____

Date of last pelvic exam _____

Date of last Pap test and result _____

Unusual discharge? _____

Vaginal itching _____

How many pregnancies? _____

How many children born?_____Stillbirths?_____

How many c-sections? _____

How many miscarriages? _____ Abortions? _____

Pregnancy complications? _____

Men Only:

___ Enlarged Prostate _____

___Elevated PSA_____

___Urethral discharge_____