

Demographic Information

Last Name _____ First Name _____ Middle _____
Preferred Name _____ AKA _____
Date of Birth _____ Time of Birth (Newborns only) ____:____AM/PM Sex: M / F
Race _____ Ethnicity _____
Primary Language _____
Mailing Address _____ Home Address (if different) _____
Zip Code _____ City _____ State _____
Home phone _____ Cell phone _____ Email _____
Preferred Communications Mail ____ Home phone ____ Cell phone ____ Email ____
Preferred Pharmacy _____

Associated Party/Responsible Party Name

Name _____ Association _____
Relationship to patient _____ Date of Birth _____
Address _____ City _____ State ____ Zip _____
Preferred Telephone number _____

Primary Insurance Information

Policy Holder's Name _____ Date of Birth _____
Policy Holder Social Security Number _____ Relationship to patient _____
Insurance Company _____
Patient ID # _____ Group ID # _____
Employer _____ Occupation _____

Secondary Insurance Information (if applicable)

Policy Holder's Name _____ Date of Birth _____
Policy Holder Social Security Number _____ Relationship to patient _____
Insurance Company _____
Patient ID # _____ Group ID # _____
Employer _____ Occupation _____

Assignment and Release

I, the undersigned, certify that I, or my dependent, have insurance coverage with the above insurance company, and assign directly to Lisa Callahan CPNP all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Lisa Callahan CPNP to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ **Relationship to patient** _____

You are responsible for all deductible, co-pays, non-covered services, co-insurance, and items considered “not medically necessary” by your insurance company. **Your insurance plan** may require that you pay co-payments and co-insurance amounts on the day of your appointment. If we are asked to bill you for your co-pay, there will be an additional \$10.00 charge. The remaining balance must be taken care of within 30 days of notice from the insurance company. If you make payments exceeding your balance, your account will have a credit balance unless you request a refund. If payment cannot be made at each visit, notify the front-desk to make other arrangements. **Returned checks will be charged an additional \$25.00 fee, and must be taken care of within 30 days or will be subject to collections.**

Insurance Billing

As a courtesy, we will bill your insurance for you. If the insurance company has not paid within 90 days, the bill will be your responsibility unless it was our error causing the delay; it is your responsibility to contact your insurance company with any questions as we are not able to do this on your behalf.

Missed Appointment Policy

We have set-aside the time for your appointment. In lieu of charging a fee for missed appointments, we reserve the right to dismiss any person who does not keep an appointment or cancel within 24 hours of your appointment time.

I acknowledge by signing that I understand and agree to the above. If you have any questions before signing, please ask for assistance.

Signature of Responsible Party _____ **Date** _____

THIS PAGE MUST BE COMPETED BEFORE PATIENT CAN BE SEEN.

Special Situations

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

1. **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
2. **Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.
3. **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.
4. **Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.
5. **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
6. **Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
7. **Public Health Risks.** We may disclose health information about you for public health reason in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
8. **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
9. **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
10. **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
11. **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death.

12. **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
 13. **Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object.
 14. **Deceased Person's PHI** may be disclosed by our practice to family or others involved in the person's care or payment for care, unless our practice knows the deceased preferred that certain people not receive the PHI. Disclosures are limited to the PHI directly relevant to the person's involvement.
- For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care.

Other Uses and Disclosures of Health Information

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. We must obtain your *Authorization* separate from any *Consent* we may have obtained from you.

If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time.

If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*. However, we cannot take back any uses or disclosures already made with your permission.

You have the right to be notified following a breach of your PHI by our practice.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact:

Lisa Callahan CPNP
1601 NE 6th St
Grants Pass, OR 97526
541.472.0021

You will not be penalized for filing a complaint.

Lisa Callahan CPNP **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.

*If you have any questions about this notice, please contact the designated privacy officer of our office at Lisa Callahan CPNP
1601 NE 6th St
Grants Pass, OR 97526*

We take our responsibility to safeguard your protected health information very seriously. We value your trust as an important part of our ability to provide you with the best possible medical care. We are dedicated to defending your right to a confidential relationship with your physician.

This notice is intended to inform you of how we protect, use and disclose your information, as well as to explain your right to control these disclosures.

Your Health Information

We may use and disclose health information about you without your permission for the following purposes:

1. We may disclose your information for **treatment purposes and to coordinate your medical care.**
2. We may disclose your information **to ensure that you receive insurance benefits.**
3. We may disclose your information internally **to enhance the operation of our practice.** This includes our commitment to reviewing the quality of care we provide.
4. We may disclose your information **to comply with a limited number of legal requirements,** as outlined in this notice.

Additional information regarding each of these disclosures is provided in this notice. In any case, we will only disclose the minimum amount of information necessary for the purpose it was requested.

Effective Date: March 23, 2013

Our Duties

We are required by law to keep your information private. We must also provide you with this Notice and abide by its terms. We may need to revise our privacy practices from time to time. We expressly reserve the right to change the terms of our Notice of Privacy Practices and to make the new terms effective for all information covered by our Notice. If such changes occur, we will let you know about the new terms by providing a copy of the changes.

Your Privacy Rights

Please note that you are entitled to very specific rights regarding the use and disclosure of your information. We have listed your rights below:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our designated contact in order to inspect and/or copy your information. If you request a copy of your information, we may charge a fee for the costs of copying, mailing or other associated supplies. You may also choose to receive a copy of your health information in electronic form.

We may deny your request to inspect and/or copy information in certain limited circumstances. If you are denied access to your health information, you can ask that the denial be reviewed. If the law requires such a review, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request and we will comply with the outcome of the review.

Right to Amend

If you believe our records contain errors, you may make a written request that they be amended. We reserve the right to review your request and can decline to amend the record. We are required to place a copy of your proposed amendment in the record, even when we do not agree to amend the record itself.

We may deny your request for an amendment if we did not create the information, unless the person or entity that created the information is no longer available to make the amendment.

Right to Request Restrictions

You have the right to request restrictions on the use and disclosure of your information. We are not required to agree to your request. If we do agree, we will comply to the best of our ability unless the information is needed to provide you with emergency treatment. To request restrictions, you may complete and submit the **Request for Restriction on Use/Disclosure of Medical Information** to our designated Privacy Officer/Contact. If your restriction invalidates your insurance coverage, we may require you to execute a waiver of insurance benefits and a payment agreement.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the form **Request for Restriction on Use/Disclosure of Medical Information** to our designated Privacy Officer/Contact. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact our designated Privacy Officer/Contact.

Right to an Accounting of Disclosures

You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations.

To obtain this list, you must submit your request in writing to our designated Privacy Officer/Contact. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what format you want the list (for example, on paper or electronically).

The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Complaints and Investigations

We have developed procedures for investigating any complaints or concerns you may have regarding our use and disclosure of your information or any other complaint you may have regarding our services. The law allows you to contact the Secretary of the Department of Health and Human Services with complaints about our use and disclosure of information.

You may also contact our on-site Privacy Officer/Contact, who is dedicated to investigating complaints regarding the use and disclosure of information in our care. We will not, and legally cannot, retaliate against you for any complaint.

Types of Use and Disclosure of Your Protected Health Information

We may disclose your information for the following purposes without your consent:

For Treatment Purposes

We may disclose information needed for the provision, coordination or management of health care and related services, including the coordination between our office and a third party, such as a consultation between medical providers or a referral from our office to another provider. Personnel in our office may share

information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning prescriptions to your pharmacy, scheduling lab work and ordering X-rays. Family members and other health-care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment

To obtain reimbursement from your insurer, we may be required to disclose your information. This may be necessary for determining your eligibility for coverage and adjudication of claims, billing, claims management and collections activities. We may also be required to disclose your information to your insurer for review of the medical necessity, coverage, appropriateness or justification of our charges.

For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment. You have the right to restrict disclosures of your PHI to a health plan if you have paid out-of-pocket in full for the treatment.

For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. Healthcare operations may include:

- Quality assessment and improvement activities
- Reviewing the competence or qualifications of healthcare professionals or evaluating practitioner and provider performance
- Conducting training programs, accreditation, certification, licensing or credentialing activities
- Arranging for or conducting medical review, legal services or auditing functions, including fraud and abuse detection and compliance programs
- Managing and operating our practice, including activities such as customer service and complaint resolution

Appointment Reminders

We may contact you (via voicemail messages, postcards or letters) as a reminder that you have an appointment for your treatment or medical care at our office.

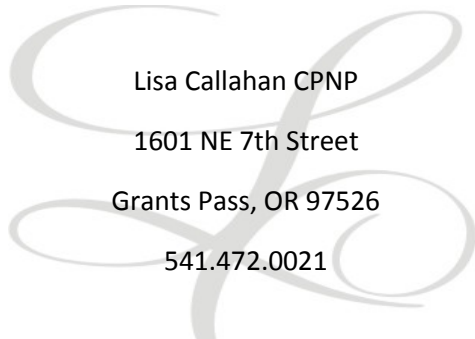
Treatment Alternatives

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you. We also may tell you about health-related products or services that may be of interest to you.

Marketing Health-Related Services

We will not use your health information for marketing communications without your written, prior authorization. We will not sell your PHI to another organization for marketing or any other purposes.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT



Lisa Callahan CPNP
1601 NE 7th Street
Grants Pass, OR 97526
541.472.0021

Effective

I understand that under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and certifications.

I have received, read and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time 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. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Signature _____

Relationship to Patient: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize: _____
(Name of Previous Health Care provider)

to use and disclose a copy of the specific health and medical information described below

regarding: _____
(Name of Patient) (Date of Birth)

To: **Lisa Callahan, CPNP**
1601 NE 6th St
Grants Pass, OR 97526
Phone (541) 472-0021
Fax (541) 476-4003

for the purpose of _____
(Such as "transfer of medical care")

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

- _____ **HIV/AIDS Information**
- _____ **Mental Health Information**
- _____ **Genetic Testing Information**
- _____ **Drug/Alcohol diagnosis, treatment, or referral information**

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send a written statement to our privacy officer. Unless revoked earlier or otherwise indicated, this Authorization shall remain in effect for the duration of the Trustor's trust.

SIGNATURE: I have read this authorization and I understand it.

By: _____ Date: _____
(Patient)

By: _____ Date: _____
(Patient Representative)

Description of Representative's Authority _____



Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Lisa Callahan CPNP for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Lisa Callahan CPNP. I understand that diagnosis or treatment of me by Lisa Callahan CPNP may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Lisa Callahan CPNP is not required to agree to the restrictions that I may request. However, if Lisa Callahan CPNP agrees to a restriction that I request, the restriction is binding on Lisa Callahan. I have the right to revoke this consent, in writing at any time, except to the extent that Lisa Callahan CPNP has taken action in reliance on this consent.

My “**protected health information**” means health information, including my demographic information, collected from me and created or received by my Nurse Practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Lisa Callahan CPNP’s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Lisa Callahan CPNP. The Notice of Privacy Practices for Lisa Callahan CPNP is also provided in the lobby and at the front desk. This Notice of Privacy Practices also describes my rights and the duties of Lisa Callahan’s office with respect to my protected health information.

Lisa Callahan CPNP reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail, or asking for one at the same time of my next appointment.

Signature of Patient or Personal Representative

Date

Name of Personal Representative **and** description of authority