ACTIVEFAMILY HEALTHCARE
8836 N Hess St. Suite E
Hayden, ID 83835
(208)758-0560

PATIENT INFORMATION

Full Legal Name: _____ Previous Last Name: _____
Last First MI

Date of Birth: ____/____/____ Male ____ Female ____ SSN: _____-_____-_____

Marital Status (please circle): Single Married Widowed Divorced

Address: _____
Street or PO Box City State Zip Code

How did you hear about Active Family HealthCare? _____

CONTACT INFORMATION

Primary Contact Number: (____) _____ Cell or Home Ok to leave messages? YES/NO

Secondary Contact Number: (___) _____, if any. Work Phone: (____) _____

Pharmacy: _____

Email: _____

EMERGENCY CONTACT

Name: _____ Relationship _____Phone #: (____) _____

INSURANCE (filling out more than the name is not necessary if you provided a copy of your card)

Primary Insurance:

Insurance Company Name: _____

ID#: _____ Group #: _____

Subscriber/Employee Name: _____

Sex: _____ DOB: _____ SSN: _____ Relationship to patient: _____

If secondary Insurance, please give name: _____

GUARANTOR INFORMATION (*person responsible for the bill*)

Full Name: _____ Relationship to Patient: _____
Last First MI

Social Security Number: _____ DOB: _____ Male___ Female___

Mailing Address: _____
Street or PO Box City State Zip Code

Home Phone: (____) _____ Cell Phone: (____) _____

Employer/School: _____ Work Phone: (____) _____

If patient is under 18, please provide Mother's name If not the Guarantor:

_____
Last First MI Maiden Name

ACTIVEFAMILY
HEALTHCARE

FINANCIAL AGREEMENT/RELEASE OF INFORMATION/OFFICE POLICIES

I request that payment of authorized Medicare or other insurance benefits be made to Active Family Healthcare for any services furnished to me by Active Family Healthcare. I authorize Active Family Healthcare to furnish all requested medical information of the persons or entity names above if requested by my insurance company in order to process my claim. I acknowledge that I have reviewed Active Family Healthcare's policy and procedures. I understand that regardless of my insurance status, I am solely responsible for payment of any professional services rendered to me, or on my behalf, whether or not paid by my insurance company. I acknowledge I have received and read a copy of the Active Family Healthcare office policies.

Signature of Patient or Legal Guardian: _____ **Date:** _____

Relationship to Patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Active Family Healthcare Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be made available to me upon request.

Signed: _____ **Date:** _____

Print Name: _____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

AUTHORIZATION FOR ACTIVE FAMILY HEALTHCARE TO UTILIZE INFORMATION AS DESCRIBED IN PRIVACY NOTICE

Name of Patient: _____

Please indicate by signature below that you are authorizing us to use private patient information as indicated in our Notice of Privacy Practices. This is not a change in how we have historically used your information. New laws require us to disclose how we use this information.

Signed: _____ **Date:** _____

PATIENT'S CONSENT FOR ACTIVE FAMILY HEALTHCARE TO SHARE PROTECTED HEALTH INFORMATION WITH OTHER NAMED PARTIES

In addition to our normal operational disclosures of privacy information, please identify to whom we may release your health care information. Each name must be identified. These should be people who help you with your health care needs and may need to be knowledgeable about your condition, treatment, and options. It is still the responsibility of the below named parties to request this information.

Name:	Relationship:
_____	_____
_____	_____

Signed: _____ **Date:** _____

ACTIVEFAMILY
HEALTHCARE

NOTICE OF PRIVACY PRACTICES

Effective April 2003—Revised July 2013

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.

PURPOSE OF THIS NOTICE

Active Family Healthcare is committed to preserving the privacy and confidentiality of your health information which is created and/or maintained at our clinic. State and federal laws and regulations require us to implement policies and procedures to safeguard the privacy of your health information. This Notice will provide you with information regarding our privacy practices and applies to all of your health information created and/or maintained at our clinic, including any information that we receive from other health care providers or facilities. This Notice describes the ways in which we may use or disclose your health information and also describes your rights and our obligations concerning such uses or disclosures.

We will abide by the terms of this Notice, including any future revisions that we may make to the Notice as required or authorized by law. We reserve the right to change this Notice and to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, which will identify its effective date, in our clinic and on our website at activefamilyhealthcare.com

The privacy practices described in this Notice will be followed by:

1. Any health care professional authorized to enter information into your medical record created and/or maintained at our clinic;
2. All employees, students, residents, and other service providers who have access to your health information at our clinic; and,
3. Any member of a volunteer group which is allowed to help you while receiving services at our clinic.

The individuals identified above will share your health information with each other for purposes of treatment, payment, and health care operations, as further described in the Notice.

Uses and Disclosures of Health Information for Treatment, Payment, and Health Care Operations

The following section describes different ways that we may use and disclose your health information for purposes of treatment, payment, and health care operations. We explain each of these purposes below and include examples of the types of uses or disclosures that may be made for each purpose. We have not listed every type of use or disclosure, but the ways in which we use or disclose your information will fall under one of these purposes.

1. **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, 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.

   For example, we may order physical therapy services to improve your strength and walking abilities. We will need to talk with the physical therapist so that we can coordinate services and develop a plan of care. We also may need to refer you to another health care provider to receive certain services. We will share information with that health care provider in order to coordinate your care and services.

2. **Payment**. We may use or disclose your health information so that we may bill and receive payment from you, an insurance company, or another third party for the health care services you receive from us. We also may disclose health information about you to your health plan in order to obtain prior approval for the services we provide to you, or to determine that your health plan will pay for the treatment.

For example, we may need to give health information to your health plan in order to obtain prior approval to refer you to a health care specialist, such as a neurologist or orthopedic surgeon, or to perform a diagnostic test such as a magnetic resonance imaging scan (MRI) or a CT scan.

3. **Health Care 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, employee review, 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. 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 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, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Uses and Disclosures of Health Information in Special Situations

We may use or disclose your health information in certain special situations as described below. For these situations, you have the right to limit these uses and disclosures as provided for below.

1. **Appointment Reminders.** We may use or disclose your health information for purposes of contacting you to remind you of a health care appointment.

2. **Treatment Alternatives & Health-Related Products and Services.** We may use or disclose your health information for purposes of contacting you to inform you of treatment alternatives or health-related products or services that may be of interest to you. For example, if you are diagnosed with a diabetic condition, we may contact you to inform you of a diabetic instruction class that we offer at our clinic.

2. **Family Members and Friends.** We may disclose your health information to individuals, such as family members and friends, who are involved in your care or who help pay for your care. We may make such disclosures when: (a) we have your verbal agreement to do so; (b) we make such disclosures and you do not object; or (c) we can infer from the circumstances that you would not object to such disclosures. For example, if your spouse comes into the exam room with you, we will assume that you agree to our disclosure of your information while your spouse is present in the room.

   We also may disclose your health information to family members or friends in instances when you are unable to agree or object to such disclosures, provided that we feel it is in your best interest to make such disclosures and the disclosures relate to that family member or friend's involvement in your care. For example, if you present to our clinic with an emergency medical condition, we may share information with the family member or friend that comes with you to our clinic. We also may share your health information with a family member or friend who calls us to request a prescription refill for you.

Other Permitted or Required Uses and Disclosures of Health Information

There are certain instances in which we may be required or permitted by law to use or disclose your health information without your permission. These instances are as follows:

1. **As required by law.** We may disclose your health information when required by federal, state, or local laws to do so. For example, we are required by the Department of Health and Human Services (HHS) to disclose your health information in order to allow HHS to evaluate whether we are in compliance with the federal privacy regulations.

2. **Public Health Activities.** We may disclose your health information to public health authorities that are authorized by law to receive and collect health information for the purpose of preventing or controlling disease, injury or disability; to report births, deaths, suspected abuse or neglect, reactions to medications; or to facilitate product recalls.

3. **Health Oversight Activities.** We may disclose your health information to a health oversight agency that is authorized by law to conduct health oversight activities, including audits, investigations, inspections, or licensure and certification surveys.

These activities are necessary for the government to monitor the persons or organizations that provide health care to individuals and to ensure compliance with applicable state and federal laws and regulations.

4. **Judicial or Administrative Proceedings.** We may disclose your health information to courts or administrative agencies charged with the authority to hear and resolve lawsuits or disputes. We may disclose your health information pursuant to a court order, a subpoena, a discovery request, or other lawful process issued by a judge or other person involved in the dispute, but only if efforts have been made to (i) notify you of the request for disclosure or (ii) obtain an order protecting your health information.

5. **Worker's Compensation.** We may disclose your health information to worker's compensation programs when your health condition arises out of a work-related illness or injury.

6. **Law Enforcement Official.** We may disclose your health information in response to a request received from a law enforcement official to report criminal activity or to respond to a subpoena, court order, warrant, summons, or similar process.

7. **Coroners, Medical Examiners, or Funeral Directors.** We may disclose your health information to a coroner or medical examiner for the purpose of identifying a deceased individual or to determine the cause of death. We also may disclose your health information to a funeral director for the purpose of carrying out his/her necessary activities.

8. **Organ Procurement Organizations or Tissue Banks.** If you are an organ donor, we may disclose your health information to organizations that handle organ procurement, transplantation, or tissue banking for the purpose of facilitating organ or tissue donation or transplantation.

9. **Research.** We may use or disclose your health information for research purposes under certain limited circumstances. Because all research projects are subject to a special approval process, we will not use or disclose your health information for research purposes until the particular research project for which your health information may be used or disclosed has been approved through this special approval process. However, we may use or disclose your health information to individuals preparing to conduct the research project in order to assist them in identifying patients with specific health care needs who may qualify to participate in the research project. Any use or disclosure of your health information which is done for the purpose of identifying qualified participants will be conducted onsite at our facility. In most instances, we will ask for your specific permission to use or disclose your health information if the researcher will have access to your name, address, or other identifying information.

10. **To Avert a Serious Threat to Health or Safety.** We may use or disclose your health information when necessary to prevent a serious threat to the health or safety of you or other individuals.

11. **Military and Veterans.** If you are a member of the armed forces, we may use or disclose your health information as required by military command authorities.

12. **National Security and Intelligence Activities.** We may use or disclose your health information to authorized federal officials for purposes of intelligence, counterintelligence, and other national security activities, as authorized by law.

13. **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may use or disclose your health information to the correctional institution or to the law enforcement official as may be necessary (i) for the institution to provide you with health care; (ii) to protect the health or safety of you and another person; or (iii) for the safety and security of the correctional institution.

Uses and Disclosures Pursuant to Your Written Authorization

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes. You may revoke the 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 Regarding Your Health Information

You have the following rights regarding your health information. You may exercise each of these rights, in writing, by providing us with a completed form that you can obtain from medical records department. In some instances, we may charge you for the cost(s) associated with providing you with the requested information. Additional information regarding how to exercise your rights, and the associated costs, can be obtained from the receptionist.

1. **You have the right to inspect and copy your protected health information (fees may apply) –** Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

2. **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 your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

3. **You have the right to request to receive confidential communications** – You have the right to request confidential communication 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.

4. **You have the right to request an amendment to 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.

5. **You have the right to receive an accounting of certain disclosures –** You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

6. **You have the right to receive notice of a breach** – We will notify you if your unsecured protected health information has been breached.

7. **You have the right to obtain a paper copy of this notice** from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

Questions or Complaints

If you have any questions regarding this Notice or wish to receive additional information about our privacy practices, please contact our Privacy Officer, Jennifer. If you believe your privacy rights have been violated, you may file a complaint with our clinic or with the Secretary of the Department of Health and Human Services (HHS). To file a complaint with our clinic, contact our Privacy Officer at Active Family Healthcare. All complaints must be submitted in writing. You will not be penalized for filing a complaint.