MedStop One
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Date_____

PATIENT INFORMATION FORM

Thank you for choosing MedStop One. Please completely fill out this form to ensure the fastest and best healthcare service. We may ask you to update this information from time to time to make sure it stays up-to-date. Please inform this office if any changes occur. **(PLEASE PRINT)**

Name _____ DOB _____

Social Security # _____ Spouse Name _____

Home Address _____

City, State, Zip _____

Home # _____ Cell # _____

Email Address _____

Employer _____ Work # _____

Primary Care Physician _____ Phone # _____

Pharmacy _____

PARENT/GUARDIAN INFORMATION IF PATIENT UNDER AGE 18

Name _____ DOB _____ SS# _____

Relationship _____ Phone # _____

EMERGENCY CONTACT (PLEASE LIST SOMEONE OTHER THAN SPOUSE)

Name _____

Relationship _____ Phone # _____

How did you first hear about MedStop One? ( ) Word of Mouth/Friend ( ) Google Search/Website

( ) Yellow Pages ( ) Office Presence ( ) Other_____

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Name: _____ Date: _____
DOB: _____ Sex: M / F Race: _____

For what reason are you here today: _____

_____

_____

Please check conditions which you have/have had:

GENERAL:
- ☐ Serious Infections (pneumonia)
- ☐ Diabetes Mellitus
- ☐ Rheumatic Fever
- ☐ HIV Infection
- ☐ Cancer: _____

CVS:
- ☐ High Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ Heart Valve Disease
- ☐ Angina
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ Abnormal Heart Rhythm
- ☐ Blood Clots in Veins
- ☐ Blocked Arteries in Neck
- ☐ Blocked Arteries in Legs

HEENT:
- ☐ Glaucoma
- ☐ Allergies
- ☐ Frequent Ear Infections
- ☐ Frequent Sinus Infections

RESPIRATORY:
- ☐ Asthma
- ☐ Emphysema
- ☐ Blood Clots in Lungs
- ☐ Sleep Apnea

MUSCULOSKELETAL:
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Degenerative Joint Disease
- ☐ Fibromyalgia
- ☐ Neck Pain (herniated disc)
- ☐ Back Pain (herniated disc)

LYMPHATIC/HEMATOLOGIC:
- ☐ Thyroid Goiter
- ☐ Over Active Thyroid
- ☐ Under Active Thyroid
- ☐ Transfusions
- ☐ Anemia

GI/GU:
- ☐ Stomach Ulcers
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease
- ☐ Bleeding From Intestines
- ☐ Diverticulitis
- ☐ Colon Polyps
- ☐ Irritable Bowel Syndrome
- ☐ Hepatitis
- ☐ Cirrhosis of the Liver
- ☐ Liver Failure
- ☐ Pancreatitis
- ☐ Gallstones
- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Prostate Disease
- ☐ Endometriosis
- ☐ Sex Transmitted Infections

SKIN/BREAST:
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Fibrocystic Breast Disease

NEUROLOGIC/PSYCHIATRIC:
- ☐ Chronic Vertigo
- ☐ Peripheral Nerve Disease
- ☐ Migraine Headaches
- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Depression
- ☐ Anxiety

Please indicate any surgeries you have had and *what year* you had them:
- ☐ Angioplasty
- ☐ Carotid Artery Surgery
- ☐ Other Vascular Surgery
- ☐ Coronary Bypass Surgery
- ☐ Chest/Lung Surgery
- ☐ Tonsillectomy
- ☐ Neurosurgery
- ☐ Trauma Related Surgery
- ☐ Back or Neck Surgery
- ☐ Hip Surgery
- ☐ Knee Surgery
- ☐ Carpal Tunnel Surgery
- ☐ Sinus Surgery
- ☐ Ear Surgery
- ☐ Stomach Surgery
- ☐ Inguinal Hernia
- ☐ Colonoscopy
- ☐ Gallbladder
- ☐ Appendectomy
- ☐ Prostate Surgery
- ☐ Bladder Surgery
- ☐ Tubal Ligation
- ☐ C-Section
- ☐ Hysterectomy
- ☐ Ovary Removed
- ☐ Breast Surgery
- ☐ Thyroid Surgery
- ☐ Other _____

NOTES: _____

_____

_____

MEDICATIONS / ALLERGIES

Please list any allergies to any medications, and what reaction you have: _____
_____
_____

Please list medications currently taken, their dosages, and how many times per day you take them:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY MEDICAL HISTORY

Please check any major illness in your family members (mother/father, brother/sister or children):

☐ Tuberculosis	☐ High Blood Pressure	☐ Thyroid Disease	☐ Seizures
☐ Emphysema		☐ Anemia	☐ Cancer
☐ Heart Disease	☐ Osteoporosis	☐ Blood Disorder	_____
☐ Liver Disease	☐ Diabetes	☐ Kidney Disease	☐ _____

PERSONAL INFORMATION

Please write in or circle information that applies to you:

Education:	Sexuality:	Marital Status:	Living Status:
Primary	Heterosexual	Single	Alone
Secondary	Homosexual	Married	With spouse
College	Bisexual	Divorced	With parents
Post grad	Transsexual	Widowed	Assisted living
Doctorate		Separated	Nursing home

Tobacco:	Alcohol:	Illicit Drugs:	Caffeine:
Never / Past / Active	Never / Past / Active	Never / Past / Active	Never / Past / Active
Cigarette / Cigar / Pipe	Liquor / Wine / Beer	Cocaine / Marijuana	Coffee / Tea / Soda
Snuff / Dip / Chew	____ drinks per	Heroine / Amphetamine	____cans / cups per day
Start:____ / Stop: ____	Day / Week / Month	Barbiturate / LSD / PCP	
Packs per Day: _____	AA / Alcohol Rehab	IV Drug Abuse / Drug Rehab	

Please indicate when you last had any of the following preventative tests or services:

_____ Chest X-Ray	_____ Pneumonia Vaccine	_____ PSA Blood Test (Prostate)
_____ Abdominal Aortic Aneurysm Screening (AAA Scan)	_____ Shingles Vaccine	_____ Colonoscopy
	_____ Tetanus Vaccine	_____ Mammogram
_____ EKG	_____ Hepatitis Vaccine	_____ Pap Smear
_____ Influenza Vaccine	_____ Bone Density Test	_____ Physical Exam

NOTES: _____
_____

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PATIENT QUESTIONNAIRE

Patient Name: _____ Date: _____

I. Please list the family members or other person, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and healthcare operations):

_____

_____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IF AN EMERGENCY:

_____

_____

_____ _____

Patient/Guardian Signature Date

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HIPPA NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date: _____

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.

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 your past, present or future physical or mental health condition and related health care services.

Uses and Disclosures of Protected Health Information (PHI)

Uses and Disclosures of Protected Wealth 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 of 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 a 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 name 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; 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 and 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 that 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 protected 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 HIPPA 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: _____

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Carlos A. Rivas, MD * Megan Glastetter, FNP-BC * Lisa Kail, FNP-BC

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

All portions of this form must be completed to constitute a valid authorization for release of health information.

Patient's Name: _____ Date of Birth:_____ Telephone:_____

Address: _____

I request and authorize ***MedStop One*** to: (please check one)***(Please list any other facilities we could obtain records from)***

[] release information to [] obtain information from [] exchange information with

Name:_____

Address:_____

Phone:_____Fax:_____Email:_____

This request and authorization applies to:

[] Healthcare information relating to the following treatment, condition or date: _____

[] All Healthcare information

Purpose of Disclosure: _____

I understand that the above-mentioned named receiving agency/person/facility has a right to inspect and copy the information disclosed. I further understand that if the receiving agency/person/facility is not covered by Health Insurance Portability and Accountability Act (HIPPA) privacy regulations, the information described above may be re-disclosed and may no longer be protected by HIPPA regulations. I understand I may revoke the release of information at any time, in writing, except where the facility has already made disclosures in reliance upon my prior authorization. I understand the no revocation of this consent shall be effective to prevent disclosure of records and communications until it is received by Rural Health, Inc. It is my understanding that the records and communication to be disclosed may contain information about diagnoses/evaluation/rehabilitation/treatment/recommendation for mental health, developmental disabilities, and/or substance abuse/use and that my signature indicates my informed consent.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if HIPPA prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

Definition: Sexually transmitted disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma, venereuem, HIV (Human Immunodeficiency Virus), AIDS (acquired Immunodeficiency Syndromes), and gonorrhea.

[] Yes [] No *I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above.*
[]Yes [] No *I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.*

Patient's (or Guardian's) Signature: _____ Date: _____

Relationship to Patient/Authority to Act on Patient's Behalf_____

Witness Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES 180 DAYS AFTER IT IS SIGNED UNLESS REVOKED EARLIER

NOTICE TO WHOMEVER DISCLOSURE IS MADE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY STATE AND FEDERAL LAW. THESE LAWS PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHROIZATION FO RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.