Name: Date:

DOB:

Chart:

Anton J. Fakhouri MD FACS FICS Gary A. Kronen MD Beverlee A. Brisbin MD James E. Moravek MD
Jeremy T. Bell PA-C Sara B. Lennon PA-C Kelly J. Hermann PA-C Cindy M. Spicka APN

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: _____ Date of Birth: _____ SSN: _____

This notice advises you about the ways in which we may use and disclose your Protected Health Information (PHI). Protected Health Information (PHI) means any of your health information that could be used to identify you and that relates to your past, present, future physical or mental health or condition and related health care services. It also describes your rights and our duties with respect to you PHI. The law requires us to provide a copy of this notice to you which explains our legal duties and privacy practices.

My signature acknowledges that I have been offered a copy of MidAmerica Hand to Shoulder Clinic's Notice of Privacy Practices at the time of registration.

Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the release of any and all records of my treatment to be forwarded to the following:
(Please check all that apply)

( ) The referring occupational clinic, my employer, workers compensation representative who will be handling my claim, as well as any physicians and ancillary personnel involved in my medical care.

( ) The referring physician and any physicians and ancillary personnel involved in my medical care.

( ) My primary care physician.

( ) My private health insurance carrier and any associated entities.

( ) My employer: _____
Name of Employer

Signature: _____ Date: _____

PHONE MESSAGE AND CONTACT AUTHORIZATION

At what phone number can we, or our representatives, call to speak with you and or leave a message regarding appointments or any other details related to your account? (Please circle Yes or No for each option)

Home Phone: YES NO Work Phone: YES NO Cell Phone: YES NO

Would you like to allow someone, other than yourself, to receive information regarding your treatment, appointments and billing/financial status at MidAmerica Hand to Shoulder Clinic? (Circle One) YES NO

If yes, please list their names, relationship and phone number:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Signature: _____ Date: _____