PIZER FAMILY PRACTICE, PLLC (1)
PATIENT (ADULT) MEDICAL HISTORY
TODAYS DATE________________ PATIENT NAME: ____________________________________

PREFERRED NAME:____ DATE OF BIRTH: _______________________

PARENT'S NAME (IF MINOR)_______________________________ PATIENT SS#:_________________________

ADDRESS: PO BOX:_________________ STREET ADDRESS:____

CITY/STATE/ZIP:____

PHONE (HOME) ______________________________ (CELL) ________________________

☐SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

EMERGENCY CONTACT:____ PHONE #: __________________

E-mail: ____

RESPONSIBLE PARTY INFORMATION (*IF DIFFERENT THAN ABOVE*)

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT: ____
RELATIONSHIP TO PATIENT: ☐ SELF ☐PARENT/GUARDIAN ☐ SPOUSE ☐ OTHER
ADDRESS:____
CITY/STATE/ZIP:____
PHONE (HOME) ______________________________ (CELL) ________________________

***PLEASE FILL OUT COMPLETELY:**

***Sex**: ☐ Male ☐ Female		***Race**: ☐ African American/ Black ☐ American Indian/ Native American ☐ Asian ☐ Hawaiian/Polynesian ☐ Caucasian/White ☐ Other ____________	***Ethnicity**: ☐ Hispanic ☐ Non-Hispanic
Employer: ____________________________	**Occupation:** __________________________		***Primary Language**: ☐ English ☐ Spanish ☐ Other _______________
***Highest Education Level Completed**: ____		***Children Living**: (born to you) #____________	
***Preferred Pharmacy:** ☐ Express Care Pharmacy - Otway ☐ CVS - Beaufort ☐ Rite-Aid - Beaufort ☐ Walmart ☐ Express Scripts – Mail Program ☐ Medco – Mail Program ☐ CVS/Caremark ☐ Other ______________________________		Any additional information you think we should know about you.: ____ ____ ____ ____ ____ ____	

Please write any additional concerns, questions, medications, or personal history on this form.
This will allow us to give you the best care possible.

PIZER FAMILY PRACTICE, PLLC (2)
PATIENT (ADULT) MEDICAL HISTORY
TODAYS DATE________________ PATIENT NAME: __________________________________

Are you taking any medications (including herbal, vitamins, or over the counter medications)? ☐ Y ☐ N ☐?

Current Medications	Dosage	Frequency

Health History: Please indicate if any of the following conditions apply to you and/or anyone in your family (living or dead) and include relationship: (y – yourself, m-mother, f-father, b-brother, s-sister, gf – grandfather, gm – grandmother, c –child)

☐Abuse (drug/alcohol)
☐Anemia
☐Anxiety
☐Arthritis
☐Artificial Heart Valves/Joints
☐Asthma
☐Back Problems
☐Bleeding Abnormally
☐Blood Disease/Disorder
☐Cancer _____________
☐Chest Pain
☐Cholesterol - High
☐Chronic Cough
☐Chronic Constipation
☐Chronic Diarrhea
☐Circulatory Problems
☐Congenital Heart Lesions
☐COPD/Chronic Lung Disease
☐Current Infection(s)
☐Deep Vein Thrombosis
☐Depression/Mental Illness
☐Diabetes
☐Emphysema
☐Epilepsy Convulsions/Seizures
☐Fainting
☐Tired/Fatigue
☐Glaucoma
☐Gout
☐Hay Fever/Allergies
☐Headaches/Migraines
☐Hearing Loss
☐Heart Attack/Disease
☐Heart Murmur
☐Heart Problems
☐Hepatitis
☐Hernia Repair
☐High Blood Pressure
☐HIV/AIDS
☐Irregular Heartbeat/Atrial Fib
☐Jaundice/Liver Disease
☐Joint Replacement/Implant
☐Kidney/Bladder/Urinary Problems
☐Leukemia
☐Low Blood Pressure
☐Mitral Valve Prolapse
☐Nerve Problems
☐Osteoporosis
☐Pacemaker/Defibrillator
☐Psychiatric Care
☐Radiation Treatment
☐Recent Weight Gain/Loss
☐Respiratory/Breathing Problems
☐Rheumatic Fever
☐Sexually Transmitted Disease
☐Shortness of breath
☐Skin Problems
☐Stomach Ulcers/Troubles
☐Stroke
☐Substance Abuse
☐Swollen Ankles
☐Swollen Neck Glands
☐Thyroid Problems
☐Tuberculosis (TB)
☐Vision Problems
☐OTHER:

Are you under any medical treatment now? ☐ Y ☐ N ☐?
Have you ever been hospitalized? ☐ Y ☐ N ☐?
Have you had any surgery? ☐ Y ☐ N ☐?
List with dates: ____
Are you allergic to any medications, foods, latex, or dyes? If yes, list: ☐ Y ☐ N ☐?
____
When was your last menstrual period?__________ Are you pregnant/nursing? ☐ Y ☐ N ☐?
Are you taking birth control pills or using other method of birth control? ☐ Y ☐ N ☐?
Do you smoke or use tobacco/snuff? ☐ Y ☐ N ☐?
Do you drink alcoholic beverages? ☐ Y ☐ N ☐?
Do you use any illegal substances (marijuana, cocaine, meth, etc.)? ☐ Y ☐ N ☐?
Do you exercise regularly? How often? _____ days/week ☐ Y ☐ N ☐?
Are you on a special diet? Low fat/ Low carb/ DASH/ Diabetic ☐ Y ☐ N ☐?
Are you wearing contact lens or do you need corrective lens? ☐ Y ☐ N ☐?

Most Recent	**Date**	**Place**
Prostate Exam/PSA		
Pap Smear		
Mammogram		
Colonoscopy		
Eye Exam		
Dental Exam		
Tetanus Shot		
Flu Vaccine		

Please write any additional concerns, questions, medications, or personal history on this form.
This will allow us to give you the best care possible.

PIZER FAMILY PRACTICE PLLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

PATIENT'S NAME: ______________________________

I hereby acknowledge that I have seen a copy of this health practice's Notice of Privacy Practices (it is below this form) and that I may receive a copy of the Notice of Privacy Practices at any time upon request. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

SIGNATURE: ______________________________ **DATE:** ________________

PRINT NAME: ______________________________ **PHONE:** ________________

If not signed by the patient, please indicate your relationship to the patient: ________________

Who may we speak with regarding your healthcare or healthcare billing information?

Name	Relationship	Phone No.

*********************************** **FOR OFFICE USE ONLY** *********************************

☐ Signed form received by: ______________________________

PIZER FAMILY PRACTICE, PLLC

Notice of Privacy Practices

IMPORTANT: 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.

As an essential part of our commitment to you, Pizer Family Practice, PLLC maintains the privacy of certain confidential health care information about you known as Protected Health Information or PHI.

The Notice outlines our legal duties and privacy practices with respect to your PHI. It not only describes our privacy practices and your legal rights, but lets you know, among other things, how Pizer Family Practice, PLLC is permitted to use and disclose PHI about you, how you can access and copy that information, how you may request amendments to that information and how you may request restrictions on our use and disclosure of your PHI.

We respect your privacy, and treat all health care information about our patients with care under strict policies of confidentiality that all staff members are committed to following at all times.

Please read this detailed Notice. If you have any questions about it please contact our privacy officer at 252-838-1743.

Purpose of this notice: Pizer Family Practice, PLLC is required by law to maintain the privacy of certain confidential health care information, Known as Protected Health Information (PHI), and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. This Notice describes your legal rights, advises you of our privacy practices, and leys you know how Pizer Family Practice, PLLC is permitted to use and disclose PHI about you.

Pizer Family Practice, PLLC is also required to abide by the terms of the version of this Notice currently in effect. In most situations we may use this information as described in this Notice without your permission, but there are some situations where we may use it only after we obtain your written authorization, if we are required by law to do so.

Uses and Disclosure of PHI: Pizer Family Practice, PLLC may use PHI for the purposes of treatment, payment and health care operations, in most cases without your written permission. Examples of our use of PHI:

For treatment – This includes such things as verbal and written information that we obtain about you pertaining to your medical condition and treatment provided to you by us and other medical personnel (including doctors and nurses who give orders to allow us to provide treatment to you). It also includes information we give to other health care personnel to whom we transfer your care and treatment, and includes transfer of PHI via radio, telephone or fax to the hospital, physician or dispatch center as well as providing them with a copy of the written record we create in the course of providing you with treatment and/or transport.

For health care operations – This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes, fundraising and certain marketing activities.

Reminders for other services – We may contact you to provide you with for other information about alternative services we may provide or other health-related benefits and services that may be of interest to you.

Use and Disclosure of PHI Without your Authorization: Pizer Family Practice, PLLC is permitted to use PHI without your written authorization or opportunity to object in certain situations, including:

- For Pizer Family Practice, PLLC use in treating you or in obtaining payment for services provided to you or in other health care operations;
- For the treatment activities of another health care provider
- To another health care provider or entity for the payment activities of the provider or entity that receives the information (such as your hospital or insurance company);
- To another health care provider (such as the hospital to which you are transported) for the health care operations activities of the entity that receives the information as long as the entity receiving the information has or has had a relationship with you and the PHI pertains to that relationship;
- For health care fraud and abuse detection or for activities related to compliance with the law;
- To a family member, other relative, close personal friend or other individual involved in your care 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 PHI to your family, relatives or friends if we infer from the circumstances that you would not object. For example, we may assume you agree to our disclosure of your PHI to your spouse when your spouse has called the ambulance for you. In situations where you are not capable of objecting (because you are not present or due to your incapacity or medical emergency), we may, in our professional judgment, determine that a disclosure to your family member, relative or friend is in your best interest. In that situation we will disclose only PHI relevant to that person's involvement in your care. For example, we may inform that person who accompanied you to the health center or ambulance that you have certain symptoms and we may give that person an update on your vital signs and treatment that is being administered by our staff;
- To a public health authority in certain situations(such as reporting a birth, death or disease as required by law, as part of a public health investigation to report child or adult abuse, neglect or domestic violence, to report adverse events such as products defects, or to notify a person about exposure to a possible communicable disease as required by law;
- For health oversight activities including audits or government investigations, inspections, disciplinary proceedings and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;
- For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;
- For law enforcement activities in limited situations, such as when there is a warrant for the

request, or when the information is needed to locate a suspect or stop a crime;

- For military, national defense and security and other special government functions;
- To avert serious threat to the health and safety of a person or public at large;
- For workers' compensation purposes, and in compliance with workers' compensation laws;
- To coroners, medical examiners and funeral directors for identifying a deceased person, determining cause of death or carrying on their duties as authorized by law;
- If you are an organ donor, we may release PHI to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate organ donation and transplantation;
- For research projects, subject to strict oversight and approvals and PHI will be released only when there is a minimal risk to your privacy and adequate safeguards are in place in accordance with the law;
- We may use or disclose PHI about you in a way that does not personally identify you or reveal your identity.

Any other use or disclosure of PHI other than those listed above will only be made with your written authorization (the authorization must specifically identify the information we seek to use or disclose, as well as when and how we seek to use or disclose it.) You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.

Patient Rights: As a patient you have a number of rights with respect to the protection of your PHI, including the right to access, copy or inspect your PHI. This means you may come to our office and inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a reasonable fee for you to copy any medical information that you have the right to access. In limited circumstances we may deny you access to your medical information, and you may appeal certain types of denials.

We have available forms to request access to your PHI and we will provide a written response if we deny you access and advise you of your appeal rights. If you wish to inspect and copy your medical information you should contact the HIPPA Privacy Officer listed at the end of this Notice.

The Right to Amend Your PHI: You have the right to ask us to amend written medical information that we may have about you. We will generally amend your information within 60 days of your written request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information only in certain circumstances, i.e., when we believe the information you have asked us to amend is correct. If you wish to request that we amend the medical information that we have about you, you should contact the HIPPA Privacy Officer.

The Right to Request an Accounting of Our Use and Disclosure of Your PHI: You may request an accounting from us of certain disclosures of your PHI that we have made in the last six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations, or when we share your PHI with our business associates, i.e., our billing company or a medical facility to which we have transported you.

We are also not required to give you an accounting of our uses of PHI for which you have already given us written authorization. If you wish to request an accounting of the PHI about you that we have used or disclosed that is not exempted from the accounting requirement, you should contact the HIPPA Privacy officer.

The Right to Request That We Restrict the Uses and Disclosures of Your PHI: You have the right to request that we restrict how we use and disclose your PHI that we have about you for treatment, payment or health care operations, or to restrict the information that is provided to family, friends and other individuals involved in your health care. If you request a restriction and the information you asked us to restrict is needed to provide you with emergency treatment, then we may use the PHI or disclose the PHI to a health care provider to provide you with emergency treatment. Pizer Family Practice, PLLC is not required to agree to any restrictions you request, but any restrictions agreed to by Pizer Family Practice, PLLC are binding.

Internet, Electronic Mail, and the Right to Obtain Copy of Paper Notice on Request: If we maintain a web site, we will prominently post a copy of this Notice on our web site and make the Notice available electronically through the web site. If you allow us, we will forward you this Notice by electronic mail instead of paper and you may always request a paper copy of the Notice.

Revision to the Notice: Pizer Family Practice, PLLC reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all PHI that we maintain. Any material changes to the Notice will be promptly posted in our facility and posted to our web site, if we maintain one. You may also obtain a copy of the latest version of this Notice by contacting the HIPPA Privacy Officer.

Your Legal Rights and Complaints: You have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or with the U.S. Department of health and Human Services. Should you have any questions, comments or complaints, you may direct all inquiries to the HIPPA Privacy Officer. Individuals will not be retaliated against for filing a complaint. If you have any questions or if you wish to file a complaint or exercise any rights listed in this Notice, please contact the HIPPA Privacy Officer at

Pizer Family Practice, PLLC
700 Hwy 70 E Otway
Beaufort, NC 28516
252-838-1743

Effective Date of the Notice: May 1, 2013