

HISTORY AND PHYSICAL:

Is there a particular health concern you wish to discuss with the doctor? _____

Date of last Pap Smear _____ Was it normal? _____

If not, please explain any testing _____
 Colposcopy/LEEP/Cryo/Laser _____

First day of your last period: _____ Was it normal? _____ Previous Period: _____

Age at time of first period: _____ How many days between cycles? _____

Bleeding how many days? _____

Any problems or pain with period? _____ If so, explain: _____

Any medication required? _____ Please list: _____

Current method of birth control: _____

Past methods of birth control: _____ Any problems: _____

Do you need to discuss birth control today? _____

Do you need to discuss safe sex and condom usage? _____

Any history of sexually transmitted diseases? _____

Pregnancy History:

How many Full term # _____ Premature Birth # _____ Abortion: Induced # _____ Miscarriage # _____

Month/Year	# Weeks Delivery	Labor Duration	Vag or C/S	Sex	Weight	Complications?

Hospitalizations:

Year	Illness/Surgery	Hospital/Surgeon	Follow-up

Are you receiving any medical treatment at this time? _____

Please explain: _____

List All Medication you are now taking:	Reason	Doctor

PERSONAL AND FAMILY HISTORY

Check those that apply:

	Yourself	Mother	Father	Grandparents	Siblings	Spouse	Children
AIDS							
Alcoholism							
Allergies							
Alzheimer's							
Asthma							
Birth Defect							
Breast Cancer							
Cancer							
Colon Cancer							
COPD							
Depression							
Diabetes							
Glaucoma							
Heart Attack							
Heart Trouble							
Emphysema							
High Blood Pressure							
Kidney Disease							
Liver Disease							
Migraines							
Ovarian Cancer							
Stroke							
Sickle Cell Anemia							
Suicide							
Thyroid							
Tuberculosis							
Ulcers							
Other							

HIPAA Notice of Privacy Practices

Scott D. Lauer D.O.
210 Park Blvd. Suite 105
Grapevine, TX 76051
(817) 812-3044

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW 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 you 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 or 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 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 named 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: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you 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 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 unprotected 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 **April 14, 2003.**

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: _____



Acknowledgment Form

I acknowledge receipt of this Notice of Privacy Rights, which I have reviewed, and give my permission to **Scott D. Lauer D.O.** to use and disclose my health information in accordance with it.

Name of Patient

Signature of Patient

Date

Signature of Parent or Guardian

I give permission to **Scott D. Lauer D.O.** to release medical information to the following person(s):
(Please print names and relationship below).

This Authorization will expire in two (2) years from the above date unless written revocation is received.

Assignment of Benefits Form

Patient Insurance Coverage Responsibility Disclaimer and Authorization

I understand that it is my responsibility to know if Dr. Scott D. Lauer DO is an authorized provider according to my insurance contract. I also understand that Dr. Lauer is required by law and contracted to collect from me, on the date of service, any present co-payment amount required by my insurance contract.

I understand that I am responsible to know which lab and outside facilities my insurance company utilizes for all lab work, diagnostic testing, and specialist appointments. If prior authorization is required by my insurance contract for diagnostic testing and specialists' appointments I realize that it is my responsibility to request a referral authorization from my primary care provider. Failure to do so may result in my insurance company denying payment for services and I will be responsible for the services performed. I authorize my insurance company to pay all benefits directly to Dr. Scott D. Lauer and thereby agree to the release of relevant medical information to insurance carriers.

Acknowledgement of Notice of Privacy Practices

I acknowledge that I have read the Notice of Privacy Practices. I understand that Dr. Scott D. Lauer may at its in discretion, change the terms and conditions of this notice. I understand the content of the Notice of Privacy Practices will be provided, upon my request.

I give/ do not give (Please Circle one) Dr. Scott D. Lauer's office permission to leave a message on my answering machine or with family members regarding reports, or blood work if I am not home.

Authorization to Release Information

I hereby authorize Dr. Scott D. Lauer, DO PA to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

Office Charges

I hope you will understand our office staff's time is extremely valuable having to jump through continuous hoops to collect insurance and patient payments. The following services are not reimbursable by insurance and provided at the following upfront cost: Completion of Disability/ FMLA forms (\$35) and Missed Appointment fee, defined as failure to notify the office greater than 24 hours prior to your scheduled visit of your inability to keep your office appointment (\$35) or scheduled surgery (\$200), no exceptions. If for any reason you need copies of your medical records, there is a charge of \$50 for the first 20 pages and the \$.60 per page thereafter, in accordance with the Texas Medical Board. If your account is placed with our outside collections agency, a fee equal to 50% of what is owed will be applied to the balance due. Unpaid collection accounts will be terminated from the practice and records will only be released on an emergency basis until account is paid in full.

Patient/Responsible Party Signature

Date

Witness

Date



Please NO Walgreens or CVS

All **PRESCRIPTION'S** are done electronically at the end of each day. Please fill out the attached form for pharmacy information; it will be your responsibility to inform us of any pharmacy changes.

If you are in need of a refill and do not have any left on your medications please call the pharmacy so they can send in the refill request. Please allow 24hrs for all requests to be filled.

Pharmacy Name

Pharmacy Address

Pharmacy Phone Number

Name :

Date of Birth:
