CHERUBINO HEALTH CENTER

Confidential Patient Information

Please fill in the sections that apply to you.
If you need assistance or have any questions, please feel free to ask the office staff.

Today's Date: _____ / _____ / _____

Patient's Name: _____ Preferred Name / Pronouns: _____

Date of Birth: ____ / ____ / _____ Age: _____ Height: _____ Weight: _____

Address (Street, City, State, Zip): _____

_____

Email Address: _____

Cell Phone: _____ Other Phone: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Health Insurance Carrier (if applicable): _____

Primary Care Provider: _____

How did you find us? (i.e. referral, internet, etc.) _____

Reason for your visit today: _____

Are you interested in? (mark all that apply):
◯ Correction of specific condition(s) ◯ Maintenance care
◯ Improvement of overall health ◯ Preventative care ◯ A quick fix
◯ Care of a chronic condition ◯ Pain control ◯ Other:_____

Are you seeking treatment related to a personal injury (PI)? : ◯ Yes ◯ No

Health History

Please fill in the date and type for those that apply.

Surgeries:_____

_____

Procedure(s)/Injection(s):_____

_____

Imaging(X-ray,MRI,etc.):_____

_____

Are you currently taking any medication, supplements, herbs, etc.? ◯ Yes ◯ No

If yes, please complete the additional medication and supplement sheet for our records.

★Initials: _____

Past Medical History

Please mark any of the following that apply to you – ***"©" for current & "℗" for past & provide an approximate date***

General:
© ℗ Sudden weight change without trying
© ℗ Fever
© ℗ Chills
© ℗ Night Sweats
© ℗ Weakness
© ℗ Fatigue

Eyes:
© ℗ Vision changes
© ℗ Pain
© ℗ Discharge

Ears:
© ℗ Hearing changes
© ℗ Ringing
© ℗ Pain
© ℗ Discharge

Nose:
© ℗ Pain
© ℗ Bleeding
© ℗ Smell changes

Mouth/Throat:
© ℗ Sores
© ℗ Bleeding
© ℗ Taste changes

Skin:
© ℗ Rash
© ℗ Itching
© ℗ Hair changes
© ℗ Nail changes
© ℗ Skin changes

Neurological:
© ℗ Headache
© ℗ Dizziness
© ℗ Fainting
© ℗ Convulsions
© ℗ Memory changes

Gastro-Intestinal:
© ℗ Appetite changes
© ℗ Abdominal pain
© ℗ Nausea
© ℗ Vomiting
© ℗ Diarrhea
© ℗ Constipation

Urinary:
© ℗ Frequent urination
© ℗ Painful urination
© ℗ Incontinence

Cardiovascular:
© ℗ Murmur
© ℗ Chest pain
© ℗ Palpitations
© ℗ Difficulty breathing
© ℗ Cough
© ℗ Wheezing
© ℗ Blue extremities
© ℗ Swollen extremities

Breasts (if applicable)
© ℗ Mass
© ℗ Pain
© ℗ Discharge

Psychological:
© ℗ Anxiety
© ℗ Depression
© ℗ Mood changes
© ℗ Memory loss

Musculoskeletal:
© ℗ Neck
© ℗ Upper extremities
© ℗ Upper back
© ℗ Lower extremities
© ℗ Lower back

Please mark any of the following conditions you have been or are currently diagnosed with and indicate when. (If unable to provide certain dates, please give approximate dates)

◯ High Blood Pressure _____
◯ Heart Disease _____
◯ Stroke _____
◯ Diabetes _____
◯ Kidney disease _____
◯ Lung disease _____
◯ Seizures _____
◯ Concussion _____
◯ Prostate issues _____
◯ Venereal Disease _____
◯ Allergies _____
Epi-Pen required? Y N
◯ Scoliosis _____
◯ Mental/Emotional _____
◯ Traumatic Brain Injury _____
◯ Asthma _____
◯ Multiple Sclerosis _____
◯ Ulcer _____
◯ Cancer _____
◯ Serious injury/Fall/Accident _____
◯ Digestive issues _____
◯ Osteoporosis/-penia _____
Last DEXA Scan: _____
◯ Other: _____

Family History

Please list any <u>immediate</u> family members that have/had any of the following illnesses:

High Blood Pressure: _____
Heart Disease: _____
Stroke: _____
Diabetes: _____
Cancer: _____
Connective tissue disorder: _____
Other: _____

Habits

(amount per day)

Sleep: _____ Work: _____
Exercise: _____ Relaxation: _____
Caffeine: _____ Alcohol: _____
Tobacco: _____ Recreational Drugs: ____

Other

If you have children, how many do you have? _____
How many live with you? _____

★Initials: _____

CHERUBINO HEALTH CENTER

Medication and Supplement List

Please fill out any of the following areas that currently apply to you.

Prescription medications that you are currently taking:

Please also include any side effects that you may experience from these medications.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Over the counter pharmaceuticals you are currently taking:

_____

_____

_____

_____

_____

Nutritional supplements, herbs, and nutraceuticals that you are currently taking:

(i.e. any non-drug or pharmaceutical products)

_____

_____

_____

_____

_____

_____

_____

Allergies

Please list any allergies that you have – medications, foods, seasonal, etc.

_____

_____

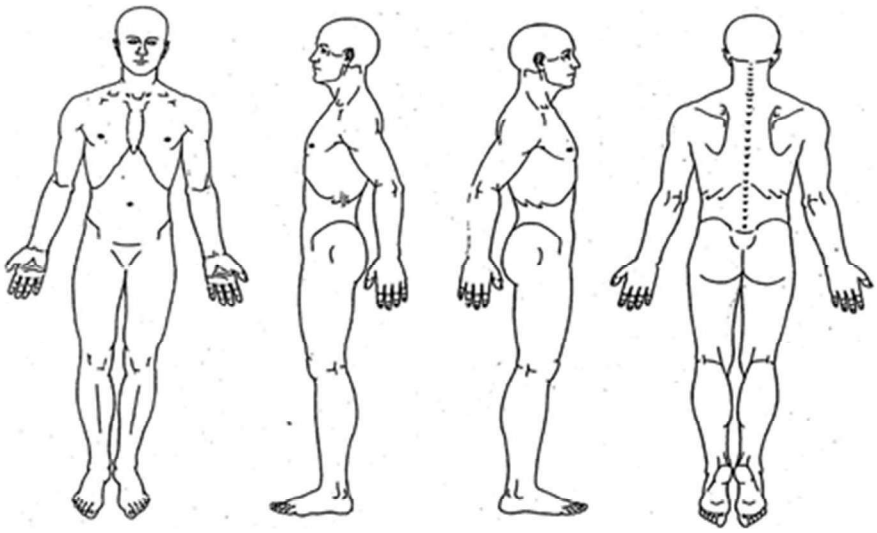
_____

★Initials: _____

Please fill out the following diagram, if applicable to you.

Using the following descriptive symbols, draw the location of your pain/discomfort on the body figures below.

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
^^^^	=====	000000	……	//////	XXXXX



Describe other pain/complaints:

_____

_____

Please circle the appropriate number as it applies to your pain. Remember you can only circle one number along the scale.

Over the past week, on average, how would you rate your pain?

0	1	2	3	4	5	6	7	8	9	10

No pain — *Worst possible pain*

I can do some form of work, despite the pain ("work" includes housework and paid and unpaid work).

0	1	2	3	4	5	6

Not at all confident — *Completely confident*

I can live a normal lifestyle, despite the pain.

0	1	2	3	4	5	6

Not at all confident — *Completely confident*

Based on all the things you do to cope with, or deal with, your pain, on an average day, how much control do you feel you have over it?

0	1	2	3	4	5	6

No control — *Some* — *Complete control*

Based on all the things you do to cope with, or deal with, your pain, on an average day, how much are you able to decrease it?

0	1	2	3	4	5	6

Can't decrease it at all — *Can decrease it somewhat* — *Can decrease it completely*

What are two important activities that you cannot do or are having trouble doing because of your pain? (i.e., "I can't get dressed without help," "I have trouble playing golf," "I can't go to work.")

Activity 1.
Please rate activity

0	1	2	3	4	5	6	7	8	9	10

Able to perform at same level as before problem — *Unable to perform*

Activity 2.
Please rate activity

0	1	2	3	4	5	6	7	8	9	10

Able to perform at same level as before problem — *Unable to perform*

★Initials: _____

CHERUBINO HEALTH CENTER

Informed Consent

The following applies to chiropractic treatment, chiropractic supportive therapy, and therapies related to functional neurology. Doctors of Chiropractic, medical doctors, and physical therapists using certain types of forceful manual manipulation therapies are required to explain that there have been rare cases of injury as a result of treatment. At this Center, we use a variety of treatment methods including light-force and non-forceful, non-rotational light pressure chiropractic manipulation therapies.

We also use a number of supportive physical therapies, in conjunction with chiropractic treatments. These include, but are not limited to, low pulse electrical stimulation, myofascial release, thermal therapy (heat packs), cryotherapy (cold packs), manual traction, and exercise therapy. While rare, reactions such as muscle soreness, skin irritations, allergic reactions, muscle spasm, inflammatory reactions, and other such reactions may occur. Every reasonable effort is made to anticipate the likelihood of these reactions in an effort to avoid them. If you have any questions about this, please do not hesitate to speak with one of the doctors directly.

Request for Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures by any licensed Chiropractic Physician in the office (includes Dr. Christabella Cherubino, D.C., Dr. Grace Cherubino, D.C., Dr. Ronald Cherubino, D.C., and Dr. Sarah Koch, D.C.).

I have had an opportunity to discuss with the Doctor(s) of Chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, as mentioned above. I do not expect the doctor(s) to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor(s) to exercise judgment during the course of the procedure which the doctor(s) feels is in my best interest, based upon the facts then known to him or her.

I have read, or have had read to me, the Notice of Privacy Practices (contained on a separate page). I have also had an opportunity to ask questions about their content, and by signing below I agree to the above-named procedures and policies. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

★ **Patient Signature** _____ **Date:** _____

★ **Guardian Signature** _____ **Date:** _____

Witness Signature _____ **Date:** _____

CHERUBINO HEALTH CENTER

Policies and Procedures

Each patient, (or the patient's guardian when the patient is a minor), must read, and agree to the provisions of this document prior to receiving investigative and/or alternative treatment at Cherubino Health Center.

Treatment

The treatment offered at Cherubino Health Center is rendered with the intent of correcting what practitioners at the center see as the underlying cause of physiological imbalance, dysfunction, and disease. We therefore attempt to treat causes not symptoms.

Investigative Procedures and Techniques

Many of the alternative procedures, recommendations, treatments and therapies utilized at Cherubino Health Center are classified, by the traditional medical system, as "investigational procedures".
This pertains to all treatments offered at the center with the exception of chiropractic adjustments and chiropractic/medical physical therapies. Therapies used in conjunction with chiropractic treatment are utilized for their biologic and therapeutic effect. In contrast, therapies used as part of an alternative treatment protocol are not used for biologic or therapeutic effect.

Alternative Health Care

With the exception of chiropractic treatments and supportive physical therapy, Cherubino Health Center offers what in today's society is commonly known as alternative health care. We believe that a more appropriate term would be "Natural" Health Care. As such, it is entirely possible that other health-care providers, in particular traditional non-alternative, allopathic, health care providers may view the type of treatment and advice that we offer at this center as inappropriate, unrelated or even useless.

Most people in this society are somewhat familiar with the use of drugs and surgery as the primary way of "treating" disease. A profound lack of education and training has resulted in ignorance and therefore prejudice and misunderstanding among medical personnel, which may include, but is not limited to, medical doctors, Doctor of Chiropractic, doctors of osteopathy, other medical personnel and members of the general public.

Guarantee of Results

In response to treatment, no specific or implied guarantees are given, for the relief or elimination of any symptoms, specific disease(s) or conditions. Nor is any specific outcome guaranteed.

Symptoms

The improvement of one's health is a process. Symptoms may or may not change during or after a course of treatment. Response to treatment is individual and patients typically experience periods of increases and decreases of various symptoms. They may also experience an increase in symptoms at times during their course of treatment. It is also possible for patients to experience no apparent change in their symptoms for extended periods of time during or following a course of treatment at this center.

Measure of Progress

Since symptoms are often times poor indicators as to the amount of progress that has occurred in a particular course of treatment, measurement of response to treatment is determined at this center by other means. Each practitioner has at his or her disposal a variety of indicators that are unique to the treatments and therapies that they are using. A number of other testing methods may also be recommended at the practitioner's discretion.

Payment for Services and Refunds

Charges for investigational and/or alternative treatments are not submitted to, or expected to be covered by, a patient's insurance plan. Payment for services rendered is due at the time the services are performed. No refunds of payments will be given once a service has been performed. In some cases, prepayment arrangements may be made. A refund for the unused portion of prepaid services will be honored for up to 45 days from the date of purchase. Any portion of an advance payment discount credit that has been redeemed for products or services will be deducted from the amount refunded. No refunds will be given past 45 days from the original date of purchase. Treatment/services/credits must be redeemed within a period of three years following the original date of purchase.

Advice from Practitioners

In most cases, practitioners will offer feedback from time to time during a course of treatment. This may include opinions as to the effectiveness of a particular treatment or the course of treatment in general as well as their opinion as to specific outcomes. This feedback is based on the observations and experience of the individual practitioner. It is their personal opinion and cannot be construed as a specific or implied guarantee of any kind.

★ **TURN OVER →**

Treatment Recommendations

As the need arises a practitioner may recommend that a patient under his or her care seek treatments, therapies and/or modalities that they, the practitioner, do not perform. Recommendations are made for specific types of treatment, not as a referral to a specific practitioner. While other practitioners at the Cherubino Health Center may perform some of these services, each patient is responsible for the choice of a practitioner, whether they are located at the center or elsewhere.

In order to help you in the decision-making process, information is available that pertains to each of our practitioners. It is available at the center and online and may be requested via e-mail or by phone.

Intent

It is the intent of each practitioner and staff member at Cherubino Health Center to offer the highest quality of alternative health care, with honesty and integrity, in an attempt to meet the specific needs of each patient to the best of that practitioner's ability. We consider it our mission to educate, share, treat and motivate each patient under our care.

Patient Responsibility

Our type of alternative health care is anything but passive. It requires a degree of trust in the competency and integrity of our practitioners. Therefore, each patient is encouraged to actively participate in his or her healing process. This may include, but is not limited to, maintaining the recommended treatment schedule, following at-home nutritional and exercise advice, educating themselves with resources that may be available through the center or from outside sources. This also includes following through with recommendations to receive other types of treatment and therapy not offered at Cherubino Health Center.

Purchasing Supplements

If you are choosing to purchase supplements through our office, we will allow for a full refund back to a patient who experienced an immediate sensitivity or allergic reaction to the supplement or if the supplement is unopened. If the supplement is opened, the patient will be refunded half the amount of the supplement that was purchased. The return must occur within 10 business days to receive a refund. Supplement recommendations are given on a patient-by-patient basis. Most supplements that are recommended can be purchased at Cherubino Health Center through trusted vendors. The office will not be held liable if a recommended supplement is purchased outside of Cherubino Health Center. The office will not be held liable for any supplement purchased for individuals who are not current patients at our office and have not received recommendations for those supplements from a provider within the office. Additionally, we will not allow for purchasing of or advice on supplements if the patient has not been seen in the office for more than one year.

Informed Consent

The procedures used at this center may involve hands-on techniques and/or the use of various noninvasive instrumentation for evaluation and treatment, or may include techniques that do not require direct contact with the practitioner including certain types of energy work, cognitive techniques and distance healing.

These include, but are not limited to, low pulse electrical instruments, heat, cold, massage and exercise therapies. While rare, reactions such as muscle soreness, skin irritations, allergic reactions, muscle spasm, inflammatory reactions and other such reactions may occur. Every reasonable effort is made to anticipate the likelihood of these reactions in an effort to avoid them.

Request for Treatment

I have read, or have had read to me, the two pages of above information and the Notice of Privacy Practices (contained on a separate page). I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named policies and procedures.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of natural medicine there are some risks to treatment, as mentioned above. I do not expect my practitioner to be able to anticipate and explain all risks and complications, and I wish to rely upon him or her to exercise judgment during the course of each procedure.

Furthermore, I agree to abide by the decision of Cherubino Health Center and my individual practitioner as to whether a particular service qualifies or does not qualify as a billable insurance procedure. I also understand that it is my sole responsibility to stay informed as to which of the treatments/services that I am receiving falls into an insurance or noninsurance category.

I also request and consent to the performance of investigational and/or alternative treatments and procedures on me (or on the patient named below, for whom I am legally responsible) by the practitioners and staff of Cherubino Health Center. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

★ **Patient Name (print):** _____

★ **Signature:** _____ **Date:** _____

★**Legal Guardian Signature (if applicable):** _____ **Date:** _____

Witness Signature: _____ **Date:** _____

CHERUBINO HEALTH CENTER

Office Policies

24-Hour Cancellation Notice
Late Arrival
No Show

Our goal is to serve each of our patients with the highest quality of personalized care possible. To this end, we have established the following set of policies and reserve the right to implement them when applicable. We understand that in life, things come up, and we will do out best to be accommodating.

Please read this document carefully and indicate your agreement by signing and dating below.

- **Cancelling your appointment with less than 24-hours notice** will result in a charge equal to 50% of the fee for the type of appointment that was scheduled. If you need to cancel your appointment, we ask for a minimum of 24 hours advance notice.
  **If insurance is utilized, 50% of the allowed or billed amount will be charged, not the co-pay or co-insurance.
  Please note: These guidelines do not apply to Psychotherapy patients.
  Specific guidelines are highlighted in Psychotherapy Informed Consent.

- **No shows** (with no notice of cancellation) will result in a charge of 100% of the fee for the type of appointment that was scheduled.

- **Late arrivals** may still be able to be treated, depending on how late you arrive. If you are 5 to 10 minutes late to your appointment, we may need to reschedule you.

Please sign and date below:

★ **Patient Name (print): _____**

★ **Signature: _____ Date: _____**

Witness Signature: _____ Date: _____

CHERUBINO HEALTH CENTER

Email Communication Policy

I, ★_____, agree to receive/send email and/or text communications from Cherubino Health Center. I realize that this communication may not be secure and choose to waive HIPAA rights in favor of ease of access. I have reviewed the information below and potential risks to electronic communication.

If, at any time, I choose to rescind this permission, I will notify Cherubino Health Center in writing of this change.

★ **Patient Signature** _____ **Date:** _____

The Physicians and staff of Cherubino Health Center uses unencrypted email, which could be a risk to the security and confidentiality of information and received using electronic communication. Because of the risks outlined below, the Physicians/staff cannot guarantee the security and confidentiality of electronic communications:

- The use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Despite any efforts to protect the privacy and security of electronic communication, it is not possible to completely secure the information.
- Employers and online services may have a legal right to inspect and keep electronic communications that pass through their system.
- Electronic communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.
- Electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the Physician/Staff or the patient.
- Even after the sender and recipient have deleted copies of electronic communications, back-up copies may exist on a computer system.
- Electronic communications may be disclosed in accordance with a duty to report or a court order.

CHERUBINO HEALTH CENTER

Financial Responsibility Statement for Services

By utilizing our services, you acknowledge and agree to the following terms regarding financial responsibility, particularly for Blue Cross Blue Shield (BCBS), out-of-network insurance arrangements, and cash-rated services.

1. Primary Responsibility for Payment

- You, the patient or the patient's legally responsible party, are ultimately responsible for the full payment of all services rendered by our practice at the time of service.

2. Insurance Coverage and Benefits

- **Not a Guarantee of Payment:** We will submit in-network claims to your insurance company. However, the filing of a claim is not a guarantee of payment by your insurer.

3. Out-of-Network Balances, Cash-Rated Services and Patient Responsibility

- **Verification of Benefits**: We will attempt to verify your benefits as a courtesy. This is only an estimate and not a final determination of coverage. You are responsible for knowing the specifics of your insurance policy, including network status (in-network or out-of-network), covered services, deductibles, co-pays, and co-insurance.
- **Deductibles:** You are responsible for paying the amount applied toward your annual deductible as determined by your insurance carrier.
- **Co-payments (Co-pays)**: All applicable co-payments are due at the time of service.
- **Co-insurance:** You are responsible for the percentage of the allowed amount (co-insurance) determined by your policy.
- **Unpaid Balances:** If, after processing the claim, your insurance company denies a portion of the charge, or if there is a remaining balance due to any of the above requirements, you are responsible for the payment of that remaining balance.
- **Cash-Rated Service:** Cherubino Health Center offers competitive cash rates for patients who pay for their care at the time of service and choose *not* to bill their insurance for reimbursement.

4. Appeals and Collections

- If a claim is denied, CHC staff will assist with the **initial** resubmission of necessary documentation. However, responsibility for pursuing complex appeals may become the responsibility of the patient.
- Unpaid patient balances may be subject to collections if the outstanding balance is not paid within a reasonable timeframe, as determined by CHC. Please note that we understand certain situations may require special circumstances; we are willing to work with you and develop an appropriate payment plan if proper documentation of financial hardship is received by our office.

By signing below or receiving services, I acknowledge that I have read and understand this Financial Responsibility Statement and agree to be personally responsible for all charges not covered or paid by my insurance company.

Patient/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

CHERUBINO HEALTH CENTER

Notice of Privacy Practices – HIPAA

Cherubino Health Center is committed to maintaining the privacy of your protected health information known as (PHI), which is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and the care and treatment you receive from our practice. In addition, this Notice describes your rights to access and control your PHI. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice carefully and if you should have any questions or concerns about this Privacy Notice, please do not hesitate to contact our privacy officer: *Dr. Ronald Cherubino, 23 Turnpike Rd., Southborough, MA 01772, (508)229-0007.* – This office is required by law to abide by the terms of this Notice of Privacy Practices as well as abiding by any other applicable state laws that may govern privacy practices and/or the scope of the practice of licensed practitioners. Our office may change and/or the scope of the practice of licensed practitioners. Our office may change and/or modify the terms of this Notice at any time and the new Notice will be effective for all PHI that we obtain at that time. Our office and/or doctor and/or clinician/practitioner will provide you with a copy of our Notice of Privacy Practices and make a good faith effort to obtain your written acknowledgement of our Notice, no later than the date of your first service delivery. We will also keep you notified of any changes to our Notice of Privacy Practices and if requested by you our office will provide you with an updated copy of same.

Uses and Disclosures of PHI:

Our office may use and disclose of your PHI for health care delivery purposes, which is known as treatment, payment and health care operations (TPO). Your PHI may be used and disclosed by your doctor and/or clinician/practitioner, 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. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of the doctor and/or clinician/practitioner's practice. It should be noted that even though our list of uses and disclosures of your PHI is fairly comprehensive, it is difficult to take into account each and every single possibility of how your PHI may be used or disclosed. We can assure you that your doctor and/or clinician/practitioner and his office staff will do everything possible to maintain the confidentiality of your PHI. Listed below are some of the more common types of uses and disclosures of your PHI that our office is allowed to make without your consent and/or authorization. Any other uses and/or disclosures other than those listed below will only be made with your written authorization.

Treatment - Your PHI may be used and disclosed for the coordination or management of your health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding you or the referral of you from one health care provider to another.

Payment - Your PHI may be used and disclosed for payment which encompasses the various activities of health care providers to obtain payment or be reimbursed for their services and of a health plan to obtain premiums to fulfill their coverage responsibilities and provide benefits under the plan and to obtain reimbursement for the provision of health care.

Health Care Operations - Your PHI may be used and disclosed for healthcare operations for certain administrative, financial, legal and quality improvement activities that are necessary to run its business and to support the core functions of treatment and payment.

Emergency Situations - Our office and/or doctor and/or clinician/practitioner may use or disclose your PHI in an emergency treatment situation. If an emergency situation happens to arise we are not required to obtain a written acknowledgement from you of our Notice of Privacy Practices until after the emergency situation has ended.

Minimum Necessary Standard - Our office and/or staff will make reasonable efforts to limit the use and disclosure of and requests for your PHI to the minimum necessary to accomplish the intended purpose.

Employee Limitations - Your doctor and/or clinician/practitioner will also limit the use and disclosure of your PHI to members of his or her workforce to those who may need access to your PHI for treatment, payment and health care operations.

Public Health Purposes and Activities - Your PHI may be disclosed to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury or disability which would include reporting of disease or injury, reporting vital events like births or deaths and conducting public health surveillance, investigations or interventions. In addition, your PHI may be disclosed for public health activities like child abuse or neglect, quality, safety or effectiveness of a product or activity regulated by the FDA and persons at risk of contracting or spreading disease as well as

workplace medical surveillance. Again, this information will be limited to the minimum amount necessary to accomplish the public health purpose.

Business Associate Contract - A business associate is a person or entity that performs certain functions or activities that involve the use or disclosure of PHI on behalf of, or provides services to, a covered entity i.e.: health care provider, health care plan or clearinghouse. Your PHI may be used or disclosed to a business associate provided we obtain satisfactory assurances from the business associate that the business associate will safeguard your PHI it receives or creates from any misuse and will use the information only for the purposes for which it was engaged to do and not for the business associates independent use or purposes, except as needed for proper management and administration of the business associate.

Research Purposes - Your PHI may be used or disclosed for research purposes which has been de-identified and/or you have authorized the use and disclosure of your PHI.

Workers' Compensation Purposes – Due to variability among State laws the privacy Rule permits disclosure of your PHI for purposes as authorized by and to extent necessary to comply with workers' compensation laws without your authorization and no minimum necessary determination is required.

Marketing Purposes - Your PHI may be used and disclosed for marketing purposes if it is in the form of a face-to-face communication or a communication involving a promotional gift of nominal value by the covered entity i.e.: health care provider, health care plan or clearinghouse. Marketing is defined as making a communication about a product or service that encourages recipients of the communication to purchase or use the product or service. This type of marketing has certain exceptions, which do not require authorization for the use and disclosure of your PHI and are listed as follows.

1. A communication is not marketing if it is made to describe a health-related product or service that is provided by or included in a plan of benefits of the covered entity making the communication.
2. A communication is not marketing if it is made for treatment of the individual.
3. A communication is not marketing if it is made for case management or care coordination for an individual or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the individual.

Note: Besides from the above exceptions any other form of marketing would require your authorization to use and disclose your PHI.

Personal Representative - Your PHI may be used and disclosed, under State law, to a person who is authorized to act on your behalf in making your health care related decisions.

Legal Proceedings – Your PHI may be disclosed if requested by any judicial or administrative proceedings, court order, a subpoena, law enforcement purposes etc.

Miscellaneous Uses and Disclosures of PHI - We may use a sign-in-sheet at our front desk so our staff can easily see who is seeking care. We are allowed to use and disclose your name in the waiting room when your doctor and/or clinician/practitioner is ready to see you. We may use and disclose your PHI to contact you to remind you of your appointment. We are also allowed to use and disclose your name and address to send you a newsletter about our practice and services we offer. In addition, we may send you information about products or services that we feel may benefit you.

Patient's Rights to Access and Control their PHI:

The Privacy Rule allows you certain rights with regards to your records, which are as follows.

You have the right to review and receive copies of your records as it relates to your own care.

Your request would have to be put in writing and the law requires that your doctor and/or clinician/practitioner respond within 30 days of your request. In addition, your doctor and/or clinician/practitioner is allowed to deny you access to your records, but only if it is going to cause you harm or someone else harm. If your doctor and/or clinician/practitioner denies you access to your records the denial has to be referred to a health care review professional, which would be the privacy officer who was designated. Your doctor and/or clinician/practitioner is allowed to charge a copy fee, which should not exceed State law allowance.

You have the right to request that the use and disclosure of your PHI be restricted.

This means you have the right to request restrictions on how your doctor and/or clinician/practitioner will use or disclose your PHI about treatment, payment and health care operations. Your doctor and/or clinician/practitioner is not required to agree to your request for restriction, but would be bound by any restrictions to which you and your doctor and/or clinician/practitioner agree on.

You have the right to request to receive confidential communications from your doctor and/or clinician/practitioner by alternative means or at an alternative location.

Your doctor and/or clinician/practitioner must accommodate your request, provided it is reasonable, and you clearly state that not doing so could endanger you.

You have the right to request amendments (changes) to your records.

If changes are made to your record it does not mean that your doctor and/or clinician/practitioner will destroy his or her records or your doctor and/or clinician/practitioner will rewrite their records it means that your doctor and/or clinician/practitioner will add an addendum to your current records to reflect your changes. Your doctor and/or clinician/practitioner has the right to deny or reject your request to change your records, but you have the right to submit a statement in the medical record that you disagree. Your doctor and/or clinician/practitioner also has the right to add to the record a rebuttal statement.

You have the right to receive your doctor and/or clinician/practitioner's Notice of Privacy Practices.

The law requires that your doctor and/or clinician/practitioner provide you in writing their policy on how they are protecting and using your PHI.

You have the right to revoke an authorization.

The revocation can be done at any time provided it is in writing. There is an exception to revocation that is if your doctor and/or clinician/practitioner has taken any action in reliance on the use or disclosure indicated in the doctor and/or clinician/practitioner's Authorization Notice.

Patient's Right to File a Complaint:

If you believe, that any of your Privacy Rights have been violated by us you can file a written complaint with our Privacy Officer (please see our privacy officer to obtain a complaint form). Your complaint must be filed within 180 days of when you knew or should have known that the act had occurred. In addition, you can also file a written complaint either on paper or electronically with the Office of Civil Rights (OCR). Please note that the Privacy law prohibits our office from taking any retaliatory actions against you.

Copies available upon request.

I have read, or have had read to me, the above information (3 pages) Notice of Privacy Practices HIPAA . I have also had an opportunity to ask questions about their content, and by signing below I agree to the above-named procedures and policies. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment at Cherubino Health Center.

★ **Patient Name (print): _____**

★ **Signature: _____ Date: _____**

★ **Legal Guardian Signature (if applicable): _____ Date: _____**

Witness Signature: _____ Date: _____

CHERUBINO HEALTH CENTER

HIPAA Authorization for Family Members/Friends

I, ★ _____,

◯ ***give permission*** to the below listed person(s) to have access to my health information.
Please fill out the rest of this form.

OR

◯ ***decline*** to designate another person(s) to speak with a physician or staff member at Cherubino Health Center.
You only need to provide your name and signature below.

Name(s):	Relationship
_____	_____
_____	_____
_____	_____

The above listed person(s) can have access to the following:

◯ My complete health record – including but not limited to appointments, diagnoses, lab tests, prognosis, treatment, and billing for all conditions

◯ Only appointments

◯ Only billing

◯ Other: _____

_____

This authorization shall be effective until (check one):

◯ All past, present, and future periods.

◯ Date of event: _____

Note: You may revoke this authorization at any time by notifying your health care provider(s), in writing.

★ **Patient Name (printed)** _____

★ **Patient Signature** _____ **Date:** _____

Witness Signature _____ **Date:** _____