New Patient Registration

Today's Date: _____

Patient Name: _____ **Date of Birth:** _____

Social Security #: _____**Sex: Male** __ **Female**__ **Marital Status:**Single__ Married_ Divorced__ Widow__ Other__

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone #: (___) _____ **Work Phone #: (___)** _____ **Cell Phone #: (___)** _____

Referred From: _____

Primary Insurance: _____ **Effective Date:** _____

Policy Holder: _____ **SS #:** _____ **Date of Birth:** _____

Policy Number: _____ **Group Number:** _____

Secondary Insurance: _____ **Effective Date:** _____

Policy Holder: _____ **SS #:** _____ **Date of Birth:** _____

Policy Number: _____ **Group Number:** _____

Nearest Relative: _____ **Relationship:** _____ **Phone #: (___)** _____

Street Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

I give permission to ***Laurel Medical Group*** and its employees, agents and medical providers to release medical information to insurance carriers, health organizations, governmental agencies and other entities charged with fiscal responsibility for the payment of medical services rendered to me. I hereby authorize payment of the medical benefits otherwise payable to me, to be directed to ***Laurel Medical Group*** or appropriate provider. I consent to have any monies received by the provider of services on my behalf to be applied to my outstanding accounts. I assume full responsibility for payment of any charges for medical services provided. I understand that any or all of my medical information may be used for blinded-data research, in which **NONE** of the data will be linked to my identity. I understand that my medical information may be electronically submitted to any or all treating physicians, hospitals and/or health care entities.

X_____

Signature **Relation to Patient** **Date**

A referral form from my primary care physician is required for any and all non-emergency outpatient hospital/specialist services. I acknowledge that I do not have a referral form with me at this time, but I choose to receive the services without the required referral. I understand that without the appropriate referral I will be held responsible for any payments incurred for these services.

X_____

Signature **Relation to Patient** **Date**

HIPAA Notice of Privacy Practices

The Health Portability and Accountability Act of 1966 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, or paper or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is use. "HIPAA" provides penalties for covered entitles that misuse personal health information.

As required by "HIPAA" we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, and managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improving activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friend, or any other person identified by you. We are, however, not required to agree to a request restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. As required by law, we will notify you if a breach of unsecured protected health information occurs.

HIPAA Notice of Privacy Receipt

This notice is effective as of _____, 20__ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, and violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Laurel Medical Group, LLC

1124 S. Central Avenue

Laurel, DE 19956

302-875-7753

For more information about HIPAA, or to file a complaint:

The U.S. Department of Health and Human Services

Office of Civil Rights

200 Independence Avenue, S.W.

Washington, D.C. 20201

202-619-0257

Toll Free 1-877-696-6775

_____ _____

Patient Signature Date