

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

CarePlus Medical Center
14731 Aurora Avenue North
Shoreline, WA 98133
(206) 365-0220

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my healthcare care provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my healthcare provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations, and I understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

If you are signing as legal guardian ** *Your Relationship to Patient* _____

Dependent family members also covered by this acknowledgement:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason: (Circle one of the following)

- The patient refused to sign
- Communication barriers
- Emergency Situation
- Other (list please!) _____



PATIENT'S REPORT OF MEDICAL HISTORY

(CONFIDENTIAL INFORMATION — WILL NOT BE RELEASED WITHOUT PATIENT'S APPROVAL)

DATA BASE

1—PATIENT'S NAME	LAST	FIRST	MIDDLE	2—DATE OF BIRTH	3—AGE	4—DATE OF EXAM
2—PURPOSE OF EXAM	6—HOW TO YOU JUDGE YOUR CURRENT STATE OF HEALTH <input type="checkbox"/> EXCELLENT <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR					
8—CURRENT MEDICATIONS (LIST DRUG AND DOSAGE IF KNOWN)						

PAST MEDICAL HISTORY

9—HOSPITALIZATIONS: (LIST YEAR AND CONDITION BEGINNING WITH MOST RECENT. IF NONE, SO STATE.)

10—SIGNIFICANT ILLNESSES: (HAVE YOU HAD OR DO YOU NOW HAVE ANY OF THESE CONDITIONS?)

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA
<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS OR POSITIVE TB SKIN TEST
<input type="checkbox"/>	<input type="checkbox"/>	THYROID DISEASE
<input type="checkbox"/>	<input type="checkbox"/>	CANCER OR TUMOR
<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY DISEASE
<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATIC FEVER
<input type="checkbox"/>	<input type="checkbox"/>	HEART DISEASE
<input type="checkbox"/>	<input type="checkbox"/>	LUNG DISEASE
<input type="checkbox"/>	<input type="checkbox"/>	DIABETES
<input type="checkbox"/>	<input type="checkbox"/>	ULCER DISEASE
<input type="checkbox"/>	<input type="checkbox"/>	LIVER DISEASE

SOCIAL HISTORY

11—DO YOU CURRENTLY SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO 12—IF YES, ABOUT HOW MANY PACKS PER DAY? 13—IF NO, DID YOU SMOKE PREVIOUSLY? <input type="checkbox"/> YES <input type="checkbox"/> NO 14—MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED 15—DO YOU EXERCISE THREE OR MORE TIMES A WEEK? <input type="checkbox"/> YES <input type="checkbox"/> NO	16—DO YOU DRINK ALCOHOL? <input type="checkbox"/> YES <input type="checkbox"/> NO 17—HAVE YOU OR OTHERS EVER BEEN CONCERNED ABOUT YOUR DRINKING? <input type="checkbox"/> YES <input type="checkbox"/> NO 18—DO YOU USE NONPRESCRIBED DRUGS? <input type="checkbox"/> YES <input type="checkbox"/> NO 19—DO YOU FEEL YOU ARE UNDER A HIGH LEVEL OF STRESS AT HOME OR AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO
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FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	IF DEAD, CAUSE OF DEATH	AGE AT DEATH	HAS ANY BLOOD RELATION HAD ANY OF THE FOLLOWING CONDITIONS: (PARENT, BROTHER, SISTER, OTHER)				
					YES	NO	CHECK EACH ITEM	RELATIONSHIP	AGE OF ONSET
FATHER							DIABETES		
MOTHER							HIGH BLOOD PRESSURE		
SPOUSE							HEART DISEASE		
BROTHERS AND SISTERS							STROKE		
							ASTHMA		
							TUBERCULOSIS		
							CANCER		
							TYPE:		
CHILDREN							ALCOHOLISM		
							PSYCHIATRIC PROBLEMS		
							OTHER INHERITED DISEASES		

SYSTEMS REVIEW

20—GENERAL: (IN THE RECENT PAST HAVE YOU HAD ANY OF THESE SIGNS OR SYMPTOMS?)

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	UNPLANNED GAIN OR LOSS OF WEIGHT
<input type="checkbox"/>	<input type="checkbox"/>	FATIGUE/WEAKNESS
<input type="checkbox"/>	<input type="checkbox"/>	APPETITE DISTURBANCE
<input type="checkbox"/>	<input type="checkbox"/>	FREQUENT TROUBLE SLEEPING
<input type="checkbox"/>	<input type="checkbox"/>	FREQUENT OR SEVERE HEADACHES
<input type="checkbox"/>	<input type="checkbox"/>	DIZZINESS OR FAINTING SPELLS
<input type="checkbox"/>	<input type="checkbox"/>	EXCESSIVE THIRST
<input type="checkbox"/>	<input type="checkbox"/>	FEELING MUCH HOTTER OR COLDER THAN OTHERS



PATIENT INFORMATION
PLEASE PRINT

PATIENT Last Name First Name Middle Initial MR MISS MRS MS TODAY'S DATE

ADDRESS HOME PHONE WORK PHONE City State Zip

PATIENT'S RELATIONSHIP TO PERSON RESPONSIBLE FOR BILL: SELF SPOUSE CHILD DEPENDENT

MARITAL STATUS: SINGLE MARRIED WIDOWED SEPARATED DIVORCED BIRTHDATE AGE

SEX: MALE FEMALE SOC. SEC. # DRIVER'S LICENSE #

REFERRED TO THIS OFFICE BY:

PATIENT'S EMPLOYER SPOUSE'S NAME SPOUSE'S EMPLOYER HOME PHONE WORK PHONE ADDRESS CITY, STATE, ZIP OCCUPATION

PERSON RESPONSIBLE FOR BILL, IF NOT PATIENT

NAME SOC. SEC. # MAILING ADDRESS CITY, STATE, ZIP HOME PHONE WORK PHONE EMPLOYER ADDRESS CITY, STATE, ZIP DRIVER'S LICENSE # SPOUSE'S NAME SPOUSE'S EMPLOYER ADDRESS CITY, STATE, ZIP WORK PHONE OCCUPATION

INSURANCE AND/OR INJURY INFORMATION

PRIMARY INSURANCE SUBSCRIBER'S NAME GROUP # ID # PATIENT'S RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD DEPENDENT SUBSCRIBER'S EMPLOYER SECONDARY INSURANCE SUBSCRIBER'S NAME GROUP # ID # PATIENT'S RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD DEPENDENT SUBSCRIBER'S EMPLOYER

IF INJURED: DATE PLACE: HOME OR SCHOOL WORK AUTO ACCIDENT

NATURE OR CAUSE OF INJURY:

IN CASE OF EMERGENCY, LOCAL FRIEND OR RELATIVE TO BE NOTIFIED (NOT LIVING AT SAME ADDRESS):

NAME RELATIONSHIP TO PATIENT HOME PHONE WORK PHONE

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release any information required for this claim.

MEDICARE PATIENTS: I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by or in (name of provider), including physician services. I authorize any holder of medical or other information about me to release to the health care financing administration and its agents any information needed to determine these benefits or benefits for related services.

Signature of patient or authorized representative Date

Printed name if signed on behalf of patient / Relationship (parent, legal guardian, personal representative, etc.) (Notation, if any, by staff)