

How did you hear about our office? \_\_\_\_\_

Who is your Primary Physician? \_\_\_\_\_

**Patient Information: PLEASE PRINT CLEARLY; Need Accurate Information**

Last Name \_\_\_\_\_, First Name \_\_\_\_\_ Sex M  F

MAILING Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

STREET Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone numbers: Home \_\_\_\_\_  Please indicate at which number  
Cell \_\_\_\_\_  we may leave a message

Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number \_\_\_\_\_

E-Mail address \_\_\_\_\_

You will be given secure access to the Patient Portal where you can view your medical records and communicate with our office via the internet

Would you like to receive our electronic newsletter?  Yes  No

Pharmacy Name \_\_\_\_\_ Location \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Name of Insured \_\_\_\_\_

**For Minor Children Only:** Parent/Legal Guardian Name \_\_\_\_\_

Parent Date of Birth \_\_\_\_\_ Parent Social Security Number \_\_\_\_\_

**Work comp or Occupational patients only: Employer Information Required**

Company Name \_\_\_\_\_ Supervisor \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**We are required by the federal government to gather and report the following information on every patient, we appreciate your cooperation.**

Race (Please check all that apply)

- American Indian or Alaska Native
- Asian
- Native Hawaiian or other Pacific Islander
- Black or African American
- White
- Hispanic
- Other Race
- I do not wish to answer this question

Ethnicity

I do not wish to answer this question

Preferred Language

I do not wish to answer this question

Residence Type

- Private Home
- Assisted Living Facility
- I do not wish to answer this question
- Residential Home (Apartment, Condominium, etc)
- Skilled Nursing Home

Please check here if you are using a translator

Patient/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*It is your responsibility to know your insurance benefits. This is a contract between you and your insurance company and we cannot always accurately predict which services will be covered. In the event that services are non-covered, you will be responsible for these charges.

# Physicians Immediate Care

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Your privacy is as important to us as it is to you. Rest assured that Physicians Immediate Care is committed to treating and using your personal health information responsibly. This notice describes the information we collect, how and when we use or disclose that information, and your rights as they relate to your protected health information.

## **Understanding Your Personal Health Information**

Each time you visit Physicians Immediate Care, a record of your visit is made which typically contains your symptoms, examination and test results, diagnoses, treatment, and referral information. This medical record may be used in some of the following ways:

- To plan your care and treatment and to communicate to other health professionals who contribute to your care.
- As a legal document describing the care you received
- As a way for you or a third-party payer to verify that services billed were provided to you
- As a tool in educating health professionals
- As a source of data for medical research or public health officials As a source of data for our business planning, evaluation and marketing.
- We may send your information through secure electronic communication to pharmacies, physicians, business associates or others as deemed appropriate.

Understanding what is in your record and how your health information is used, helps you to be sure it is accurate, understand why others may access your health information, and make more informed decision when authorizing disclosure to others.

## **Your Health Information Rights**

Although your health record is the physical property of Physicians Immediate Care, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices. Inspect and copy your health record as provided for in 45 CFR 164.524.
- Amend your health record as provided in 45 CFR 164.528.
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528.
- Request communication of your health information by alternative means or at alternative locations.
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

## **Physicians Immediate Care's Responsibilities**

- Maintain the privacy of your health information.
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain.
- We will not use or disclose your health information without your authorization, except as described in this notice.

If you have questions and would like additional information, you may contact Physicians Immediate Care's Privacy Officer (772) 343-1774.

Patient/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_