

**EDEN HILL EXPRESS CARE PATIENT INFORMATION**

NAME(FIRST,MI,LAST) \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ SEX:M/F \_\_\_\_\_ MARITAL STATUS: S M W D \_\_\_\_\_

ADDRESS (STREET) \_\_\_\_\_

(CITY) \_\_\_\_\_ (STATE) \_\_\_\_\_ (ZIP) \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ PRIMARY PHYSICIAN \_\_\_\_\_

**PARENT OR RESPONSIBLE PARTY** (if different from patient)

NAME (FIRST, MI, LAST) \_\_\_\_\_

ADDRESS (STREET) \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

DOB \_\_\_\_\_ AGE \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ SEX: M/F \_\_\_\_\_ MARITALSTATUS: S M W D \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURANCE \_\_\_\_\_ NAME OF INSURED \_\_\_\_\_

INSURED DOB: \_\_\_\_\_ INSURED'S # \_\_\_\_\_ GROUP # \_\_\_\_\_

RELATIONSHIP OF PATIENT TO INSURED \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_ NAME OF INSURED \_\_\_\_\_

INSURED DOB: \_\_\_\_\_ INSURED'S # \_\_\_\_\_ GROUP # \_\_\_\_\_

RELATIONSHIP OF PATIENT TO INSURED \_\_\_\_\_

**FOR AUTOMOBILE ACCIDENT OR WORKMAN'S COMPENSATION INFORMATION ONLY**

INSURANCE CO. \_\_\_\_\_

ADDRESS \_\_\_\_\_

INSURANCE PHONE # \_\_\_\_\_ CONTACT PERSON \_\_\_\_\_

CLAIM # \_\_\_\_\_ DATE OF ACCIDENT \_\_\_\_\_

**PATIENT CONTACT PERMISSION**

I wish to be contacted in the following manner (check all that apply)

\_\_\_\_\_ OK to leave an answering machine message with detailed information \_\_\_\_\_ OK to speak to other adults

\_\_\_\_\_ OK to mail my home address \_\_\_\_\_ OK to e-mail (e-mail address) \_\_\_\_\_

I have been given a copy of Eden Hill Express Care Notice of Privacy Practices and have the opportunity to review it.

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**Eden Hill Express Care Terms for Treatment and Consent for Treatment**

I consent to and authorize the physicians and employees of Eden Hill Express Care to furnish the necessary treatments, drugs, and supplies as ordered or requested by the physician for my medical care. I understand that no guarantee or assurance has been made as to the results or treatment or examination by **Eden Hill Express Care**.

**Patient Financial Responsibilities**

I acknowledge financial responsibility for any and all charges incurred during my examination or treatment. I authorize **Eden Hill Express Care** to apply for benefits on my behalf for the covered services rendered and request that payments from the named insurance company/companies be made directly to: **Eden Hill Express Care** for the treated person named. I certify that the information reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to the above named agent. I permit a copy of this authorization to be used in place of the original. Our office will do all we can to facilitate claims payment, but we do not have the power to make your plan pay.

**IN ALL CASES, PROFESSIONAL FEES ARE THE PATIENT, SPOUSE, GUARDIAN AND/OR PARENTS' RESPONSIBILITY.**

**Medicare Assignment of Benefits**

Where Medicare benefits are applicable, I certify that the information given by me in applying for payment under Title VIII of the Social Security Act is correct. I assign and request payment of authorized Medicare benefits to **Eden Hill Express Care** and to physicians providing hospital-based service on my behalf for any services furnished me. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine the benefits for related services.

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PATIENT SIGNATURE OR PARENT OF MINOR CHILD

DATE

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EDEN HILL EXPRESS CARE REPRESENTATIVE

DATE

**REASON FOR TODAY'S VISIT**

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**ATTENTION: IF YOU ARE HAVING CHEST PAIN, DIFFICULTY BREATHING OR FEELING FAINT PLEASE INFORM THE RECEPTIONIST IMMEDIATELY.** Also, Health Insurance will not pay for visits concerning dental/tooth complaints. Please speak to the receptionist if today's visit is for a dental problem.

## Eden Hill Express Care Financial Policy

We are committed to providing you with the best possible medical care. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. Our office participates with a variety of insurance plans. It is your responsibility to :
  - Bring your insurance card to every visit.
  - Be prepared to pay your copayment at each visit. Payment can be made by cash, check or credit card.
  - For medical care **not covered** under your insurance, these charges are your responsibility and you will receive a bill for these charges.
2. It is your responsibility to provide us with your **correct** and **active** insurance at the time of service along with any other secondary insurance that is applicable. If the information you provide is not correct or your coverage is found to be inactive at the time of service and these charges are denied or recouped by your insurance company, **you will be responsible for payment of these charges.**
3. **Referrals:** It is your responsibility to obtain any required referrals for treatment at, or prior to the visit. **If you do not have a referral and one is required, you will be financially responsible.**
4. If the patient is a minor (18 years and younger), the parent or guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at time of service, bringing the necessary referrals and insurance card.
5. If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company member services departments (number is on the insurance card.)
6. If you fail to make the payment in full for the services that are rendered to you, you are responsible for the fees assessed by the collections agency.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the receptionist or billing department. Please sign that you have read and agree to this Financial Policy.

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Signature of Patient or Responsible Party

Date

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Signature of Co-Responsible Party

Date

Express Care Patient History

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

**Medical Conditions** – Please circle all that you currently have or have had in the past **None**

Diabetes High Blood Pressure Heart Disease Heart Attack Heart Failure High Cholesterol Stroke Migraine  
Atrial Fibrillation Thyroid Disease Asthma Emphysema/COPD Ulcers Reflux Kidney Disease Depression

Cancer of Breast Lung Prostate Cervical Colon Other Cancers \_\_\_\_\_

Other Medical Conditions - \_\_\_\_\_

**Surgeries/Hospitalizations** – list any surgeries or times when you stayed in the hospital overnight **None**

Appendix Removed Gallbladder Removed Hernia Repair Hysterectomy Tonsils Removed Heart Stents Heart Bypass

Other surgeries or hospital stays \_\_\_\_\_

**Allergies** – Please list all medications that you are allergic to and the type of reaction **None**

\_\_\_\_\_

**Current Medications** – please list all current medications and dosage **None**

- 1) \_\_\_\_\_ 5) \_\_\_\_\_
- 2) \_\_\_\_\_ 6) \_\_\_\_\_
- 3) \_\_\_\_\_ 7) \_\_\_\_\_
- 4) \_\_\_\_\_ 8) \_\_\_\_\_

**Adult Social History**

Do you smoke? Yes No Packs per day \_\_\_\_\_ Did you smoke but quit? Yes No When did you quit? \_\_\_\_\_

Do you drink alcohol? Yes No Number of drinks/week? \_\_\_\_\_ Do you use illegal drugs? Yes No

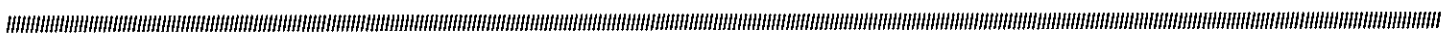
**Family History** - Do your parents/siblings/children have or have they had: **None**

Diabetes High Blood Pressure Heart Disease Heart Attack Stroke Kidney Disease

Cancer of Breast Lung Prostate Cervical Other Cancer: \_\_\_\_\_

\_\_\_\_\_

Reviewed by Clinical Staff \_\_\_\_\_



Reviewed by Provider \_\_\_\_\_

## 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.

**Eden Hill Express Care** is required by law to maintain the privacy of Protected Health Information ("PHI") and to provide you with the notice of our legal duties and privacy practices with respect to PHI. PHI is 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. This Notice of Privacy Practices ("Notice") describes how we may use and disclose PHI to carry out treatment, payment or health care operations and for other specified purposes that are permitted or requires by law. The Notice also describes your rights with respect to your PHI. We are required to provide this notice to you by the Health Insurance Portability and Accountability Act ("HIPAA").

**Eden Hill Express Care** is required to follow the terms of this Notice. We will not use or disclose your PHI without your written authorization, except as described or otherwise permitted by this Notice. We reserve the right to change our practices and this Notice and to make the new Notice effective for all PHI we maintain. Upon request, we will provide any revised Notice to you.

### Examples of How We Use and Disclose Protected Health Information

Treatment. We may use your health information to provide you with Medical treatment or services.

Example: in treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

Payment: We may use and disclose medical information about you so that the treatment and services you receive from us maybe be billed and payment may be collected from you, and insurance company, or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

Health Care Operations. We may use your health information for certain operational, administrative and quality assurance activities. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

We are permitted to use or disclose your PHI for the following purposes.

However, **Eden Hill Express Care** may never have reason to make some of these disclosures.

To Communicate with Individuals Involved in You Care or Payment for Your Care. We may disclose to a family member, other relative, close personal friend or any other person you identify, PHI directly relevant to that person's involvement in your care or payment related to your care.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Public Health. As required by law, we may disclose your PHI to public health or legal authorities charge with preventing or controlling disease, injury, or disability.

Law Enforcement. We may disclose your PHI for law enforcement purposes as required by law or in response to a subpoena or court order.

As Requires By Law. We will disclose your PHI when requires to do so by federal, state, or local law.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Notification. We may use or disclose your PHI to notify or assist in notifying a family member, personal representative, or another person responsible for your care, regarding your location and general condition.

Correctional Institution. If you are or become an inmate of a correctional institution, we may disclose to the institution or its agents PHI necessary for your health and the health and safety of other individuals.

To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Veterans. If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

National Security, Intelligence Activities, and Protective Services for the President and Others. We may release PHI about you to federal officials for intelligence, counterintelligence, protection to the President, and other national security activities authorized by law.

Victims of Abuse or Neglect. We may disclose PHI about you to a government authority if we reasonably believe you are a victim of abuse or neglect. We will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent serious harm to you or someone else.

#### Other Uses and Disclosure of PHI.

We will obtain your written authorization before using or disclosing your PHI purposes other than those provided for above (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

#### Health Information Rights.

Obtain a paper copy of the Notice upon request. You may request a copy of our current Notice at any time.

Request a restriction on certain uses and disclosures of PHI. You have the right to request additional restrictions on our use or disclosure of your PHI by sending a written request to the Privacy Office. We are not required to agree to those restrictions. We cannot agree to restrictions on uses or disclosures that are legally required, or which are necessary to administer our business.

Inspect and obtain a copy of your PHI. In most cases, you have the right to access and copy the PHI that we maintain about you. To inspect or copy your PHI, you must send a written request to the Privacy Office. We may charge you a fee for the costs of copying, mailing and supplies that are necessary to fulfill your request. We may deny your request to inspect and copy in certain limited circumstances.

You have recourse if you feel that your privacy protection may have been violated. You may have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violation of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.