Western Medicine, Inc.

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Dear Patient,

Due to all the changing regulations and new restrictions that are being implemented by HIPPA, it is necessary to ask you to answer the following questions. These new rules are for your protection and this information will help us better serve you, while safeguarding your personal health care operations.

PATIENT QUESTIONAIRE:

1.) Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations).

Name	Relationship	Phone Number
________________	________________	________________
________________	________________	________________
________________	________________	________________

2.) Please list the family members or significant others, if any, to whom we may inform about you medical condition ONLY IN AN EMERGENCY.

Name	Relationship	Phone Number
________________	________________	________________
________________	________________	________________

3.) Please print the address of where you would like any written correspondence from us sent if other than your home. ____
____
____

4.) Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL ". Yes _______ No ______

5.) Please print the telephone number where you would want to receive calls about your health, i.e., appointments, lab results, x-ray results, etc. ( ) ______________________

**** I am fully aware that a cell phone is not a secure and private line***

6.) Can confidential messages be left on your answering machine or voice mail? Yes _____ No _____

7.) I am fully aware that my health information can be transmitted electronically, by fax or e-mail.

Patient Name {Please print}: ____

Patient / Guardian signature: ____ Date: _____________

This "Release of Information" will remain in effect until terminated by me in writing

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

I, _______________________, understand that as part of my health care, Western Medicine, Inc. originates and maintains paper and/or electronic 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 Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Western Medicine, Inc. 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 take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Western Medicine, Inc. reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Western Medicine, Inc. change their notice, they will provide you a revised copy upon your next scheduled visit at the office.

I wish to have the following restrictions to the use or disclosure of my health information:
____
____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent

______________________________ ______________________

Patient's Signature Date

FOR OFFICE USE ONLY

[ ] Consent received by___________________________ on ____________________.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____________________.