SOUTH SOUND FAMILY & SPORTS MEDICINE
NOTICE OF PRIVACY PRACTICES

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.

South Sound Family & Sports Medicine respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

For treatment:

- Information obtained by a nurse, physician or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For health care operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
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- We may use and disclose your information to conduct or arrange for services, including:
    1. Medical quality review by your health plan;
    2. Accounting, legal, risk management, and insurance services;
    3. Audit function, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request, but we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice");
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.

- Have us review a denial of access to your health information- except in certain circumstances;
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records;
- When you request, we will give you list of disclosures of your health information. The list will not include disclosures to third-party payers. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date and give us your request in writing;
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during our normal business hours, please contact:

Kelli Osborne
Assistant Clinic Administrator
South Sound Family & Sports Medicine

Our Responsibilities

We are required to:

- Keep your protected health information private;
- Give you this Notice;
- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office/medical records department to pick one up.

To Ask for Help or Complain

- If you have questions, want more information, or want to report a problem about the handling of you protected health information, you may contact: Kelli Osborne, Assistant Clinic Administrator (360)709-9500.
- If you believe your privacy rights have been violated, you may discuss your concern with any staff member. You may also deliver a written complaint to Kelli Osborne at our practice/health care facility. You may also file a complaint with the U.S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

Notification of Family and Others

- Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.

- [Hospitals] Information may be provided to people who ask for you by name. We may use and disclose the following information in a hospital directory:
    1. your name,
    2. location
    3. general condition, and
    4. religion (only to clergy)

You have the right to object to this use or disclosure of your information. If you object we will not use or disclose it.

We may use and disclose your protected health information without your authorization as follows:

- **With Medical Researchers**-if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **To Funeral Directors/Coroners** consistent with applicable law to allow them to carry out their duties.
- **To Organ Procurement Organizations** (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- **To the Food and Drug Administration** (FDA) relating to problems with food, supplements, and products.
- **To Comply With Workers' Compensation Laws**-if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law:**
    1. To prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
    2. To public health or legal authorities
        - To protect public health and safety
        - To prevent or control disease, injury, or disability
        - To report vital statistics such as births or deaths
- **To Report Suspected Abuse or Neglect** to public authorities.
- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.
- **For Law Enforcement Purposes** such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- **For Health and Safety Oversight Activities**. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **For Work-Related Conditions That Could Affect Employee Health**. For example, an employer may ask us to assess health risks on a job site.
- **To the Military Authorities of U.S. and Foreign Military Personnel**. For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions**. For example, we may share information for national security purposes.

Other Uses and Disclosures of Protected Health Information

Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization

Effective Date:
July 12, 2004.

ACCOUNT #

_____

SOUTH SOUND FAMILY & SPORTS MEDICINE

NOTICE OF PRIVACY PRACTICES-
ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting **Kelli Osborne**, *Assistant Office Manager*.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Policies.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name **if signed on behalf** of patient Relationship

This form will be retained in your medical record.

Last update___/___/___

HIPAA PRIVACY

SOUTH SOUND FAMILY & SPORTS MEDICINE
PATIENT MEDICAL HISTORY

Name:	Birthdate:	Today's Date:
Single __ Married __ Widowed __ Divorced __	Occupation:	Years of Education:

ALLERGIES:

HABITS

Smoking? Y N Quit _____ years ago

Packs per day _____ How many years?

Chewing Tobacco? Y N

Alcohol? Y N Quit _____ years ago

Amount per week:

Coffee? Y N Amount per day:

Other Drugs? Y N Please describe:

EXERCISE:

☐ No regular exercise ☐ Occasional (once/week)

☐ Regular (3 times/week) ☐ Frequent (daily)

Types of exercise:

Previous primary physician:

Other health care providers you currently see:

CURRENT MEDICATIONS AND DOSAGES:

CURRENT MEDICAL PROBLEMS:

SURGERIES / INJURIES AND DATES:

PAST MEDICAL PROBLEMS / HOSPITALIZATIONS

FAMILY HISTORY:

	LIVING		DECEASED	
	Age	Major Illnesses	Age at Death	Cause of Death
Father				
His Father				
His Mother				
Mother				
Her Mother				
Her Father				
Brother(s)				
Sister(s)				
Children				

Please check if any immediate family have had:

☐ Asthma ☐ Thyroid problems ☐ Heart disease

☐ Allergies ☐ Kidney problems ☐ High blood pressure

☐ Cancer ☐ Bleeding disorders ☐ Heart attacks

☐ Diabetes ☐ Alcoholism ☐ Strokes

☐ Arthritis ☐ Mental illness ☐ Seizures (epilepsy)

GYNECOLOGIC HISTORY

Age at onset of periods: ____ Date of last period:

Type of flow (circle): regular irregular light moderate heavy

Days of flow: ____ Number of days between periods: ____

Pain/cramping with periods? Y N

Birth control method:

Number of pregnancies ____ miscarriages ____ abortions ____

Date of last pap smear:

Have you had an abnormal pap smear? Y N Date:

Have you had any sexually transmitted diseases? Y N

Have you had a mammogram? Y N Date:

PREVIOUS HEALTH MAINTENANCE

Date of last complete physical exam:

Date of last tetanus booster:

Do you get annual flu shots? Y N

Have you had a pneumonia shot? Y N Date:

Most recent cholesterol level:

Have you ever had a blood transfusion? Y N Date:

Do you always wear seatbelts? Y N

Please list things you want to discuss with your provider today:

SOUTH SOUND FAMILY & SPORTS MEDICINE
ACCOUNT REGISTRATION FORM

ACCOUNT # _____

PATIENT INFORMATION

Full Name_____
FIRST MIDDLE LAST

Home Address_____

Billing Address (if different)_____

City, State, Zip_____

Home Phone_(_____)_____ Work Phone_(_____)_____

Birthdate_____ Sex: Female _____Male_____

S.S. #_____ Occupation_____

Employer_____ Driver's License#_____

Employer's Address_____ City_____St_____Zip_____

May we call you at work? Yes_____ No_____ May we contact you through Email? Yes _____ No _____

Email Address _____ @ _____

MARITAL STATUS
- SINGLE ☐
- MARRIED ☐
- DIVORCED ☐
- LEG. SEP ☐
- WIDOWED ☐

SPOUSE, PARENT OR GUARDIAN INFORMATION *Living in the same household as the patient*

Full Name _____
FIRST MIDDLE LAST

Relationship to Patient Parent ____ Guardian ____ Spouse ____ Other (specify) _____

Work Phone_(_____)_____ Birthdate_____

PARENT NOT LIVING IN PATIENT HOUSEHOLD *Required it child is covered under this parent's Insurance*

Full Name_____
FIRST MIDDLE LAST

Home Address_____

City, State, Zip_____

Home Phone_(_____)_____ Work/Day Phone_(_____)_____

EMERGENCY NUMBER *Nearest Relative/friends outside of you household*

Name_____ Day Phone_(_____)_____

Relationship to Patient_____ Eve. Phone_(_____)_____

Name_____ Day Phone_(_____)_____

Relationship to Patient_____ Eve. Phone_(_____)_____

DO YOU HAVE:			
	YES	NO	A LIVING WILL
	YES	NO	DURABLE POWER OF ATTORNEY FOR HEALTH CARE
	YES	NO	ADVANCE DIRECTIVE
	YES	NO	DO YOU WISH ADDITIONAL INFORMATION

THE EXISTANCE OR EXECUTION OF A LIVING WILL, DURABLE POWER OF ATTORNEY FOR HEALTH CARE, OR WRITTEN ADVANCE DIRECTIVE IS NOT A CONDITION OF RECEIVING HEALTH CARE SERVICES AND MAY NOT OTHERWISE BE USED TO DISCRIMINATE AGAINST AN INDIVIDUAL.

Signature_____ Date_____

INSURANCE INFORMATION SOUTH SOUND FAMILY AND SPORTS MEDICINE

IS THIS INSURANCE THROUGH: ____YOUR EMPLOYER ____SPOUSE EMPLOYER
____PARENT'S EMPLOYER ____OTHER

ACCOUNT # _____

Relationship to insurance policy holder: _____ (*i.e. Self, spouse, parent, or partner*)
Date insurance plan began: _____
Insurance policy holder's name_____
Insurance policy holders' birthdate_____

AUTHORIZATION/RESPONSIBILITY FOR THE TREATMENT OF A MINOR:

I, _____, the parent or legal guardian of my child, _____, authorize and consent to emergency and routine medical treatment and procedures to be performed for my child by licensed medical personnel when deemed necessary or advisable and I cannot be contacted. Regarding financial responsibility for this child, he/she will remain on my account and I will be responsible for his/her medical bills regardless of changes in family situation, (i.e. divorce, custody issues etc.) until he/she is 18 years of age. I also authorize the release of the minor's PHI for payment purposes. Authorization and financial responsibility shall continue and be in full force and effect until revoked in writing by me.

Signature_____ **Date**_____

RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, & FINANCIAL RESPONSIBILITY:

I authorize South Sound Family and Sports Medicine or my insurance company to release any PHI information required for processing any insurance claim(s). I also authorize my insurance benefits to be paid directly to the doctor. I understand that direct billing of insurance companies is done as a courtesy by South Sound Family & Sports Medicine and that I am financially responsible for the full amount of the charges which are not covered by insurance benefits. I also understand that South Sound Family & Sports Medicine will submit claims to my insurance company using the information that I have provided for this purpose, and I agree that I will be responsible for the charges if the insurance company indicates that coverage was not in effect or that I was assigned to a Primary Care Physician (PCP) elsewhere. If being signed by a spouse or partner, I understand that these provisions apply to the patient named above.

Signature_____ **Date**_____

SOUTH SOUND FAMILY AND SPORTS MEDICINE
2960 LIMITED LANE NW STE A
OLYMPIA, WA 98502
(360) 709-9500
(360) 754-4517

ACCOUNT #

_____

TODAY'S DATE_____

I, _____, authorize South Sound Family & Sports Medicine to disclose the following health care information: (please check box)

☐ All health care information in my medical record, this does **NOT** include HIV/STD/Psychiatric/Drug/Alcohol

☐ All health care information in my medical record, this **DOES** include HIV/STD/Psychiatric/Drug/Alcohol

☐ Appointment information

☐ Test results

☐ Other (x-rays, bills etc.) please specify

_____

_____

Information may be shared with the following individuals:

Name	**Relationship**

_____
Patient signature

_____
Printed name

**This authorization is valid until South Sound Family and Sports Medicine receives written rovocation from the patient.
This form will be retained in your medical record.