SUMMIT | Medical Clinic

Patient Registartion

Patient Name: (Print) _____

Home Phone: _____ Work Phone: _____ Cell Phone _____

Address: _____

City _____ State _____ Zip Code _____

Email _____

Date of Birth: _____ Social Security: _____

Primary Insurance: _____ Member ID: _____

Secondary Insurance: _____ Member ID: _____

Pharmacy and Location _____

Patient's Employer: _____ Employer's Address: _____

Spouse's Name _____

Spouse's Employer: _____ Spouse's Employer's Address: _____

Is there a referring physician? Name: _____

Responsible Party Name: _____

Reason for Today's Visit: _____

Is this injury work related? _____ Is this injury related to an auto accident? _____

Personal Medical History

please mark all that apply

- ☐ Headache
- ☐ Traumatic Brain Injury
- ☐ Stroke
- ☐ Seizure Disorder
- ☐ Memory Loss
- ☐ Depression
- ☐ Anxiety
- ☐ Edema
- ☐ Abdominal Pain
- ☐ Reflux
- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Urinary Infections
- ☐ Allergies
- ☐ Diabetes Mellitus
- ☐ Heart Attack
- ☐ Hypertension
- ☐ Atrial Fibrillation
- ☐ Hepatitis
- ☐ Hernia
- ☐ Arthritis
- ☐ Asthma/COPD
- ☐ Lung Disorder
- ☐ Thyroid Disease
- ☐ Blood Clots
- ☐ High Cholesterol
- ☐ Skin Disorders
- ☐ HIV
- ☐ Cancer
- What type _____

Other Chronic Medical Problems _____

_____

Previous Major Surgeries (please list date, reason and hospital) _____

_____

Current Medication

Name _____ Dose _____

Name _____ Dose _____

Name _____ Dose _____

Name _____ Dose _____

Allergies

Type of Allergy: _____ Reaction you had _____

Type of Allergy: _____ Reaction you had _____

Type of Allergy: _____ Reaction you had _____

Type of Allergy: _____ Reaction you had _____

Immunizations

Check if you have had:

☐ Tetanus Year last received _____

☐ Flu Shot Year last received _____

☐ Shingles Year last received _____

☐ Other _____

Social History

Check as appropriate:

Tobacco use	☐ Yes	☐ No	Quantity _____	Years _____
Alcohol use	☐ Yes	☐ No	Quantity _____	Years _____
Illicit Drug Use	☐ Yes	☐ No	How Often _____	
Caffeine	☐ Yes	☐ No	Quantity _____	Years _____
Exercise	☐ Yes	☐ No	How Often _____	

Check all that apply:

☐ Eye Exam Date _____

☐ Dental Exam Date _____

☐ Colonoscopy Date _____

☐ Mammo Date _____

☐ Bone Density Date _____

Family Medical History

(Please list any medical issues: ex. Kidney disease, High cholesterol, Cancer, Hypertension, Depression)

	Age if Living	Age at Death	Illness/Medical Problem
Mother			
Grandmother			
Grandfather			
Father			
Grandmother			
Grandfather			
Sisters/Brothers			
Children			

To be answered by women only:

Are you still having monthly periods? ☐ Yes ☐ No Date of last period: _____

Are you bleeding between periods? ☐ Yes ☐ No Length of cycle _____

Date of last Pap Smear? _____

Number of pregnancies: _____

Contraception: _____

To be answered by men only:

Any discharge from the penis? ☐ Yes ☐ No Discharge Date : _____

Prostate problems (urinary difficulty)? ☐ Yes ☐ No Describe: _____

SUMMIT | Medical Clinic

Patient Insurance

Date _____

Patient Name: (Print) _____

Date of Birth: _____ ☐ Male ☐ Female Email: _____

SSN: _____ ☐ Single ☐ Married ☐ Separated ☐ Divorced

Street Address/P.O. Box: _____

City _____ State _____ Zip Code _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Business Phone: _____

Street Address/P.O. Box: _____

City _____ State _____ Zip Code _____

Medical Insurance

Responsible Party: _____ Relationship to Patient: _____

Date of Birth: _____ SSN: _____

Street Address/P.O. Box: _____

City _____ State _____ Zip Code _____

Home Phone: _____ Cell Phone: _____

Primary Insurance Company: _____

Policy Holder's Name: _____ Subscriber: _____ Group: _____

Secondary Insurance Company: _____

Name: _____ Subscriber: _____ Group: _____

Preferred Pharmacy: _____ Phone: _____ Policy: _____

In case of emergency, who should be notified? _____ Phone: _____

How did you learn about our practice? _____

_____

ASSIGNMENT AND RELEASE / MEDICARE AUTHORIZATION

I request that payment of authorized medical benefits to include all Medicare benefits be made on my behalf to Summit Medical Clinic for any services furnished me. I authorize any holder of medical information about me to release to the insurance payor and/or the Center of Medicare and Medicaid Services or its agents any information needed to determine benefits payable for billed services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. My signature authorizes the release of information to the insurer or agency shown in Medicare assigned cases, Summit Medical Clinic agrees to accept the determination of the Medicare carrier. The patient is responsible for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based on the charge determination of the Medicare carrier.

Signature of Insured/Guardian _____ Date _____

Notice of Health Information 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.

Summit Medical Clinic is required to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices. We will not use or disclose your health information except as described in this Notice. This Notice applies to all of the medical records generated by Summit Medical Clinic, as well as records we receive from other providers.

Use & disclosure of protected health information in treatment, payment & health care operations.

Treatment: Summit Medical Clinic may use and disclose your protected health information in the course of providing or managing your health care as well as any related services. For the purpose of treatment, we may coordinate your health care with a third party. For example, we may disclose your protected health information to a pharmacy to fulfill a prescription for medication, to a radiology facility to order an X-ray, or to another physician who is assisting in your health care. In addition, we may disclose protected health information to other health care providers related to the treatment provided by those other providers.

Payment: When needed, Summit Medical Clinic will use or disclose your protected health information to obtain payment for its services. Such uses or disclosures may include disclosures to your health insurer to get approval for a recommended procedure or to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. When obtaining payment for your health care, we may also disclose your protected health information to your insurance company to demonstrate the medical necessity of the care or for utilization review when required to do so by your insurance company. Finally, we may also disclose your protected health information to another provider where that provider is involved in your care and requires the information to obtain payment.

Operations: Summit Medical Clinic may use or disclose your protected health information when needed for the practice's health care operations for the purposes of management or administration of the practice and for offering quality health care services. Health care operations may include: (1) quality evaluations and improvement activities; (2) employee review activities and training programs; (3) accreditation, certification, licensing, or credentialing activities; (4) reviews and audits such as compliance reviews, medical reviews, legal services, and maintaining compliance programs; and (5) business management and general administrative activities. For instance, we may use, as needed, protected health information of patients to review their treatment course when making quality assessments regarding ophthalmologic care or treatment. In addition, we may disclose your protected health information to another provider or health plan for their health care operations.

Other Uses and Disclosures: As part of treatment, payment, and health care operations Summit Medical Clinic may also use or disclose your protected health information to: (1) remind you of an appointment; (2) inform you of potential treatment alternatives or options; or (3) inform you of health-related benefits or services that may be of interest to you.

Uses & Disclosures to which You may object

Family/Friends: Summit Medical Clinic may disclose your protected health information to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose protected health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you have any objection to the use and disclosure of your protected health information in this manner, please tell us.

Uses & disclosures that are required or permitted without Your authorization

Research: Under certain circumstances, Summit Medical Clinic may use and disclose your protected health information to approved clinical research studies. While most clinical research studies require specific patient consent, there are some instances where a retrospective record review with no patient contact may be conducted by such researchers. For 2 Notice of Health Information Privacy Practices Effective Date: September 23, 2013 Updated Sept 2013 example, the research project may involve comparing the health and recovery of patients who received one medication for their medical condition to those who received a different medication for that same condition.

Regulatory Agencies: Summit Medical Clinic may disclose your protected health information to government and certain private health oversight agencies, e.g., the Department of Public Health and Environment or the Board of Medical Examiners, for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary to monitor compliance with the requirements of government programs.

Law Enforcement/Litigation: Summit Medical Clinic may disclose your protected health information for law enforcement purposes as required by law or in response to a court order or other process in litigation.

Public Health: As required by law, Summit Medical Clinic may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. For example, we are required to report the existence of a communicable disease, such as acquired immune deficiency syndrome (“AIDS”), to the Department of Public Health and Environment to protect the health and well-being of the general public.

Workers’ Compensation: Summit Medical Clinic may release protected health information about you for workers’ compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Military/Veterans: Summit Medical Clinic may disclose your protected health information as required by military command authorities, if you are a member of the armed forces.

Organ Procurement Organizations: To the extent allowed by law, Summit Medical Clinic may disclose your protected health information to organ procurement organizations and other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

As Otherwise Required or Permitted By Law: Summit Medical Clinic will disclose your protected health information in any situation in which such disclosure is required by law (e.g., child abuse, domestic abuse) or any other use permitted under HIPAA, its amendments or regulations.

Uses & disclosures requiring Your authorization

Other than the circumstances described above, Summit Medical Clinic will not disclose your protected health information unless you provide written authorization. An authorization is specifically required in most situations involving uses or disclosures of protected health information for marketing purpose, for the sale of protected health information, or for psychotherapy purposes. You may revoke your authorization in writing at any time except to the extent that we have already taken action in reliance upon the authorization.

Your rights related to Your health information

Although all records concerning your treatment obtained at Summit Medical Clinic are the property of Summit Medical Clinic, you have the following rights concerning your protected health information:

- Right to Confidential Communications: You have the right to receive confidential communications of your protected health information by alternative means or at alternative locations. For example, you may request that we contact you at work or by mail.
- Right to Inspect and Copy: You generally have the right to inspect and copy your protected health information, except as restricted by your physician or by law. Further, if we maintain your health records on an electronic health records system, you have the right to request an electronic copy of your health records.
- Right to Amend: You have the right to request an amendment or correction to your protected health information. If we agree that an amendment or correction is appropriate, we will ensure that the amendment or correction is attached to your medical record.
- Right to an Accounting: You have the right to obtain a statement of the disclosures that have been made of your protected health information other than by your authorization, other than to you and other than for the purpose of treatment, payment or routine operational purposes.
- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your protected health information. If we agree, we will abide by the restrictions. Additionally, if you (or anyone on your behalf besides a health plan) pay for the care or services at issue in full out of your own pocket, we are required to comply with your request not to disclose your protected health information to a health plan, unless

required by law to do so. 3 Notice of Health Information Privacy Practices Effective Date: September 23, 2013 Updated Sept 2013 Right to Receive a Copy of this Notice: You have the right to receive a paper copy of this Notice, upon request, if this Notice has been provided to you electronically.

- Right to Revoke Authorization: You have the right to revoke your authorization to use or disclose your protected health information, except to the extent that action has already been taken in reliance on your authorization.
- Right to Notice of Breach of Security: You have the right to be notified in the event of a breach of unsecured protected health information occurs.
- Right to Opt Out: You may be contacted for certain fund-raising purposes and you have the right to opt out of receiving such communications.

For more information regarding how to exercise these rights:

If you have questions or would like more information regarding any of the rights listed above, please contact the Compliance Officer at 719-630-1006

If You believe that Your rights have been violated:

You may file a complaint with Summit Medical Clinic or with the U.S. Secretary of Health and Human Services. To file a complaint with Summit Medical Clinic, please contact the Compliance Officer at 719-630-1006. All complaints must be submitted in writing. There will be no retaliation for filing a complaint.

Notice effective date:

This Notice is effective for all protected health information created on or after September 23, 2013.

SUMMIT | Medical Clinic

Patient Privacy Practices

Summit Medical Clinic, P.C. is committed to serving our patients with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information in accordance with the Health Insurance Portability and Accessibility Act of 1996 (HIPAA).

During the course of serving your interests it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to get a laboratory or radiology analysis
- For payment purposes, we may use a billing service
- During health care treatment, we may need a second opinion

We here at Summit Medical Clinic are dedicated to obeying all Federal, State and local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law. If you have any questions or comments regarding your Protected Health Information, feel free to contact our practice administrator at the phone number listed above.

In order to assist us in protecting your privacy, please complete the following:

Patient Name: (Print) _____

Who may we speak with other than yourself regarding your medical care:
(if more than one, please list them all)

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

May we leave a message on your voice mail at home? ☐ Yes ☐ No

May we leave a message on your voice mail at work? ☐ Yes ☐ No

May we mail medical information to your home? ☐ Yes ☐ No

I have read and understand the above Patient Privacy Practices and have received (or made available to me) a copy of the Notice of Privacy Practices of Summit Medical Clinic, P.C.

Signature _____ Date _____

Summit Medical Clinic. PC endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the <CORHIO> HIE, or cancel an opt-out choice, at any time

Financial Policy
Patient Financial Agreement

Summit Medical Clinic, P.C. is committed to serving our patients with professionalism and caring and from our patients we expect the same commitment. This includes being on time for your appointment and calling to cancel an appointment if you can't make it. It also includes financial responsibility, like presenting your identification and insurance cards at every appointment and making your copay and deductible payments at the time of your office visit with cash, check, or credit card.

Your responsibility is to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including referral documents from other providers. Current identification and insurance benefit cards are to be presented at each office visit. As a courtesy, Summit Medical Clinic will file your insurance claim for you. If you are a Medicare patient, we will bill Medicare and your secondary insurance for you.

For services outside of our clinic, like radiology, laboratory, surgery centers, physical therapy, hospitals and rehabilitation centers, it is your responsibility to know which facility you are required to use. If you aren't sure, please talk to your insurance member services or one of our staff before scheduling.

For Medicare patients: Medicare Patient's Signature – I authorize payment to be made on my behalf to Summit Medical Clinic for any services provided to me by my provider. I authorize my provider to release to the Health Care Financing Administration and its agents any information needed to determine my benefits.

I understand that my signature requests payment be made to pay my claim. My signature also authorizes the release of medical information necessary to pay my claim. My signature also authorizes the release of benefits payable and medical information necessary to pay any secondary insurance payer.

Patient Name: (Print) _____

Patient Signature _____ Date _____

Patient Medicare Number _____

I have read and I understand Summit Medical Clinic's financial policies and I accept responsibility for the payment of any fees associated with my care.

Patient Signature _____ Date _____

Patient Financial Responsibility Contract

Please read and sign where indicated – this document describes your financial responsibilities.

This is a legally binding contract between Summit Medical Clinic and you. The words, I, me, my, you and your all refer to the patient.

- I agree to be financially responsible for payment of Summit Medical Clinic's services. Cash, check or credit cards are acceptable forms of payment for these services.
- Current insurance cards must be presented at every office visit. Summit Medical Clinic is not responsible for filing your insurance claim, but as a courtesy we will do so. I agree to pay the remaining balance after my insurance has paid on my claim immediately upon receipt of a statement.
- I agree to give Summit Medical Clinic my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I understand that if I fail to give complete and accurate information about my insurance benefits this may result in a denial of my claim or a delay in payment. I agree to pay Summit Medical Clinic the balance on my account after my insurance claim has been processed.
- I agree that if my insurance benefit requires me to provide a referral and if the referral is not in place before my appointment, that I will pay in advance an estimate of charges for my office visit or reschedule my appointment.
- I understand that I will be responsible for any missed appointments or any cancelled appointments in which a 24-hour notice was not given. There will be a fee of $70.00 for any missed office visits and $50.00 for any missed office procedures.
- I understand there will be a $35.00 fee for all returned Checks
- I understand that all services provided to me by Summit Medical Clinic are considered medically necessary, if I fail to have a procedure performed or do not comply with my provider's instructions it may be against medical advice and may void my insurance benefits. Should this occur, I agree to pay the balance remaining on my account after my insurance has been processed.
- I understand that my insurance may or may not agree to the usual, customary or reasonable charges for my local area. I understand that my benefits may not cover all services or might deny payment for services that have been approved of in advance. I agree to pay the balance remaining on my account after insurance has been processed.
- If I have a high deductible policy or do not currently have insurance benefits, I agree to pay an estimate of charges for my office visit in advance and understand that other charges may apply.
- Summit Medical Clinic has a contract with my insurance company. Summit Medical Clinic will receive payments from my insurance company for covered services provided by my

insurance benefits. I agree to pay co-payments and deductibles at the time of service. If co-payments are not made at the time of service, I understand that my appointment may be rescheduled.

- I agree to pay any balance remaining on my account for any reason upon receipt of a statement and I understand that when requested, I must give Summit Medical Clinic my current address and other contact information. I understand that if I fail to pay the balance on my account this may result in Summit Medical Clinic pursuing any collection means possible.
- If my account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs.
- If the reason for my appointment is related to a work injury or auto accident, I agree to give Summit Medical Clinic the case number or policy number, the workman's compensation or insurance carrier's name, address or other contact information at the time of my appointment so that Summit Medical Clinic can bill workman's compensation or the auto insurance carrier for my visit. If I do not provide this information at the time of the visit, I agree to pay all charges for my visit.

I have read and I understand Summit Medical Clinic's financial policies and I accept responsibility for the payment of any fees associated with my care.

Patient Signature _____ Date _____

Assignment of Benefits

I hereby authorize direct payment of medical benefits, including medical benefits to which I am entitled to Summit Medical Clinic, PC. This is a DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS. This authorization will remain in effect until cancelled by me in writing. A copy of this authorization is as valid as the original document.

I authorize the release of any medical information necessary to obtain payment and I understand that I am financially responsible for all charges, late fees, interest, attorney fees and collection charges considered patient responsibility by my insurance company. I understand that if I am not insured, I am responsible for the charges of all services provided to me. I authorize Summit Medical Clinic to deposit checks received on my account when made out in my name.

I have read and I understand Summit Medical Clinic's financial policies and I accept responsibility for the payment of any fees associated with my care.

Patient Signature _____ Date _____

_____

SUMMIT | Medical Clinic

A note about Pain Management at Summit Medical Clinic

To our new patients,

As your new primary care provider (PCP) I would like to take a moment to explain to you our guidelines regarding pain management.

First, we are your primary care physician, or PCP, this is a physician/medical doctor who provides both the first contact for a person with an undiagnosed health concern as well as continuing care for a variety of medical conditions. We possess a set of skills and scope of practice that includes basic diagnosis and non-surgical treatment of common illnesses and medical conditions. As well, Dr. Arora is a Board Certified Nephrologist able to diagnose and treat kidney related diseases.

We are **NOT** pain management doctors, nor are we specialists in prescribing narcotic, sedative, hypnotic, anxiolytic medicines, it is very important that you understand this. For these conditions, you should see a specialist, a doctor who can best treat you for those medical conditions. To you, as our new patient, that means we will NOT prescribe those types of medications (Vicodin, Oxycontin, Norco or Xanax, Ambien, Lexapro, Celexa, to name a few), even if they were prescribed to you by your previous physician. If you feel you have made a new patient appointment in error, please be considerate and call to cancel your appointment with us.

If you have fully read and understand our guidelines we ask that you sign below as your acceptance of these guidelines. **If you have any questions we will be glad to answer them for you before we proceed with your new patient appointment.**

Patient Signature _____ Date _____

SUMMIT | Medical Clinic

Medical Records Release Form

Patient Name: _____ Address: _____

DOB: _____ Phone: _____

Social Security: _____

I request and authorize Summit Medical Clinic to obtain my medical records, including diagnosis and records of any treatment or examination rendered to me, from:

Name: _____ Address: _____

Purpose of Disclosure

☐ Changing physicians ☐ Consultation/Second Opinion ☐ Continuing Care ☐ Legal

☐ Workers Compensation ☐ Other: _____

The following categories of information will not be released from your record unless you indicate your authorization by checking the appropriate box and signing below:

AIDS	☐ Release	☐ Do not release
Alcohol abuse	☐ Release	☐ Do not release
Substance abuse	☐ Release	☐ Do not release
Mental health visits	☐ Release	☐ Do not release
Sexual abuse/rape	☐ Release	☐ Do not release
Venereal disease	☐ Release	☐ Do not release

☐ Other: (Specify) _____ ☐ Release ☐ Do not release

Patient Signature _____ Date _____

AUTHORIZATION

I hereby give the releasing facility permission to disclose my individually identifiable health information as listed above. I understand that once this information is disclosed, it may no longer be protected. I understand that this authorization is voluntary, that further treatment cannot be conditional upon my signing this authorization. I acknowledge that incomplete forms cannot be processed and THAT THERE MAY BE A COST TO COPY THE RECORDS. I understand that this consent expires 180 days from the date of my signature unless otherwise specified.

I understand that I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand that the requested medical records will be released in PDF format, unless otherwise specified. I understand that I must provide notice in writing if I choose to revoke this authorization before the date/event of expiration, and that the revocation will be effective on the date of my notification. A copy, fax, scan, or electronic media (PDF) of this form is to be considered as valid as the original. I hereby release Summit Medical Clinic from any liability which may result from furnishing the information requested as authorized by this release.

Patient of Signature	Date
Signature of Parent/Legal Guardian/Authorized Person	Date
Records Received by – Relationship to Patient	Date

SMC Medical Records Department use only

Date request filled _____ By _____

PDF format _____ Paper _____

Identification presented _____ Amount of Fee Collected _____