SUMMIT MEDICAL GROUP

Summit Medical Group Registration Form

Today's Date:_____

Patient Information

First Name	Middle Name	Last Name

Sex	Marital Status	Date of Birth	Social Security Number

Patient's Address	City	State	Zip

Home Phone	Cell Phone	Work Number	Ok to call at work?

Please indicate if it is okay for us to leave a confidential voice mail that may include test results, prescription information, or any other medical information pertaining to your health. This will reduce the need for you to return our call if you do not have any additional questions. This should be a phone number where only you, or anyone that you are comfortable with hearing your medical information, has access to.

Phone number that it is ok to leave message on	Initials_____	

Ethnicity	Race	Preferred Language

Occupation	Employer	How Did You Hear About Us?

Preferred Pharmacy	Pharmacy Phone Number

Email Address	

Primary Medical Insurance/Work Comp Insurance/Auto Insurance

Insurance Company Name	ID #	Group #	Effective Date

Street Address	City, State, Zip	Phone #

Name of Subscriber,(MUST HAVE name, SSN, DOB to bill)	Social Security #	Subscriber's Date of Birth

Work Comp and Auto Insurance Only Date of Accident: Claim's Adjuster Name:

Secondary Medical Insurance

Secondary Insurance Name	ID #	Group #	Effective Date

Street Address	City, State, Zip	Phone #

Name of Policy Holder	Social Security #	Date of Birth

Parent/Guardian/Spouse/Domestic Partner

First Name	Middle Name	Last Name

Sex	Marital Status	Date of Birth	Social Security Number

Address	City	State	Zip

Home Phone	Cell Phone	Work Number	Ok to call at work?

Emergency Contact Information

Name	Relationship		Phone #
Address	City	State	Zip

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AGREEMENT TO PAY FOR TREATMENT

I, the responsible party, hereby agree to pay all the charges submitted by Summit during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization, with which this office had a contractual agreement , I agree to pay all applicable co-payments, co-insurance and deductibles, which arise during the course of treatment for the patient. The reponsible party also agrees to pay for treatment rendered to the patient, which is not considered to be a covered service by my insurer and/or a third party insurer or other payor. I further understand that if I do not give 24 hours notice to Summit when canceling an appointment, I may be responsible for the charges up to the potential cost of the visit.

X

RESPONSIBLE PARTY **DATE**

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER

I, hereby authorize Summit and its employees to release and disclose, all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I, authorize the release and disclosure of any and all of my, or my child's, medical records to any other entity, including, but not limited to specialty physicians, hospitals, or other health care providers which may be of assistance in the opinion of this office, in providing treatment of the patient.

I, authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled.

I, authorize this office and/or its employees to release, via fax or other secure electronic means, medical records which are needed in order to provide the patient with the most appropriate medical care.

I, authorize and request that payment of any third party or insurance company benefits be made directly to Summit for any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

X

RESPONSIBLE PARTY **DATE**

CONSENT FOR TREATMENT/RELEASE OF ADDRESS

By signing below, I, the undersigned patient (or authorized representatve) consent to and authorize the performance of any treatments, examinations, medical services, surgical or diagnostic procedures, including lab and radiographic studies, as ordered by this office and it's healthcare providers.
I consent to and authorize all Summit Medical Group staff members to be able to treat me in my home and/or give my address to the appropriate personal needed for my healthcare treatment.

X

RESPONSIBLE PARTY **DATE**

***Some contract Health Plans require a co-payment at the time of service-Please have this ready prior to your visit as well as any current balance due. If copayor past due balance is not paid at the time of visit, patient may be required to reschedule the appointment.**

***Patient is responsible for all labwork and must be prepared to tell the Summit staff which lab their insurance requires them to use. If presenting new insurance on the day that labs are drawn, the patient should inform the person drawing their labs. Summit staff will not be able to make changes to the lab company once the lab leaves our office for processing.**

SUMMIT
MEDICAL GROUP

444 Hospital Way, Bldg. 100, Ste. 112
Pocatello, ID 83201
P: 208.238.3593 | F: 208.252.7130

HIPAA 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.

If you have any questions about this notice, please contact Kim Hymas, HIPAA Compliance Officer, at Summit Medical Group

OUR OBLIGATIONS: We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their-health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers compensation or similar programs.
These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure.
These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals In Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official.
This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved In Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization: 1. Uses and disclosures of Protected Health Information for marketing purposes; and 2. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS: You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to **Summit Medical Group, 444 Hospital Way, Bldg. 100, Ste. 112, Pocatello, ID 83201**. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to **Summit Medical Group, 444 Hospital Way, Bldg. 100, Ste. 112, Pocatello, ID 83201**.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to **Summit Medical Group, 444 Hospital Way, Bldg. 100, Ste. 112, Pocatello, ID 83201**.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to **Summit Medical Group, 444 Hospital Way, Bldg. 100, Ste. 112, Pocatello, ID 83201**. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of*pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of~pocket (or in other words, you have requested that we not bill your health plan} in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to **Summit Medical Group, 444 Hospital Way, Bldg. 100, Ste. 112, Pocatello, ID 83201**. Your request must specify how or where you wish to be contacted. We will try to accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, you must make your request, in writing, to **Summit Medical Group, 444 Hospital Way, Bldg. 100, Ste. 112, Pocatello, ID 83201**.

CHANGES TO THIS NOTICE: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future.

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HIPAA ACKNOWLEDGMENT AND CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996(HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information(available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

_____ _____

Patient's Name DOB: (mm/dd/yy)

_____ _____

Signed (Patient or Legal Representative for Patient) Date:

_____

Legal Representative's Relationship to Patient

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AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

I authorize the release of my medical records from the organization or physician listed below:

Physician's Name: _____
Physician's Address: _____
Physician's Phone #: _____ Fax # of Physician: _____

These records are to be sent to Summit Medical Group at the address listed above.

Patient's Name: _____ Date of Birth: _____
Address: _____ State: _____ Zip Code: _____
Phone: _____

The type and amount of information to be disclosed is initialed as follows: (specify dates where appropriate)

____X-Ray films (Specify type/date)
____Immunizations
____Most recent 3 years of Records
____Entire Medical Record
____Substance and Drug Abuse, if any
____AIDS/HIV, if any
____Genetic testing, from date
____Psychological or psychiatric conditions, if any

Other: _____

I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to the state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I accept full financial responsibility for any copying or shipping fees and any applicable sales tax that may be charged.

_____ _____
Patient's Signature **Today's Date**

_____ _____
Patient's Parent/Guardian/Representative **Relationship to Patient**

SUMMIT
MEDICAL GROUP

Authorization for Verbal Communication and/or to Leave Voice Mail Messages Regarding My Personal Health Information

You are under no obligation to sign this form, and you may refuse to do so for either all or part of it.

Patient Information

Name - Last, First, MI	Date of Birth:

Your Protected Health Information Designees:
Please list below those individuals (designees) with whom we can leave a message or briefly discuss your medical information (e.g. lab or test results, prescription information).
This person (designee) will also be able to call the office on your behalf.

Please print the name and relationship and phone number to you/patient of each designee below:

Designee Name:	Relationship to Patient:	Phone #:
Designee Name:	Relationship to Patient:	Phone #:
Designee Name:	Relationship to Patient:	Phone #:
Designee Name:	Relationship to Patient:	Phone #:
Designee Name:	Relationship to Patient:	Phone #:

_____Check here if you do not want your health care information discussed with anyone other than yourself.

Confidential Voice Mail:
Please ***check below*** where we have your permission to leave a confidential voice mail (e.g. lab or test results, prescription information). Leave the space(s) blank if you do not wish to receive voice mails.

Home Phone_____ Cell Phone_____ Work Phone_____ Other Phone_____

Your signature ***below*** confirms your approval of these updated HIPPA communication preferences. You may change your selections at any time, but must do so in writing by completing an updated form.

Do you have a Power of Attorney? ☐ Yes ☐ No
If Yes, Name of Your Power of Attorney:_____
Please provide Power of Attorney documentation.

_____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE SIGNED DATE SIGNED