

Paintsville Internal Medicine Inc.

Loey J Kousa, MD, Kitta Kousa, MD, 538 Main Street, Paintsville, Kentucky 41240, (606) 789-6086

Patient Registration Form

Patient Demographics:

Mr. Miss Mrs. Ms. Dr.
 Patient Name: _____ Male Female Birth date _____ Age _____
 Address _____ City _____ State _____
 Zip _____
 Alternate address for mailing
 (optional): _____
 Social Security # _____ - _____ - _____

	OK to call?		Leave Message?		Best Time To Call
Home Phone	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Work Phone	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Cell Phone	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	

Employer/School _____ Occupation: _____
 Marital status: Single Married Divorced Widowed
 For minors only: child lives
 With both parents
 Mother
 Father
 Mother/Guardian: _____ Address (if different) _____
 Date of Birth: _____ Home Phone: _____ Work Phone: _____
 Father _____ Address (if different) _____
 Date of Birth _____ Home Phone: _____ Work Phone: _____

Authorization of Release of Health Information:

Who may we talk to about your medical concerns: _____

Is this contact only for emergency purposes only Yes No

Can we release information to this person about your health whenever needed Yes No.

Relationship _____ Phone: _____

Identification of other physicians/health care entities involved with my medical care to whom I authorize ongoing release of information for continuity of care:

Provider: _____ Phone: _____

Address: _____ Zip: _____

Type of physician/ health care provided: _____

Provider: _____ Phone: _____

Address: _____ Zip: _____

Type of physician/ health care provided: _____

Health Insurance Information:

Responsible party for insurance and bills:

- Patient
- Spouse
- Mother
- Father
- Other _____

Provide a copy of Driver's license Yes No

Primary Insurance Company Name: _____ Card Number: _____
Group Number: _____

Relationship to insurance policy Subscriber / holder:

- Self
 - Spouse
 - Mother
 - Father
 - Other
- Card Copied: Yes No

Name of Health Insurance Policy Subscriber /Holder:

Date policy went in effect: _____ Date Policy Expired: _____

Amount of co pays: _____ Amount of yearly deductible: _____

Your Insurance Carrier Representative's name (contact agent): _____

Your Insurance Carrier Representative's phone: _____

Secondary Insurance Company Name: _____ Name on contract: _____

Contract Number: _____ Card copied Yes No

Card holder: Self Spouse Child Other

I hereby instruct and direct my primary insurance company _____ and my
secondary insurance company _____ to pay by Check made out and mailed to:

Joseph Kousa, MD, 9485 Mentor Avenue, Suite 104, Mentor, Ohio 44060. or If my current policy prohibits direct payment to
doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows (name and address):

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as
payment toward the total charges for the professional services rendered. This is a direct assignment of my rights and benefits under
this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current
manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

Dated at _____ this _____ day of _____ 20 _____

* Signature of policyholder

Witness

* Signature of Claimant, if different than Policyholder

Information reviewed: ___/2008 ___/09 ___/10 ___/11 ___/12 ___/13 ___/14 ___/15 ___/16 ___/17

Privacy Consent – For the Use and Disclosure of Protected Health Information

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to _____ to use and disclose my protected health information for the purposes of treatment, payment and operations of my health care and this practice.

Consent for treatment: I, with my signature, authorize (this practice), and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventive, diagnostic therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professional for care and treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice. This release may include information about drug use/abuse, alcohol use/abuse, mental health issues or concerns, AIDs or HIV status as pertinent to my medical care.

Consent related to the Privacy Notice: I have had a chance to review and Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse delivering services to me if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time. If I revoke this consent, the revocation does not take affect until the practice receives it.

*Patient/Guardian Signature: _____ Date: _____

*Name printed: _____ If not patient, relationship: _____

Copy of Practice Privacy statement signed or initiated with patient/guardian on: _____

Patient unable to sign privacy statement due to: _____

Revocation:

I hereby revoke the consent given above:

Patient/Guardian _____ Date: _____

Name printed: _____ If not patient, relationship: _____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I understand and agree that I am ultimately responsible for any collection costs or fees including but not limited to attorney's fees and court costs incurred in the collection process in case my account is turned over for collection. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred. I have read all the information on all 3 pages of this registration and consent document and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

*Patient/Guardian initial: _____ Date: _____

**Practice Privacy Statement
Paintsville Internal Medicine Inc.**

Loey J Kousa, MD, Kitta Kousa, MD, 538 Main Street, Paintsville, Kentucky 41240, (606) 789-6086

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

I. This is a formal notification, as required by the government concerning the privacy policy of this practice. This practice has an obligation to maintain all medical information in the strictest of confidence. Our practice cannot release information without your written consent, including medical records, conversations, reminder calls, test results and other confidential issues. Patient information about health care is identified as "PHI" or protected health information. This new policy requires that you, the patient, identify at the time of registration with us specific information about release of information. **You can change this information at any time with either written notification or verbal notification, followed up in writing.** Changes can only impact the care or information from that point in time forward.

II. Your protected health information (PHI) is a part of your medical care, and can be used or disclosed as follows:

- For your treatment in this practice and other locations under the our immediate care for care needs. This may include any prevention or medical condition evaluation and exam, procedures done related to your care needs, medication management, hospice, VNA support, Nursing Home care, referral for services, diagnostic tests or treatment related to your medical care needs. This includes release of information to family and significant other, husband or wife.
- For obtaining payment for treatment with your identified health care program. This would include any documentation related to this care, including history forms, progress notes, and procedure notes. This would include eligibility verification, prior authorization and claim submission.
- For operations of this practice, such as enrolling with insurance programs, hospital privileges, accounting and compliance with federal and state laws and regulations.
- Appointment reminders and health related benefit services only with your consent identified on the registration form.
- Disclosure to your family and friends concerning any related health care information with your on the registration form which can be modified at any time orally, followed by written consent.
- **Consent is not required for emergency care and treatment. An emergency is identified as a medical condition that in the judgment of the physician requires information for care on your behalf.**

Certain disclosures can be made without your consent, and they are as follows:

- Disclosure required by the government or law enforcement agencies. An example would be victims of abuse
- Information used for public health purposes, medical examiners or related to a person's death or for the health department for disease tracking.
- Information used for health care oversight, such as a site review by an insurance program.
- For worker's compensation cases or employment related assessments

III. Your rights for your health information include: The right to request limits on the uses and disclosure at registration or any time during your care. The right to choose how we send this information to you, including an alternate address. The right to see and obtain copies of your PHI, but there may be copy and postage fees. The right to get a listing of who we have made disclosures to about your PHI. The right to correct your file through an amendment process if appropriate.

IV. This practice reserves the right to modify or change this Privacy Statement and process at any time. Revision to the Notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Privacy Notice. An updated Privacy Notice will be posted in the office within 60 days of the revision.

VI. If you have a concern or complaint about how your protected health information is being used, from this time forward you should first contact our Practice Administrator at our Business office to resolve your concerns or you may contact the Office of Civil Rights or the Ohio Medicare Carrier, GBA Palmetto.

Office of Civil Rights - Regional Manager
Department of Health & Human Services
233 N. Michigan Avenue, Suite 240
Chicago, Illinois 60601

Palmetto GBA
Part B Operations – HIPAA Compliance Concerns
PO Box 18957
Columbus, Ohio 43218

* Patient Name: _____ DOB: _____

* Patient signature on receipt of Privacy Notice: _____ Date: _____

* Patient unable to sign due to: _____ refused to sign Date: _____