Contemporary Family Practice | Family Practice + Urgent Care

How did you hear about us? Name:_____ **Or, please circle:** Billboard    yp Street

First Name:_____ **Last Name:**_____ **DOB:**_____

Sex: [ ]F [ ]M **SSN:**_____ **Marital Status:** [ ]Married [ ]Single [ ]Divorced [ ]Widowed

Street Address:_____ **City|State|Zip:**_____

Phone #:_____ **Email:**_____

Patient's Employer:_____ **Employer's Phone #:**_____

Preferred Pharmacy & Location:_____

Emergency Contact:_____ **Relationship:**_____ **Phone #:**_____

Insurance Information:

Subscriber:_____ DOB:_____ SSN:_____

Address:_____ Phone #:_____

Primary INS Co.:_____ Group #:_____ I.D.:_____

Secondary INS Co.:_____ Group #:_____ I.D.:_____

FINANCIAL AGREEMENT: I hereby authorize the providers at Contemporary Family Practice to furnish my insurance company with all the information they request concerning my present illness or injury. I request that payment of authorized benefits be made on my behalf for services provided to me by the party which accepts assignment. I understand that I am financially responsible for any charges not covered by this assignment. I also understand that failure to make payment for any services not covered will result in my account being sent to collection services.

X _____ _____|_____|_____

Patient | Guardian Signature **Date**

Recent Illnesses: Please check all that apply to you.

[ ]Fever	[ ]Headaches	[ ]Cough or Wheezing	[ ]Abdomen Pain	[ ]Chest Pain	[ ]Low Sex Drive
[ ]Fatigue	[ ]Blurred Vision	[ ]Weight Loss	[ ]Vomiting|Diarrhea	[ ]Palpitations	[ ]STD
[ ]Excessive Thirst	[ ]Numbness	[ ]Night Sweats	[ ]Constipation	[ ]Trouble Breathing	[ ]Leaking Urine
[ ]Weight Gain	[ ]Weakness	[ ]Rash	[ ]Bloody Stools	[ ]Swelling	[ ]Harmful Thoughts

Medical History: Please check all that apply to you.

[ ]High Blood Pressure	[ ]Migraines	[ ]Ulcer|Acid Reflux	[ ]Allergies (seasonal)	[ ]Anxiety	[ ]Heart Attack
[ ]High Cholesterol	[ ]Seizures	[ ]Arthritis|Gout	[ ]Asthma	[ ]Depression	[ ]Heart Failure
[ ]Diabetes	[ ]Stroke	[ ]Kidney Disease	[ ]COPD/Emphysema	[ ]Insomnia	[ ]Cancer
[ ]Thyroid Disease	[ ]Anemia	[ ]Liver Disease	[ ]Nighttime Urination	[ ]Sleep Apnea	[ ]Other _____

Surgeries: Please check all that apply to you.

[ ]Appendix [ ]Gallbladder [ ]Gastric Bypass [ ]Stent|Bypass [ ]Pacemaker [ ]Hysterectomy [ ]Bilateral Tubal Ligation

List all surgeries and dates: _____

List all medications or pills you take: _____

List medication allergies: _____

List any significant family diseases: _____

Family History: Please list all illnesses and/or diseases that apply to your biological mother and father.

Mother: _____ [ ]Alive [ ]Deceased

Father: _____ [ ]Alive [ ]Deceased

Social History: Please check all that apply to you and list type or name of each.

[ ]Alcohol Use _____ # Per Week: _____

[ ]Alternative Drug Use _____ # Per Week: _____

[ ]Tobacco Use _____ # Per Day: _____ # Years Used: _____

ACKNOWLEDGEMENT OF AVAILABILITY OF PRIVACY REGULATIONS AND CONSENT TO TREAT: I acknowledge that upon request a copy of HIPAA regulations are available to me. Furthermore, in signing this statement I give full consent to be treated by Contemporary Family Practice provider(s) and/or staff.

X _____ _____|_____|_____ _____

Signature **Date** **Relationship to Patient**

Contemporary Family Practice | Family Practice + Urgent Care

RELEASE OF MEDICAL RECORDS

Patient Information

First Name:_____ **Last Name:**_____ **DOB:**_____

Street Address:_____ **City|State|Zip:**_____

Phone #:_____ **Email:**_____

I request and authorize the following medical facility and/or provider to release my medical records as follows (please check box):

☐ **From:**

Contemporary Family Practice
Kenneth E. Zelsdorf, FNP-C
1560 W. Lacey Blvd., Suite 101
Hanford, CA 93230
P. 559-772-8285
F. 559-772-8313
E. CFP@cfphanford.com

To:

_____
_____
_____
_____
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☐ **From:**

_____
_____
_____
_____
_____
_____
_____

To:

Contemporary Family Practice
Kenneth E. Zelsdorf, FNP-C
1560 W. Lacey Blvd., Suite 101
Hanford, CA 93230
P. 559-772-8285
F. 559-772-8313
E. CFP@cfphanford.com

This request and authorization may apply to the following *(Please check the box of the medical records you are requesting and authorizing to be released.)*:

☐ All health information pertaining to my medical history, mental or physical condition

ONLY PROVIDE the following medical records:

☐ Laboratory reports ☐ Imaging Reports ☐ Medications ☐ Treatment Plan ☐ Mental Health

EXCLUDE the following medical records:

☐ HIV | AIDS ☐ STD Screening ☐ Pregnancy ☐ Drug Screening ☐ Alcohol | Drug Treatment

Purpose of requested release or disclosure:

☐ Patient Request ☐ Transfer of Care ☐ Specialty Needed

PATIENT RIGHTS:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits
- I may obtain a copy of the health information that is being requested on my behalf
- I may revoke this authorization at any time but I must do so in writing and submit it to the following: *Contemporary Family Practice | 1560 W. Lacey Blvd., Suite 101, Hanford, CA 93230*
- My revocation will take effect upon receipt of my written request, except to the extent that others have acted in reliance upon this authorization
- I have a right to and will receive a copy of this authorization upon my request
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality laws and/or HIPAA.

X _____ ____|____|____ _____

Patient Signature **Date** **Relationship to Patient**

DO NOT PRINT BELOW

The HIPAA guidelines (patient rights, medical records) following this page are for patient information only.
Do not bring to office visit.

HealthIT.gov

YOUR HEALTH INFORMATION, YOUR RIGHTS

DID YOU KNOW?

8 in 10 individuals who have viewed their medical record online considered the information useful.[1]

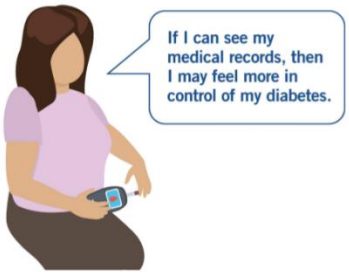
27% of individuals were unaware or didn't believe they had a right to an electronic copy of their medical record.[1]

41% of Americans have never even seen their health information.[2]

HIPAA (Health Insurance Portability and Accountability Act of 1996) gives us the right to access our health information.

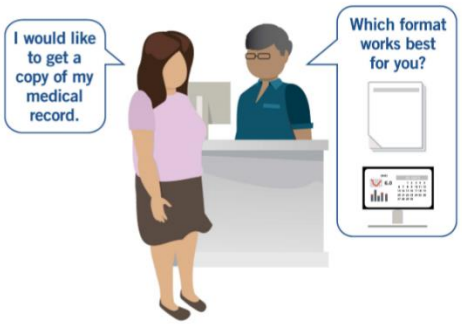
KNOW YOUR RIGHTS

Hannah is a 50-year-old woman recently diagnosed with Type 2 Diabetes.



Like all individuals, Hannah has a right to see and get a copy of her health information.

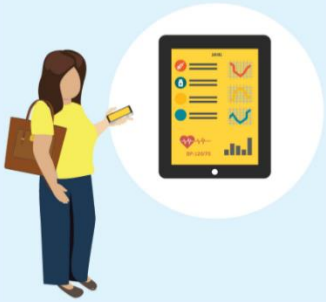
With a copy of your medical record you can become more informed about your health.



SEND YOUR HEALTH INFORMATION TO A THIRD PARTY

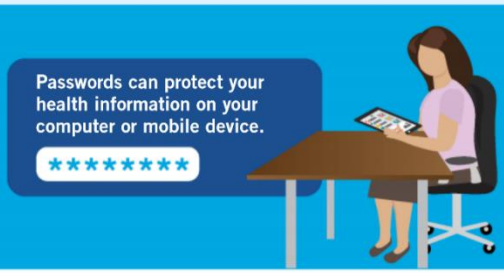
You hold the key to your health information and can send or have it sent to anyone you want. Only send your health information to someone you trust.

Your provider is no longer responsible for the security of your health information after it is sent to a third party.



Be careful when sending your health information to a mobile application or other third party.

PROTECT YOUR HEALTH INFORMATION



Sources: 1. https://www.healthit.gov/sites/default/files/briefs/oncdatabrief30_accesstrends_.pdf 2. https://www.healthit.gov/buzz-blog/consumer/making-patient-access-health-information-reality/

LEARN MORE ABOUT YOUR RIGHTS

WWW.HEALTHIT.GOV/ACCESS

www.hhs.gov/hipaa/for-professionals/privacy/guidance/access

The Office of the National Coordinator for Health Information Technology

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS