PATIENT INFORMATION SHEET

Date: ____/____/____

Last Name: ________________________ First: ___________________________ MI: _____
Address: ____
City: __________________________________ State: ______ Zip: __________
Home Phone: (   )______-________ Work: (   )______-_________ Cell: (   )_____-________

EMAIL Address: ____

Employer Name: __________________________ Occupation: ____________________________
Marital Status: { }Married { }Single { }Other DL#: ___________________________
SS#: ___________-_______-____________ DOB: ______/_____/_______ M/F

Spouse: ____________________________ DOB: ____/____/____ SS#: ______-______-______
Employer: _________________________ Occupation: ___________________________________

Nearest Friend/Relative NOT living with you to contact in an emergency.
Name: __________________________ Phone: (   )_______-________ Relation: ___________

Referred by: ____
Address: ____________________________________ Phone: (   )______-________

PRIMARY INSURANCE

Insurance Name: ____________________________________
Subscriber Name: _________________________________ Employer: _______________________
DOB _____/_____/_____ SS# ________/______/________
Group Name: _______________________________

SECONDARY INSURANCE

Insurance Name: ____________________________________
Subscriber Name: ___________________________________ Employer: _____________________
DOB: _____/____/____ SS# _________/______/________
Group Name: _______________________________

Paul A. Blair, M.D. and Jane A. Kurucz, M.D.

3667 Teays Valley Road * Hurricane, WV 25526
(304)201-3226

RESPONSIBILITY

I accept full responsibility for the cost of all health services rendered by Paul A. Blair, M.D. Inc and Jane A. Kurucz, M.D. Inc to me or my child.

CONSENT FOR TREATMENT AND EXAMINATION

I hereby consent to examination and/or treatment as recommended by the professional staff of Paul A. Blair, M.D. Inc. and Jane A. Kurucz, M.D. Inc.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize Paul A. Blair, M.D. Inc. and Jane A. Kurucz, M.D. Inc to release any or all of my medical records, or other information needed to any insurance carrier or its representatives, or to any governmental or third party to which I have requested to submit charges.

ASSIGNMENT OF PAYMENT BENEFITS

I herby authorize and assign payment directly to Paul A. Blair, M.D. Inc. and Jane A. Kurucz, M.D. Inc of any insurance or other benefits due and owing to me by reason of the health care services provided by him/her.

REVOCATION OF AUTHORIZATION

This authorization may be revoked by me at any time by delivering to Paul A. Blair, M.D> Inc and Jane A. Kurucz, M.D. Inc a written statement of revocation. I understand that may not revoke any acceptance of financial responsibility and consent to treatment or examination (paragraph 1 & 2) with respect to any medical services rendered by them prior to the date of such revocation.

RESPONSIBLE PARTY

If this authorization and consent is signed by a responsible party on behalf of a patient, such party assumes full responsibility as set forth in paragraph 1 from above, and all liability for the other consents and authorizations set forth above.

I acknowledge that I have read and fully understand the above contents.

________________________________   _____/_____/_____

Patient's Signature

Paul A. Blair, M.D. Inc and Jane A. Kurucz, M.D. Inc

3667 Teays Valley Road * Hurricane, WV 25526
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Please remember that insurance is considered a method of reimbursing the patient for fees paid to Paul A. Blair, M.D. Inc. and Jane A. Kurucz, M.D. Inc and is not a substitute for payment. Some companies pay a fixed amount for certain procedures and others pay a percentage of the charges. It is YOUR responsibility to pay any deductible, co-insurance or any other balance not paid by your insurance company.

In order to control the cost of billing, we request that our charges for services be paid at the conclusion of each visit.

If this account is assigned to an attorney or collection agency, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize the disclosure of portions of the patient record.

I hereby assign all medical and/or surgical benefits to which I am entitled including Medicare, Medicaid, Private insurance and other Health plans to Paul A. Blair, M.D. Inc. and Jane A. Kurucz, M.D. Inc.

A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all information necessary to secure payment.

____ ______/______/______

Patient's Signature **Date**

____

Person Authorized To Sign For Patient

____

Relationship

NOTICE OF PRIVACY PRACTICES (MEDICAL)

This notice describes how medical information about you may be used, disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY!

The Health Insurance Portability Act of 1996 ("HIPPA") is a federal program that requires all medical records and other individually identifiable health information be 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. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", 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, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.**
- **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 an internal quality assessment review.**

We may also created and distribute de-identified health information by removing all reference 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 the 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 issues and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are however, not required to agree to a requested restriction. If we do not agree to a restriction, we must abide by it unless you agree in writing to remove it.**
- **The right to a reasonable request 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.**

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 14, 2003, 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 Notice of Privacy Practices from this office.

You will have the 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 Department of Health & Human Services, Office of Civil rights about violations of this notice or the policies and procedures of our office. We will not retaliate against you for filling a complaint.

Please contact us for more information.

"HIPPA" Privacy Officer
Paul A. Blair, M.D. Inc
Jane A. Kurucz, M.D. Inc
3667 Teays Valley Road
Hurricane, WV 25526
(304)201-3223

The U.S. Department Of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202)619-0257
(877)696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment or health care operations. I understand you are not required to agree to my requested restrictions, but if you agree then you are bond to abide by such restrictions.

____________________________________ ____/____/____
Patient's Signature Date

____
Person Authorized to Sign for Patient

____
Relationship to Patient

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment but was unable to do so as documented below:

Reason: ____
Staff Signature: ________________________________
Date: ____/____/____

Paul A. Blair, M.D. Inc.

3667 Teays Valley Road
Hurricane, WV 25526
(304)201-3223

HOW DID YOU HEAR ABOUT US?

We would appreciate it if you would take a moment to fill out this form so that we may thank the person who referred you to our office.

Your Name: ___________________________________

Did you hear about us through:

- **Friend; Their name:______________________________________**
- **Word of Mouth; source: __________________________________**
- **Radio; Which station: ____________________________________**
- **TV; Which station: ______________________________________**
- **Newspaper; Which Paper: _______________________________**
- **Internet; Which site: _____________________________________**
- **Other: ____**

Tell us about you!

- **Which radio station do you listen to most?**
  ____
- **Which TV station do you watch the most?**
  ____
- **Which newspaper due you normally read?**
  ____
- **Do you have internet access? If yes, what is your EMAIL address?**
  ____

CONSENT FOR RELEASE AND USE
OF
PHOTOGRAPHS, VIDEOTAPES AND DIGITABLE IMAGES

The undersigned ____________________________, is a patient of Paul A. Blair, M.D. Inc. and the undersigned's image will be captured by photograph, videotape, and digital recording or otherwise during the course of treatment. The undersigned grants Paul A. Blair, M.D. Inc the ongoing and unrestricted right to use the undersigned's images for general information, education, scientific purposes. The image may be conveyed and displayed for those purposes through electromechanical means, including the internet.

The undersigned further acknowledges that he/she relinquishes all right and interest in these images, or any right to profit or gain directly realized through use of the images.

This consent may also be revoked in writing, signed by the undersigned and delivered to Paul A. Blair, M.D. Inc. Such revocation shall thereafter be effective as to any further use not already committed to be Paul A. Blair, M.D. Inc. This consent is in consideration of services performed and consultations conducted or to be performed or conducted by the physician, and there have been no representations or inducements concerning this consent except as set forth herein.

________________________________ ____/____/____
Patient's Signature **Date**

<u>CONSENT BY PARENT OR GUARDIAN</u>

I am the parent or guardian of ___________________________, a minor. I am authorized to sign this consent on his/her behalf, and I agree on my own behalf and his/her behalf to the terms of the foregoing consent.

_________________________________ ____/____/____
Parent/Guardian Signature **Date**

____
Witness Signature