Brian Bluth, MD
Bluth Family Medicine
1315 N. Washington
Weatherford OK, 73096
(580) 772-2344

To Whom It May Concern,

We would like to welcome you to our medical practice and explain a little about our office policies and goals. We believe in the theories of Modern Medical Care, which do not support the old premise that a doctor's office is only a place for the seriously ill. Most illness(s) can be treated effectively with early detection. For that reason, we recommend a system of proper preventative care and regular checkups. If you adhere to this simple philosophy, and watch your diet and exercise, you will minimize the risk of debilitating illness(s).

Our patients can expect from us:

1. A high degree of professional skill and ability.
2. A dedication to your overall health and well being.
3. A minimization of medical expenses through proper preventative care.
4. The highest effort to make your visits as comfortable as possible.
5. Maintain the privacy of your health information as required by HIPAA regulations.

In return we expect from our patients:

1. Cooperation in making and keeping appointments. Failure to keep your appointment may result in a no-show fee.
2. 3 no show appointments within a calendar year will result in dismissal of care. *A "no show" appointment is a missed appointment without notification to the clinic prior to the scheduled appt.*
3. A conscientious effort to follow prescribed treatments.
4. Attention to proper diet and exercise.
5. A definite arrangement for the payment of fees at the time of service.

In order to be mutually satisfying and beneficial we ask that any time you have a question or are unhappy about any treatment (proposed or performed), fee for service, or attitude of our staff, you will discuss it with us promptly and openly.

Thank You,
Brian Bluth, MD

Effective April 14, 2003

NOTICE OF PRIVACY PRACTICES
BRIAN BLUTH, M.D.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULY.

The Health Insurance Portability and Accountability Act of 1996 (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, on 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 used. "HIPAA" provides penalties for covered entities that misuse personal 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** means providing, coordinating, or managing health care and related services by one or more health care providers.
* **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 improvement activities, auditing functions, cost-management analysis, and customer service. An example would be and internal quality assessment review.

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 or 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, or individuals involved in your care. We are, however, not required to agree to a requested 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.
* 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.

This notice is effective April, 04, 2003 and we are required to abide by the terms of the Notice of Privacy Practices and to make the 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 a written complaint with our office, or with the Office of Civil Rights, Region VI about 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:

Brian Bluth, M.D.
1315 N. Washington
Weatherford, OK 73096

For more information about HIPAA or to file a complaint:

Office of Civil Rights, Region VI
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

PATIENT REGISTRATION

DEMOGRAPHIC INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ (mm/dd/yyyy) SEX: _____ RACE: _____

SOCIAL SECURITY #: _____ ETHNICITY: _____

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ STATE: _____ ZIP: _____

LANGUAGE: _____ LANGUAGE COUNTRY: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNER ☐ DIVORCED ☐ WIDOWED

☐ PREGNANT (check if applicable) ☐ NURSING (check if applicable)

Whom may we thank for referring you to our practice? _____

CONTACT INFORMATION

HOME PHONE: _____ WORK PHONE: _____ EXT: _____

CELL PHONE: _____ EMAIL: _____

EMERGENCY CONTACT INFORMATION

CONTACT FIRST NAME: _____ CONTACT LAST NAME: _____

CONTACT HOME PHONE: _____ CONTACT CELL PHONE: _____

RELATIONSHIP TO PATIENT: _____ CONTACT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FAMILY MEMBERS IN THE PRACTICE

_____ (name) _____ (relationship to patient)

_____ (name) _____ (relationship to patient)

_____ (name) _____ (relationship to patient)

_____ (name) _____ (relationship to patient)

PRIMARY CARE / OTHER PHYSICIAN

PHYSICIAN NAME: _____ PRACTICE NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHARMACY NAME: _____ PHARMACY PHONE: _____

PHARMACY LOCATION: _____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: **Date:**

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE COMPANY: _____ CO-PAY: _____

GROUP #: _____ SUBSCRIBER #: _____

INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____

SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ EXT: _____

ADVANCED DIRECTIVE? ☐ YES ☐ NO WHERE IS IT FILED? _____(what medical facility?)

INSURED EMPLOYED BY: _____ BUSINESS ADDRESS: _____

CITY: _____ STATE _____ ZIP: _____ BUSINESS PHONE #: _____

ADDITIONAL INSURANCE

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE? ☐ YES ☐ NO

INSURANCE COMPANY: _____ CO-PAY: _____

GROUP #: _____ SUBSCRIBER #: _____

INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____

SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ EXT: _____

INSURED EMPLOYED BY: _____

BUSINESS ADDRESS: _____ CITY: _____ STATE _____ ZIP: _____

BUSINESS PHONE # : _____

EMPLOYMENT STATUS: ☐ Employed ☐ Unemployed ☐ Full Time Student ☐ Part Time Student ☐ Retired

LAST DEGREE EARNED: ☐ HIGH SCHOOL ☐ COLLEGE ☐ GRADUATE SCHOOL

OCCUPATION: _____ BUSINESS NAME: _____

BUSINESS PHONE: _____

DRIVERS LICENSE #: _____ STATE ISSUED: _____

IS THIS AN ACCIDENT? ☐ YES ☐ NO

DATE OF INJURY _____

IS THIS A MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: **Date:**

Consent to Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health and medical care, Bluth Family Medicine, LLC-Brian L. Bluth M.D. originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I further understand that this information serves as:

+ a basis for planning my care and treatment;
+ a means of communications among the health professionals who contribute to my care;
+ a sources of information for applying my diagnosis and treatment information to my bill;
+ a means for a third-party payer to verify that services were billed as actually provided;
+ and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release futher information shall remain in force until such time as I shall revoke it in writing.

I understand and have been provided with a **PATIENT PRIVACY NOTICE** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the PATIENT PRIVACY NOTICE prior to signing this consent. I understand that Bluth Family Medicine, LLC-Brian L. Bluth, M.D. reserves the right to change their notice and practices, but that prior to implantation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Bluth Family Medicine, LLC-Brian L. Bluth, M.D. is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

By Oklahoma law we are required to notify...**that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).**

In addition to the release outlined above, information may be released to the following individuals/organizations:

Name/Phone Number	Relationship	Options
1.		___ Billing information ___ Appointment Info ___ Medical/Health Info
2.		___ Billing information ___ Appointment Info ___ Medical/Health Info
3.		___ Billing information ___ Appointment Info ___ Medical/Health Info
4.		___ Billing information ___ Appointment Info ___ Medical/Health Info

I request the following restrictions to the use and/or disclosure of my health information:

___ You May Contact me by telephone	Phone Number:
___ You May leave a message/voicemail	Phone Number:
___ Please Do Not leave a message/voicemail	

This request supersedes any prior request for communication of information I may have made.

Signature of Patient or Legal Representative

Date Notice Effective

PATIENT REGISTRATION

Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by _____ in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or heath care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I agree and consent to _____ releasing information to me in the following manners:

	PLEASE INITIAL
VIA MAIL	
☐ OK TO MAIL TO HOME ADDRESS	_____
☐ OK TO MAIL TO WORK ADDRESS	_____
VIA HOME TELEPHONE	
☐ OK TO LEAVE DETAILED MESSAGE	_____
☐ LEAVE CALL BACK NUMBER ONLY	_____
VIA WORK TELEPHONE	
☐ OK TO LEAVE DETAILED MESSAGE	_____
☐ LEAVE CALL BACK NUMBER ONLY	_____
VIA FAX	
☐ OK TO FAX TO: _____	_____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:** _____

Previous Medical Diagnosis/Surgeries and other hospitalization

Date	Diagnosis/Surgery/Hospitalization	Hospital/Doctor

Medications-List all medications you take, prescription and non-prescription

_____ I do not take any medications

Mediation Name	Dosage	Frequency

Medications and Food Allergies- List all known allergies (drug, food, animals, etc.)

_____ No Known Allergies

Name of drug/Allergy	Reaction	Name of drug/Allergy	Reaction

Family Health History

__Adopted/No History Available	Mother	Father	Brother	Sister	Other (Please Specify)
Alzheimer's Disease					
Asthma					
Blood Disease					
Heart Attack					
Cancer-Type					
Depression					
Diabetes					
Hypertension					
IBS					
Mental Illness					
Obesity					
Other					
Other					

Signature: **Date:**