MARSHALL HUSER
FAMILY MEDICINE

PATIENT INFORMATION

DEMOGRAPHICS

First Name ________________Middle Name:__________ Last Name:__________________________

SSN:________________________ DOB: ______________ Sex: ☐Male ☐Female

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

If married, spouse's name: ____

Spouse's phone number: ____

CONTACT INFORMATION

Address: ____

Street City State Zip Code

Email: ____

Home Phone#: (_____)________________________ Cell#: (_____)________________________

EMPLOYMENT INFORMATION

Employer: _________________________________ Work Phone#: (_____)__________________

EMERGENCY CONTACT

Emergency Contact: _______________________________ Relationship: __________________

Home# :(____)________________Cell# :(____)______________Work# :(_____)________________

PHARMACY

Pharmacy:_______________________________________Pharmacy Phone#:___________________

FINANCIALLY RESPONSIBLE INDIVIDUAL (GUARANTOR)

Include all information for individual responsible for bill (if different from patient):

First Name ________________Middle Name: __________ Last Name: ________________________

Relationship to Patient: _________________________

SSN: ________________________ DOB: ______________ Sex: ☐ Male ☐ Female

Address: ____

Street City State Zip Code

Home Phone#: ( )_______________________ Cell#: ( )________________________

PATIENT/GUARANTOR FINANCIAL AGREEMENT

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION FOR THE PURPOSE OF PROCESSING MY INSURANCE CLAIMS AND AUTHORIZE PAYMENT TO MARSHALL HUSER FAMILY MEDICINE FOR ANY BENEFITS PAID FOR SERVICES RENDERED.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE PAYMENT. I FURTHER UNDERSTAND PAYMENT IN FULL (WHICH MAY INCLUDE COPAYS, COINSURANCE, DEDUCTIBLE, OR PRIVATE PAY RATE) IS DUE AT TIME OF SERVICE TO MARSHALL HUSER FAMILY MEDICINE.

____ ______/______/_____

Patient Signature Today's Date

____ ______/______/_____

Parent/Guardian Signature (if under 18) Today's Date

Authorization to Release Medical Information

Patient Name: ______________________ Date of Birth: ______________

Address: ______________________ Phone: ______________

City: ____________ State: ________ Zip: ______

I authorize the release of the following protected health information:

- □ Office Notes /Name of Physician ______________________
- □ Pathology Reports □ Radiology Reports □ Laboratory Reports Date(s): __________
- □ Other: ______________ □ Paper Copy □ Electronic Copy

The purpose for this request to release medical information is:

□ Medical Care / Treatment □ Insurance □ Other (specify) ______________

Send my medical information to: Name: ______________________
Address: ______________________
City, State, Zip: ______________________

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices.
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. Marshall Huser Family Medicine shall not be held liable for any consequences resulting from re-disclosure
- If the information to be released contains any information about HIV/AIDS an additional HIPAA release of medical information form will be requested.
- Alcohol or substance abuse, mental health or psychiatry notes may have additional compliance requirements that must be met before the information can be released.
- A copy of this signed form will be provided to me.
- MHFM may charge an administrative fee to cover the cost of labor, copying, and postage. The physician's office will inform me of any charges and arrange for payment.
- This Authorization expires on ____/____/____ {if date not completed / one year after signed}

______________________ ______________
Patient / Representative Signature **Date**

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

______________________ ______________________
Print Name **Relationship to patient**

Retain this form in the patient's medical record and provide a copy to the patient.

An additional authorization (NYS DOH-2557) is required for disclosures when your medical records contain information relating to Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) including but not limited to test results and the fact that the test was taken.

Approved August 11, 2008

INFORMED CONSENT OF THE PATIENT PORTAL

Marshall Huser Family Medicine is offering a secure, HIPAA compliant communication tool as a courtesy to our patients and their guardians. You will be alerted to any changes by our clinic or via the administrators of the portal as promptly as possible. This form is intended to provide the facts and risks surrounding the of the web portal. A patient or guardian's access to the portal may be suspended or terminated at any time at the clinic's discretion.

Privacy and Security

The patient portal or webpage has a secure tunnel connection with our clinic that uses encryption to keep unauthorized persons from being able to access and read any personal health information. All access to our internal network and electronic medical records (EMR) is password protected. Our staff is instructed to lock their workstations when not physically present.

To help insure the tunnel remains secure, we need your current (private) e-mail address. It is your responsibility to update your email address with our clinic if it should change. Your e-mail address is confidential and protected information. With our best effort we will protect your information as we do all medical and persona information. We will never purposefully share this information with any third party.

Keep your portal user ID and password secure so that only you can gain access to your personal health information. If you think someone has gained access to your patient portal, immediately go to the portal site and change your password.

Similar to phone communication, message may be read and addressed by different staff members or covering providers.

By signing below, you confirm you have read, understand and agree to comply with the procedures and guidelines for using the patient portal for Marshall Huser Family Medicine. You also agree not to hold Marshall Huser Family Medicine or any of the staff liable for network infractions beyond our control.

Confidential e-mail (please print clearly) ____

Patient Name: ______________________________________ Date of Birth: ______________________

Print name of Parent /Guardian requesting access: ____

Signature:____ Date: ____________________________

MEDICAL INFORMATION AUTHORIZATION

I AUTHORIZE THE PERSONNEL OF DR. MARSHALL HUSER TO RELEASE ALL MEDICAL INFORMATION TO MY FAMILY MEMBERS AND FRIENDS LISTED BELOW.

I MAY REVOKE THIS AUTHORIZATION BY PHONE OR IN WRITING AT ANY TIME.

	Name	Relationship to patient	Phone Number(s)
1			
2			
3			
4			
5			

I GRANT PERMISSION TO LEAVE A MESSAGE ON AN ANSWERING MACHINE OR VOICE MAIL ❑ **YES** ❑ **NO**

____ _______/_______/_____

Patient Signature Today's Date

____ _______/_______/_____

Parent/Guardian Signature (if under 18) Today's Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE NOTICE

I HEREBY ACKNOWLEDGE HAVING THE OPPORTUNITY TO RECEIVE A COPY OF THE NOTICE OF PRIVACY PRACTICE.

____ _______/_______/_____

Patient Signature Today's Date

____ _______/_______/_____

Parent/Guardian Signature (if under 18) Today's Date