Amber Clinic for Health & Wellness

Please Complete The Following Information

Name: ______________________ ☐ Male ☐ Female

Date of Birth: ______ / ______ / ______ SS#: ______ – ______ – ______

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widow

Summer Address

Address: ______________________

City: ______________________ State: ________ Zip Code: ________

Phone #: ______________________ Mobile #: ______________________

Winter Address

Address: ______________________

City: ______________________ State: ________ Zip Code: ________

Phone #: ______________________ Mobile #: ______________________

E-Mail Address: ______________________

Referred By: ______________________

Insurance Information

Primary Insurance Carrier: ______________________

Name of **Primary** Insured: ______________________ SS#: ______ – ______ – ______

Insurance ID #: ______________________ Group #: ______________________

Secondary Insurance Carrier: ______________________

Name of **Secondary** Insured: ______________________ SS#: ______ – ______ – ______

Insurance ID #: ______________________ Group #: ______________________

Emergency Contact Information
Please check names of people who can be given medical information on your behalf:

☐ Spouse Name: ______________________ Phone #: ______________________

☐ Other Name: ______________________ Phone #: ______________________

☐ Other Name: ______________________ Phone #: ______________________

☐ Other Name: ______________________ Phone #: ______________________

I HEREBY AUTHORIZE SAUL AMBER, MD OR HIS AGENTS TO RELEASE MY INFORMATION ACQUIRED IN THE COURSE OF ANY TREATMENTS OR EXAMINATION TO MY INSURANCE COMPANY FOR BILLING PURPOSES ONLY. I FURTHER UNDERSTAND THAT CHANGES FOR ANY PROCEDURE OR SERVICE RENDERED BY SAUL AMBER, MD ARE DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED, UNLESS ALTERNATIVE ARRANGEMENTS HAVE BEEN MADE WITH THE OFFICE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CO-PAYS OR CO-INSURANCE DUE SAUL AMBER, MD AND THAT I MAY BE CHARGED ADDITIONAL PROCESSING FEES FOR NSF CHECKS OR IF ANY ACCOUNT GOES TO COLLECTIONS.

Signature: ______________________ Date: ______________________

NOTICE OF PRIVACY PRACTICES

THE HIPAA Privacy Rule gives an individual a right to adequate notice of the uses and disclosures of protected health information (PHI) that may be made by this office, and the individual's rights and the office's legal duties with respect to PHI.

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.

WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECED HEATLH INFORMATION (PHI)

We are legally required to protect the privacy of your health information. This is called "protected health information" or "PHI" for short. It includes information that can be used to indentify you that we have created or received about your past, present, or future health or condition, the provision of health care. We must provide you with the notice about our privacy practices that explain how, when and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of you PHI than is necessary to accomplish the purpose of the use of disclose. We are legally required to follow the privacy practices that are described in this notice.

We do, however, reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make any important change to our policies, we will promptly change this notice and post a new notice in the main reception area. You can also request a copy of this notice from the contact person listed in Section VI below at any time.

HOW WE MAY USE AND DISCLOSE YOUR PHI:

The office is permitted by federal privacy laws to make use and disclosures of your PHI for purposes of treatment, payment, and health information. Some examples of how we may disclose your PHI includes, but is not limited to, the following:

1. For treatment. During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.
2. For payment of treatment. We may provide portions of your PHI to our billing department and your health plan to get paid for the health care services were provided to you.
3. For health care operations. We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol clinical guidelines development, medical transcription, or legal services. We will share health information about you with insurers or other business associates as necessary to obtain these services. We require our insurers and other business associates to protect the confidentiality of your health information.

Other potential uses and disclosures of your PHI may include the following:

1. When federal, state, or local law, judicial or administrative proceedings, or law enforcement require a disclosure.
2. When we are requested to assist the government when it conduct an investigation or inspection of a health care provider or organization.
3. We may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.
4. In certain circumstances, we may provide PHI in order to conduct medical research.
5. In order to avoid serious threat to the health and safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
6. We may disclose PHI of military personnel and veterans in certain situations. We may disclose PHI for national security purposes such as protecting the President of the United States or conducting intelligence operations.
7. We may provide PHI in order to comply with workers' compensation laws.
8. We may use PHI to provide appointment reminders or give your information about treatment alternatives or other health care services or benefits we offer.

We may provide your PHI to a family member, friend, or other person that you indicate that is involved in your care or the payment for health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

In any other situation not described above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke this authorization in writing to stop any future uses and disclosures (to the extent that we have not taken any action relying on the authorization).

NOTICE OF PRIVACY PRACTICES

YOUR HEALTH INFORMATION RIGHTS

The health and billing records we maintain are the physical property of the doctor's office. The information in it, however, belongs to you. You have the following rights with respect to you PHI:

1. Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted. You may not limit the use and disclosures that we are legally required or allowed to make.
2. Obtain a paper copy of the Notice of Privacy Practices by making a request at our office.
3. Request that you be allowed to inspect and copy your medical record and billing record. You may exercise this right by delivering the request in writing to our office using the form we provide to you.
4. Appeal a denial of access to your PHI except in certain circumstances.
5. Request that your medical record be amended to correct incomplete or incorrect information by delivery a written request, including a reason to support it, to our office. We are not required to make such amendments.
6. File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your PHI.
7. Obtain a list of the insurances in which we have disclosed you PHI. The list will not include uses of disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family. The list also will not include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or before April 14, 2003.

OUR OFFICE RESPONSIBILITIES

1. Maintain the privacy of your health care information as required by law.
2. Provide you with notices as to your duties and privacy practices as the information we collect and maintain about you.
3. Abide by the persons of this Notice.
4. Notify you if we cannot accommodate a requested restriction of request.
5. Accommodate your reasonable requests regarding methods to communicate health information with you.

HOW TO REQUEST INFORMATION OR FILE A COMPLAINT

If you have questions, would like additional information, want to report a problem regarding the handling of your information or if you believe your privacy rights have been violated and wish to file a written complaint with your office, please contact our Security Officer. You may also send a written complaint to the Secretary of Health and Human Services.

If you file a complaint with the Secretary of Health and Human Services, we can not and will not require you to waive your rights under the Privacy Rule as a condition of receiving treatment from the office. We cannot and will not retaliate against you for filing a complaint with the Secretary of Health and Human Services.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

(Original to be maintained in patient's permanent medical record)

I acknowledge that I have received a copy of the office's Notice of Privacy Practices

____ ____________________

Patient or legally authorized individual signature   Date

____ ____________________

Printed Name if signed on behalf of the patient   Date

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