GROFOOT M.D.

DEMOGRAPHIC INFORMATION

Patient Name (First M. Last): _____ **Preferred Name**: _____

Physical Address: _____ **Apt/Unit**: _____

City: _____ **State**: _____ **Zip**: _____

Mailing Address* (if different): _____ **Apt/Unit**: _____

City: _____ **State**: _____ **Zip**: _____

** If you wish to not have your statements mailed to you, please tell the receptionist. A signed credit card authorization must be on file.*

Cell Phone: _____ (will be marked as Home # unless otherwise specified)

*What kind of message can we leave?** ◯ *Brief voice message (chosen by default)* or ◯ *Detailed voice message*

**Reminders and notifications will also be sent via text message unless you specifically request to opt-out of text messages.*

What is your date of birth: _____

This practice appreciates diversity and does not discriminate based on race, age, religion, ability, marital status, sexual orientation, sex or gender identity. These questions are asked to help us provide you with the highest quality of care.

What is your birth gender: ◯ Male ◯ Female

What gender do you identify with: ◯ Male ◯ Female Transgender: ◯ Male to Female ◯ Female to Male

Relationship/Marital status: ◯ Married ◯ Divorced ◯ Partnered ◯ Single ◯ Widowed ◯ Legally Separated

What is your social security number? (please provide): _____

***Emergency Contact**: _____ * Please refer to the back of this page for *Authorization*

Phone Number: _____ *to Release Medical Information* to your emergency contact.

Relationship: _____

***Email Address**: _____ * Please refer *HIPAA Email Consent* form attached.

Language spoke most often: _____

Race: ◯ Asian ◯ American Indian ◯ Caucasian ◯ Black ◯ Pacific Islander ◯ Other _____

Occupation: _____

Ethnicity: ◯ Hispanic ◯ Non-Hispanic ◯ Other

Number of hours work: _____

Are you employed?: ◯ Employed ◯ Not Employed ◯ Retired

Employer: _____

Are you a student?: ◯ Full-time ◯ Part-time ◯ Not Applicable

Employer Phone: _____

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

INSURANCE INFORMATION

Primary Insurance

Insured Name: ◯ Self ◯ Other: _____ Relation to patient: _____

Insured Date of Birth: _____ Insured Address (if different than patient): _____

Company: _____ Policy/Member/Insured Number (include prefix): _____

Group Number: _____ OV/PCP Copay: _____

Pharmacy Benefit Manager (PBM): _____

Secondary Insurance

Company: _____ Policy/Member/Insured Number (include prefix): _____

Group Number: _____ OV/PCP Copay: _____

PHARMACY INFORMATION

Preferred Primary Pharmacy – *Where do you want us to send your prescriptions?*

Company: _____ Phone Number: _____ Cross-streets: _____

ADDITIONAL INFORMATION

Are you part of a financial assistance fund? ◯ Yes ◯ No If yes, please indicate fund: _____

If yes, please provide the institution or program name: _____

Have you received a routine/physical examination this calendar year? ◯ Yes ◯ No

MEDICAL RELEASE AUTHORIZATION

Do you have an Attorney or Case Manager for your care? If so, please provide the information below.

Name: _____ Phone: _____ Company: _____

I, _____ , consent to share my medical records and medical information with the aforementioned Individual.

Signature: _____ Date: _____

Permission to Share Medical Information:

You have my authorization to share my medical records and medical information with the following people:

* Emergency Contact: _____ ☐ I deny authorization for my emergency contact.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

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

PATIENT CONSENTS

Authorization to Release Information:

I hereby authorize Gordon E. Crofoot MD, PA to release to my insurance carrier(s) any information acquired in the course of my examination or treatment required for payment of any insurance claim.

Initials: _____

Assignment of Benefits:

I hereby authorize payment directly to Gordon E. Crofoot MD, PA for medical benefits. I understand that I am financially responsible for the charges not covered by the insurance company.

Initials: _____

Electronic Privacy Waiver:

I understand that my medical records may be transmitted electronically. Although every effort will be made to assure the records are sent/received by the appropriate third party, I absolve Gordon E. Crofoot MD, PA from liability should they be received in error by a third party. I give my consent to fax my records for the purposes of treatment, payment, or healthcare operations and understand that I may withdraw this consent at any time in writing.

Initials: _____

Acknowledgement of Office Policies:

- **Initials:** _____ I understand that I am responsible for keeping appointments as scheduled, and I will give 24-hour notice for reschedules and cancellations. I also understand that I will be charged **$50** for missed appointments that I have not cancelled or rescheduled with at least 24 hour advanced notice.
- **Initials:** _____ I understand I am to allow 3 to 5 business days for referrals to be completed and that if I wish for an expedited referral for indications considered non-emergent by a provider of CROFOOT MD, I will be charged **$35** per referral.
- **Initials:** _____ I understand that I will be charged **$35** in preparation fees for completion of forms for: private disability, FMLA, and prior authorization appeals for non-preferred medications.

As a reminder, please reserve the after-hours services (requesting a provider to be paged) for urgent matters in hopes of optimizing provider time. Please consider the following to be brought to our attention during normal business hours: prescription refills, appointment cancelations or rescheduling, referral requests/inquiries, and other non-emergent matters. Please notify the office in a timely manner for prescription refills as the verification, consideration, and approval period is between 48 to 72 business hours.

Signature: _____ Date: _____

Printed Name: _____

Relation to Patient (if signed by guarantor): _____

If possible, please email forms to CONTACT@CROFOOTMD.COM or fax to (855) 802-2503 prior to appointment.

Gordon E. Crofoot MD, PA

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

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've 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 the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

_____

(Signature of Patient or Legal Representative)

_____

(Printed Name of Patient or Legal Representative)

_____

(Date Notice Effective)

Optional HIPAA Email Consent

VERY IMPORTANT. PLEASE READ.

- HIPAA stands for the *Health Insurance Portability and Accountability Act*
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Information stored on our computers is encrypted
- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email
- **When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it**
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA
- The information is available here: https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/combined-regulation-text/omnibus-hipaa-rulemaking/index.html
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email

◯ *OPTION 1 – **ALLOW** UNENCRYPTED EMAIL:

I understand the risks of unencrypted email and do hereby give permission to Gordon E. Crofoot MD PA to send me personal health information via unencrypted email. Furthermore, I understand I have the right to revoke this authorization in writing at any time and that my revocation will not affect any use or disclosures permitted by this authorization while it was in effect.

_____ _____

Printed Name Printed Email Address

_____ _____

Signature Date

◯ *OPTION: 2—**DO NOT ALLOW** UNECRYPTED EMAIL:

I do not wish to receive personal health information via email.

_____ _____

Printed Name Date

_____

Signature

**This consent will remain in effect unless revoked in writing.*

CROFOOT M.D.

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AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

I, (name) _____, (DOB) _____, authorize **Gordon E. Crofoot MD, PA**

Please Print Clearly

to ◯ **RECEIVE** from or ◯ **SEND** records to: _____

Address: _____ Phone: _____ Fax: _____

City: _____ State: _____ Zip: _____

For the following purpose(s): ◯ patient's request, ◯ continued medical care, ◯ insurance, or ◯ other _____

I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, r ports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers. All physical, occupational and rehab requests, consultations and progress notes. All disability, Medicaid or Medicare records including claim forms and record of denial of benefits. All employment, personnel or wage records. All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myelogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports. I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

I understand the following: See CFR §164.508(c)(2)(i-iii)
a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein.

Signature _____ Date _____

Instructions

Patient: Complete this form to request transfer of medical records from your previous Primary Care Physician(s), Specialist(s), etc.

Recipient: Please remit respective correspondence to the following fax numbers:

Medical Records **(855) 802-2503** or STAT Requests (713) 808-9571