The Rocking Chair LLC

www.therockingchair.org

NEW PATIENT INFORMATION SHEET

Patient's Last Name:_____ First:_____ Middle Initial_____

Mailing Address_____ City/State/Zip_____

Home Phone(_____)_____ Work Phone(_____)_____ Cell Phone(_____)_____

Birthdate_____ Soc.Sec.Number_____-_____-_____ Male_____ Female_____

E-mail*_____ Marital Status: M S D W Employed by:_____

Employer's Address_____ City/State/Zip_____

Referred by_____

IF PATIENT IS A CHILD OR DEPENDENT, PLEASE COMPLETE THE FOLLOWING:

Responsible Party's Name:_____ Relation To Patient_____

Mailing Address_____ City/State/Zip_____

Home Phone(_____)_____ Work Phone(_____)_____ Cell Phone(_____)_____

Birthdate_____ Soc.Sec.Number_____-_____-_____ Male_____ Female_____

E-mail_____ Marital Status: M S D W Employed by:_____

Employer's Address_____ City/State/Zip_____

Primary Insurance Company Name_____

Secondary Insurance Company Name_____ Third Insurance Name_____

IF INSURANCE HOLDER IS DIFFERENT FROM PATIENT:

Check if same as responsible party_____ If not, please complete the following:

Insurance Holder's Name_____ Relationship to Patient_____

Mailing Address_____ City/State/Zip_____

Home Phone(_____)_____ Work Phone(_____)_____ Cell Phone(_____)_____

Birthdate_____ Soc.Sec.Number_____-_____-_____ Male_____ Female_____

E-mail_____ Marital Status: M S D W Employed by:_____

* By placing my email address here I understand I may receive emails from you about updates and special offers. I understand I can unsubscribe from your email list at any time.

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Employer's Address_____City/State/Zip_____

EMERGENCY CONTACT (Someone who does not live with you):

Name_____Relationship_____

Address_____City/State/Zip_____

Home Phone(_____)_____Work Phone(_____)_____Cell Phone(_____)_____

I understand and agree that, regardless of my insurance status, I am responsible for the balance on my account and any professional services rendered. Having completed the above, I certify that this information is true and correct to the best of my knowledge. I will notify The Rocking Chair LLC. of any changes in the above Information

Signature _____

Date:_____

The Rocking Chair LLC

www.therockingchair.org

Welcome to The Rocking Chair LLC, serving women throughout their reproductive life span. Our goal is to provide you timely, respectful, quality care in a pleasant practice environment.

Appointments and cancellations
Patients are seen in the office by appointment only. For your convenience we attempt to adhere to our schedule as closely as possible. Notice of cancellation is requested 24 hours in advance to enable us to give your appointment to another patient. If you cannot or do not plan to keep your appointment please let us know 24 working hours in advance to avoid a charge.

Emergencies
If you have an immediate life and death emergency, call 911 or go promptly to your nearest emergency room for assistance.

During office hours, The Rocking Chair LLC will return calls as quickly as possible. We make a strong effort to return all patient calls on the day received. Please make sure that we have a current home, cell and work phone number. If you feel that your concern is urgent please make it clear when leaving a message so that we do not underestimate your concern. After hours and on weekends and holidays, physicians will respond to emergency calls only. When your treating physician is away on vacation he or she will have a physician covering for emergencies.

Prescription Refills
Our routine practice is to write prescriptions to cover your needs until your next appointment. There should be no need for additional refills if you keep scheduled appointments or reschedule promptly. If an exception occurs, please call your pharmacy (during business hours at least two working days before you run out) and ask them to call the office to approve the refill. Refills will only be approved for current patients with scheduled follow up appointments and only during office hours. Patients are generally seen for medication at least monthly at first and then up to every two to three months. Persons not seen in over four months are not considered current patients. Medication changes generally require appointments so that they can be adequately considered, explained and discussed.

Office Charges
Payment for all office charges is required at the time of the visit. We are happy to supply you with the necessary forms which you may submit to your insurance company for reimbursement. There is a charge for appointments missed, cancelled or changed with less than 24 working hours of notice. Please remember, this is fully your time. Unlike most doctors' offices, we do not over-book or double book appointments. Please notify us promptly if you cannot make your appointment so that we can offer the time to someone else. If payment is made by check and the check is returned for insufficient funds, or we are unable to collect payment for any other reason, you will be charged a fee. As of 12/30/11 such fee is $30 (provided, however, we reserve the right to increase such fee at any time without notice).

E-mail Policy
E-mail is meant for non-urgent matters only and for concise communications. E-mail is not meant for matters that should be addressed in therapy sessions. In the event you need to communicate regarding an urgent matter, please call the office at (201) 308-5325 or call 911. While we try to respond to e-mail quickly, please expect that it may take up to two business days to get a reply.

Website Disclaimer
Our website and its contents are designed for educational purposes only. Our website is not intended to and does not render any medical advice or professional services. The information provided in our website may not and should not be used for the purposes of diagnosing or treating any medical or psychiatric illness and is not intended, in any way, to be a substitute for professional care. If you have or suspect you may have any health problem (including, without limitation, any medical or psychiatric illness), you must consult your health care provider.

Signature:_____ Date:_____

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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 our office privacy officer.

Who Will Follow This Notice:

- Any physician or other healthcare professional authorized to enter information into your medical record
- All employees, staff and office personnel
- Healthcare professionals outside this office involved in your care and treatment for the purpose of providing health care services to you
- All these persons follow the terms of this notice. These persons may share medical information with each other for treatment, payment or purposes as described in this notice.

Our Pledge Regarding Medical Information:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this office, whether made by office personnel or a healthcare professional. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We Are Required By Law To:

- Make sure that medical information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you
- Follow the terms of this notice.

HowWe May Use and Disclose Medical Information About You:

The following categories describe different ways that we use and disclose medical information. The ways we are permitted to use and disclose information will fall within one of these categories and may require written consent from the patient, parent or legal guardian if the patient is a legal minor.

I. Treatment Within The Rocking Chair LLC:

We may use health information about you to provide you with medical treatment or services. We may disclose medical information about you to our staff, doctors, nurses or other office personnel who are involved in taking care of you at The Rocking Chair LLC.

II. Insurance (Payment and Provider Audits):

We may disclose medical information to coordinate and manage health care with a third party-insurance company/managed care. We may use and disclose health information about you, upon a written request, so that the treatment and services you receive at our office may be billed to and payment may be collected from you, an insurance company, or a third party (e.g. managed care). For example, we may need to give your health plan

information about treatment you received so that your health plan will pay us or reimburse you for treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may be required to submit your medical record to your insurance company for review of services provided to you by our agency. Release of this information is secured from you at the time of your initial visit to The Rocking Chair LLC. The insurance company is also required to adhere to the same confidentiality standards set forth by HIPAA (Health Insurance Portability and Accountability Act of 1996).

III. Healthcare Operations:

We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run the office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff caring for you. We may also disclose non-identifying information to doctors, nurses, healthcare professionals and personnel for review and learning purposes. We will remove identifying information so others may use it to study healthcare and healthcare deliveries without learning the identities of specific patients. We may use and disclose your medical information with a third party "business associate" that perform various activities (e.g. billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we have a written contract that will protect the privacy of your health information.

IV. Individuals Involved In Your Care Or Payment For Your Care:

We may release medical information about you to a friend or family member who is involved in you medical care. This would include persons named in any durable health care power of attorney or similar document provided to us. We may also give information to someone who helps pay for your care, upon written consent.

V. By Court Order:

We will disclose medical information about you when required to do so by court order.

VI. Serious Health Safeties and Emergencies:

We may use and disclose medical information in an emergency treatment situation. If this happens, your healthcare provider shall try to obtain your consent as soon as reasonably practicable after delivery of treatment.

VII. Evidence of Abuse and Neglect:

We may disclose medical information about you to notify the appropriate government authority if we suspect child abuse, neglect of a child or elderly person or domestic violence.

VIII. Disclosure of Intent to Harm Self or Others:

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety of the health and safety of the public or another person. However, any disclosure would only be to someone able to help prevent the threat.

IX. Workers' Compensation

We may release medical information, upon written consent, about you for your workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

X. Lawsuits and Disputes:

If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a valid court administrative order. In the event that we need to disclose medical information about you in response to a subpoena, discovery request, or other lawful process be to someone else involved in the dispute, we will need to obtain your written consent to do so.

XI. Food and Drug Administration:

We may release medical information to a person or company required by the food and drug administration to report adverse advents, product defects or problems, track products; to enable product recalls, without using information to identify you.

XII. Military Activity and National Security:

If you are a member of the armed forces we may release medical information about you, upon written request, as required by military command authorities. We may also disclose your medical information to authorized federal officials for conducting national security and intelligence activities.

XIII. Primary Care Physician:

We may use and disclose health information about you to correspond with your primary care physician when required by our insurance company/managed care company, upon written consent.

Your Rights Regarding Medical Information About You:

You have the following rights regarding medical information we maintain about you:

I. Right to Inspect and Copy:

You have the right to inspect and obtain a copy of your health information and/or summary of your medical information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes medical and billing records. To inspect or obtain a copy of your health information, please submit a request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. We require 30 to 60 days to respond after receiving the written request. If we need additional time to respond, we will notify you in writing within the time frame above to explain the reason for the delay and when you can expect to have a final answer to your request. Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we deny part or all of your request, we will provide written denial that explains our reasons for doing so. If we have reason to deny only part of your request, we will provide complete access to a copy of the remaining parts after excluding the information we cannot let you inspect or copy.

II. Right to Amend:

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be made in writing and submitted to the office. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or it does not include a reason to support the request.

III. Right to An Accounting of Disclosures:

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment or payment. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care, like a family member or friend. However, if such limitations of accounting and disclosures make it impossible for us to either provide appropriate care and/or collect payment from a payer, we have the right to discontinue services. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. You must make your request in writing.

IV. Right to Confidential Communications:

You have the right to request to receive communications from us on a confidential basis by using alternative means for receipt of information or by receiving the information at alternative locations. We must accommodate your

request, if it is reasonable. You are not required to provide us with an explanation as to the basis of your request. Contact the office Privacy Officer if you require such confidential communications.

V. Right to Paper Copy of this Notice:

You have the right to a paper copy of this notice.

VI. Changes to This Notice:

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our office.

VII. Complaints:

If you believe your rights have been violated, you may file a complaint with the office Privacy Officer or with the Secretary of the Department of Health and Human Services. ***You will not be penalized for filing a complaint.***

I have read the above notice of Privacy Practices and understand my rights.

Signature: _____ **Date:** _____

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ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. 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 to the *Notice of Privacy Practices.*

Print Patient Name:_____

Patient Signature:_____

Parent/Guardian Name:_____
(if applicable)

Date:_____

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices*, but acknowledgement could not be obtained because:

Date: **Initials:** **Reason:**

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PATIENT AUTHORIZATION FORM

I hereby authorize _____ to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be used or disclosed:

_____

_____

Person or entity requesting the information (your name):

_____

Recipient of the information:

The Rocking Chair LLC_____

This information is being requested for the following purpose(s):

_____

_____

This authorization shall remain in effect from the date signed below until (expiration date or event):

_____

I understand that:

- I may inspect or copy the protected health information to be used or discussed
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPPA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on me proving this authorization (except to the extent that the authorization is for research – related treatment, in which case you may refuse to provide that research – related treatment.)

Patient Name_____ Signature_____ Date_____

Relationship to Patient (if signed by representative)_____

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AUTHORIZATION TO DISCLOSE MEDICAL RECORDS INFORMATION

I,_____authorize the following:

The Rocking Chair LLC

TO DISCLOSE THE FOLLOWING INFORMATION:

To _____at the

following address:_____in order

to coordinate treatment.

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it. If not previously revoked, this consent will terminate one year from the date written below.

_____ _____

Signature of Patient/Parent/Authorized Representative Date

I DO NOT WISH TO AUTHORIZE RELEASE OF INFORMATION

_____ _____

Signature Date