Patient Information

First Name ________________________________ Last Name __________________________ Date of Birth __________

Address ____________________________________ City __________________________ State ______ Zip ___________

Best Contact Phone # ______________________________ Alternate Phone # __________________________________

Social Security # __________________________________

Insurance Information

Primary Carrier Name __________________________________ Primary Insured Name ___________________________

ID # ______________________________ Group Name _____________________ Group # _________________________

Secondary Carrier Name ______________________________ Secondary Insured Name ___________________________

ID # ______________________________ Group Name _____________________ Group # _________________________

I hereby authorize my insurance benefits to be paid directly to Hunterdon Integrative Physicians. I understand that I am responsible for verifying insurance participation and treatment coverage. I agree that I am financially responsible for any unpaid balances including non-covered services. In the event that Hunterdon Integrative Physicians is not a provider of my insurance carrier, I understand that I am responsible to pay any charges incurred at the time of service. I authorize Hunterdon Integrative Physicians to release any information to my insurance company as needed when processing claims.

I am aware that new patient missed appointments and appointments cancelled with less than 24 hours notice are subject to a $150 fee.

____ ____________________

Patient Signature Date

HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic 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.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

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, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. 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.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare 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 activities, employee review activities, 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. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. 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, as necessary, to contact you to remind you of your appointment.

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, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this 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
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

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 a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications 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.

You may have the right to have your physician amend 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.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on or before 6 February 2013.

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We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: ___________________________ Signature _______________________ Date _______

HUNTERDON INTEGRATIVE PHYSICIANS
A common sense approach to your health care

Patient Name: _____________________________ Date of Birth: _____________________________

How did you hear about us? ____

Please explain why you are visiting us today:

____
____
____

List any other medical problems:

1. ____
2. ____
3. ____
4. ____

List any other clinicians (name and type), therapists, etc. who are currently treating you and for what:

1. ____
2. ____
3. ____

List any vitamins, supplements, prescriptions or over-the-counter medications you are currently taking:

1. ____ 4. ____
2. ____ 5. ____
3. ____ 6. ____

What is your Pharmacy preference? (please provide phone#): ____

Social History:

Allergies/Drug Sensitivities: ____

Smoking History: Never smoked_____ Currently smoke _____ Use to smoke(amt and date quit) ______________

Alcohol History: Never/rarely _____ Currently drink (average drinks per week)___________________

Drug Use: Never _____ Past use of ________________ Current use of _____________________

Current Occupation (if retired, please state former occupation): _________________________________

Marital Status: Single ________ Married _______ Divorced ________ Widowed ___________

History of Surgeries/Hospitalization (Include dates):

____
____
____
____

Family Medical History (please list who):

Abuse_______________________________

Alcoholism___________________________

Allergies_____________________________

Arthritis______________________________

Autoimmune Disease__________________

Birth Defects_________________________

Bleeding Disorder_____________________

Cancer_______________________________

Diabetes _____________________________

Drug Abuse__________________________

Father's Blood Type__________RH_________

Eczema_____________________________________

Epilepsy/Seizures____________________________

Gastrointestinal Disease_________________________

Hearing Loss___________________________________

Heart Disease __________________________________

High Cholesterol________________________________

Migraines______________________________________

Psychological Illnesses__________________________

Smoking_______________________________________

Other____

Mother's Blood Type__________RH_______________

Children Only

Prenatal History:

Pregnancy Complications:____

Medications:_______________________________________ Illnesses:____

Trauma: ____ Location of birth:__________________________________

Duration of Pregnancy (# of weeks): ____

Birth Weight ___________________________ __ Birth Length____

Health issues: ____

Feeding: Breast_____________ Formula_______________

Developmental Landmarks (age):

______Sat up ______Started speaking ______Bladder Training

______Stood ______First Tooth ______Bowel Training

______Rolled Over ______Walked

School History:

Special Education Needs: ____

Behavior Problems:____

Sports/Recreational Activities:____

HUNTERDON INTEGRATIVE PHYSICIANS

A common sense approach to your health care

Medical History (Please list explanation to any problems)

Constitutional:

___Significant weight change (10lbs or more)___________

___Appetite problems ___________

___Low/High energy ___________

___Change in stress/mood ___________

___Unexplained fever___________

___Heat/cold intolerance___________

___Unusual thirst___________

___Sleep problems ___________

Eyes/Ears/Nose/Throat:

___Hearing loss___________

___Ringing in ears___________

___Nasal congestion___________

___Nose bleeding___________

___Bleeding gums/mouth sores___________

___Impaired taste ___________

___Visual Problems ___________

Neurological:

___Dizziness/Fainting___________

___Balance problems___________

Cardiovascular:

___Chest Pain ___________

___Palpitations___________

___Shortness of Breath ___________

___Swollen legs ___________

___Unusual cough___________

Gastrointestinal:

___Nausea/vomiting___________

___Diarrhea/constipation___________

___Change in stool___________

___Rectal bleeding___________

___Abdominal pain___________

___Gas/bloating___________

___Heartburn___________

___Trouble swallowing ___________

Genitourinary:

___Painful Urination___________

___Blood in urine___________

___Sexual difficulty___________

___Difficulty controlling urine/bowels___________

Musculoskeletal:

___Muscle cramps/pains/fatigue___________

___Joint stiffness/swelling/pain___________

Skin:

___Rashes/sores/lesions___________

___Bruising___________

Breasts:

___Pain/Discharge___________

___Lumps in breasts___________

Infectious Diseases:

___Parasites___________

___HIV___________

___Chicken Pox___________

___Hepatitis___________

___Lyme Disease___________

___Whooping Cough___________

___Diptheria___________

___TB___________

___Rheumatic Fever___________

___Venereal Disease___________

___Meningitis___________

___Other___________

Women Only:

Age of menstrual onset:___________

Regular: Y___ N ___ ___________

Cycle: (# of days) ___________

Flow: Heavy____ Medium_____ Light______

Clots? ___________

Cramps? ___________

Premenstrual symptoms ___________

Date of last period ___________

Date of last pelvic exam ___________

Date of last Pap test and result ___________

Unusual discharge? ___________

Vaginal itching ___________

Other ___________

How many pregnancies? ___________

How many children born?___________Stillbirths?___________

How many c-sections? ___________

How many miscarriages? ___________ Abortions? ___________

Pregnancy complications? ___________

Men Only:

___ Enlarged Prostate ___________

___Elevated PSA___________

___Urethral discharge___________