

Acknowledgement Form (HIPPA Privacy Release)

Patient Name: _____ Date: _____

We are required by law to provide you with our Privacy of Practices Notice, which explains in detail how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

Patient Signature _____
(or legal guardian)

Rosedale Infectious Diseases, PLLC is not permitted, by law, to provide information to anyone other than the patient except for treatment, payment, and healthcare operations as described in the Rosedale Infectious Diseases, PLLC's Notice of Privacy Practice.

The staff at Rosedale Infectious Diseases, PLLC would like to know with whom, if anyone, you want us to discuss your treatment, instructions, for treatment, treatment plans, condition updates, lab results, appointment information, and to pick up samples or written documents.

Please complete the following so the individuals you specify can have access to your information as described above:

As a patient of Rosedale Infectious Diseases, PLLC, I authorize the release of my medical information regarding my treatment and care and billing information to the following individuals upon their request.

Emergency Contact Only: (this person is NOT HIPPA acknowledged) it is only an emergency contact, if you want this same person to be

Name of Emergency Contact Only

Phone

Name (Please Print)

Relationship

Name (Please Print)

Relationship

Name (Please Print)

Relationship

Name (Please Print)

Relationship

Rosedale Infectious Diseases
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET THE ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This office reserves the right to change its privacy practices and apply revised privacy practices to Protected Health Information.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe to you your rights and certain duties we have regarding the use and disclosure of medical information.

2 OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our practices and the new terms of our notice effective for all medical information that we keep including information previously created or received before the changes.

Notice of change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we used and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: WE may use and disclose your medical information for payment purposes.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

Notification: Medical information to notify or help notify a family member, your personal representative or another person responsible for your care. We will share information about your location about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment to make decisions in your best interest. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-rays or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Research: This office and its practitioners are involved as a study site and service as researchers in connection with certain clinical trials. Our participation in the advancement of science and medicine may be of benefit to you as our clinicians are aware of certain experimental treatments that may be available here and other selected institutions, but which are not widely available elsewhere. However, in order to provide you with useful information concerning the availability to you of these treatments, we may review your medical record from time to time to determine whether you may be eligible to participate in certain experimental treatments. In certain instances, we believe it is consistent with our treatment of you to consider these kinds of options in connection with your care. Only, our clinicians, employees, or other members of our workforce will review your medical record during these reviews and none of your protected health information will be

disclosed to third parties with out your specific authorization. If it's preliminarily determined that you may be eligible for such treatment and that such treatment may be beneficial to you, your doctor or a member of our staff will contact you with further information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury, disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs, or replacements, to tract products, or to conduct activities required by the FDA. We may also when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others.

We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or who has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for activities authorized by law, including audits civil, administrative or criminal investigations or proceedings, inspections, licensure or disciplinary actions or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances including reporting required by certain laws (such as the report of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS

You have a right to:

1. Look at, or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you based on the following scale:

Page 1 – 25	\$.75 each	In addition you may be charged postage
Pages 26 – 100	\$.50 each	
Pages 101 +	\$.25 each	
2. Receive a list of all of the times we or our business associates shared your medical information for purposes other than for treatment, payment and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement except in the case of an emergency.
4. Request that we communicate with you about your medical information by different means or to different locations.

Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Compliance Officer at the address listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request we will provide you a written explanation. You may respond with a statement of disagreement, that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

Patient Initials

General Policies and Procedures:

General Office Hours:

Monday thru Thursday: 8:30 am till 5:00 pm
Friday 8:30 am till 12:00 pm

The office is closed everyday from 12:00 pm till 1:30 pm for lunch.
The office will also be closed on weekends and major holidays (these dates posted on website) and other dates due to management’s discretion.

Insurance and Co Pays:

All patients are required to present a current insurance card at each visit to our office, a copy must be kept on file for each visit. Any co-pay or co-insurance amount not billable to insurance must be paid at the time of service.

Missed Appointments:

If you miss your scheduled appointment and you do not call to cancel, a \$10.00 charge will be applied and must be paid before your next visit.

Prescription Refill Policy:

Please ask for your refills for all needed medications at the time of your visit. Please note: if you call a refill in to your pharmacy or our office, it may take 24-48 hours to get that prescription filled. Please only call the triage nurse here at the office during the hours of 9:00 am and 3:00 pm Monday thru Thursday and 9:00 am and 1:00 pm on Fridays. We appreciate your cooperation with these matters. On call hours are for emergency refills only. You forgetting to refill or loose a medication are not an emergency. It is up to the provider on call to make that assessment.

If our office becomes aware that you are filling multiple prescriptions for the same medications at numerous pharmacies, you can be dismissed from the practice without thirty days written notice.

Appointment Dates and Times:

We understand that your medical appointments are important to you, as they are very important to us, so we can continue to provide you with the finest quality healthcare. If you miss three or more appointments without notice to our office you may be discharged from the practice. If you are more than 15 minutes late for any given appointment, without notice, that appointment is forfeited and counted as a no show and you will have to be rescheduled.

Medical Records and Paperwork:

Any request for medical records or other paperwork that needs to be completed by our office can take 7 – 10 business days and applicable charges will apply. Please note the standard per page charges allowed by law in the Privacy papers and other paperwork is charged for and fees assessed on a time for service basis.

Patient Signature

Date

Witness Signature

Date

PATIENT MEDICAL HISTORY FORM

Name _____ Age _____ Birth date _____
Referring Physician _____ Phone _____
Primary Care Physician _____ Phone _____

Current Medications (list dose and frequency taken):

Prescriptions: _____

Over the Counter: _____
Vitamins: _____

DRUG ALLERGIES: _____

Have you had any of the following problems?

Check all that apply.

Heart Disease _____	Hay Fever/Hives _____	Depression _____
High Blood Pressure _____	Tuberculosis _____	Kidney Stones _____
Rheumatic Fever _____	Positive TB Skin Test _____	Cancer _____
Heart Murmur _____	Stomach Ulcer _____	Stroke _____
Enlarged Heart _____	Hepatitis _____	Convulsions _____
Pneumonia _____	Gallstones _____	Phlebitis _____
Pleurisy _____	Thyroid Trouble _____	Bleeding Disorder _____
Asthma _____	Diabetes _____	Venereal Infection _____

Operations:

Check all that apply.

Tonsillectomy _____	Date _____	Physician _____
Hernia Operation _____	Date _____	Physician _____
Appendectomy _____	Date _____	Physician _____
Hysterectomy _____	Date _____	Physician _____
Hemorrhoidectomy _____	Date _____	Physician _____
Ulcer surgery _____	Date _____	Physician _____
Gallbladder _____	Date _____	Physician _____
Biopsy _____	Date _____	Physician _____
Joint Surgery _____	Date _____	Physician _____

Other Hospitalizations or

Accidents: _____

Immunizations (give approximate date):

Tetanus ___/___/___ Polio ___/___/___ Diptheria ___/___/___
TB Skin test ___/___/___ Others ___/___/___

For Women:

Age of onset of periods _____ Interval _____ Duration: _____

Date of last period: ____/____/____ Do you have irregular periods or spotting? ____

Pregnancies ____ Miscarriages ____ Living Children: ____ Birth Control: ____

Family History:

Father: Age: _____ Health or cause of Death: _____

Mother: Age: _____ Health or cause of Death: _____

Brothers: Age: _____ Health or cause of Death: _____

Sisters: Age: _____ Health or cause of Death: _____

Children: Age: _____ Health or cause of Death: _____

Have any of your close relatives had:

Check all that apply

Diabetes ____ Tuberculosis ____ Cancer ____ Allergic Diseases ____ Heart Disease ____

Arthritis ____ Bleeding Disease ____ Psoriasis ____ High Blood Pressure ____

Chronic Back Pain ____ Depression ____ Osteoporosis ____

Personal Habits:

Do you exercise? _____ How Often? _____

Do you use tobacco products? _____ How Often? _____

Do you drink alcohol? _____ How Often? _____

Do you use drugs? _____ How Often? _____

Do you have any of the following problems:

Check all that apply

- | | | |
|-----------------------------|--------------------------------|------------------------------|
| Fever _____ | Irregular Heartbeat _____ | Painful Urination _____ |
| Skin Rash _____ | Swelling of ankles/feet _____ | Painful/Swollen joints _____ |
| Swollen Glands _____ | Trouble Swallowing _____ | Frequent Backaches _____ |
| Ear Problems _____ | Frequent Indigestion _____ | Weakness in arms/legs _____ |
| Eye Problems _____ | Abdominal Bleeding _____ | Frequent Dizziness _____ |
| Recurring Nosebleeds _____ | Vomiting Blood _____ | Fainting spells _____ |
| Persistent hoarseness _____ | Frequent constipation _____ | Frequent Headaches _____ |
| Goiter _____ | Frequent Diarrhea _____ | Double Vision _____ |
| Shortness of Breath _____ | Change in bowel habits _____ | Unusual worry/anxiety _____ |
| Wheezing _____ | Bloody Stool _____ | Depression _____ |
| Frequent cough _____ | Slow urinary stream _____ | Trouble sleeping _____ |
| Coughing blood _____ | Blood w/urination _____ | Unusual weight gain _____ |
| Chest pain/pressure _____ | Frequent night urination _____ | Unusual weight loss _____ |

When did you last have these tests?

Blood Tests ____/____/____	Rectal Exam ____/____/____	Colonoscopy ____/____/____
Urine Test ____/____/____	Pelvic Exam ____/____/____	Stool for Blood ____/____/____
EKG ____/____/____	Mammogram ____/____/____	Chest X-ray ____/____/____

What is the main reason for your visit to our office today? _____

GENERAL CONSENT INFORMATION

When you become a patient with our practice, you sign a general policy and procedure style sheet in your introduction packet. On this sheet we explain our policy for renewing prescriptions. In accordance with that policy, please let us be clear:

1. It is your responsibility to ask for prescription refills at your visit.
2. We understand that emergencies arise and you may need to call the office for a forgotten refill on RARE occasions. However, at these times, please be aware that refills WILL take 24-48 hours to be completed.
3. If you call the provider on call, AFTER HOURS, for refills, most times these requests can not be granted, as they do not have access to your entire chart, medical history, or prescribing history for medications. Pain management medications are not considered an emergency in these situations. Most times, if the provider is contacted after office hours you will be offered the very next available office appointment.

I understand the policy for prescribing any medications and will adhere to any policy relating to this set forth by Rosedale ID and it's prescribing providers.

I understand that I am asking for care at Rosedale infectious Diseases, PLLC which may or may not diagnose a medical condition, procedures to treat my condition and routine medical care. I understand that these services will be provided to me by a physician, nurse practitioner, physician's assistant, or other qualified healthcare professionals. I have no guarantees as to results of any services I receive.

I understand that my agreement to accept these services will remain in effect unless I say that I no longer want these services or until my treatment plan is complete. Rosedale Infectious Diseases, PLLC reserves the right to discharge any patient at any time, with or without notice. Failure to follow medical advice, adherence or compliance, or inappropriate behavior may result in termination of services.

I understand that I am subject to random drug and substance abuse testing, including adherence to Rx medications. If I test positive for illegal substances not prescribed to me, I may be discharged from the practice with or without notice.

I understand that my agreement to accept these services is called a General Consent for Treatment and that it includes any routine procedures, treatments, blood draws, physical exams, administration of medication or vaccinations, and any other procedures that may be deemed medically necessary by my provider.

Patient Signature: _____ Date: _____

CHRONIC OPIOID (NARCOTIC THERAPY CONTRACT AND INFORMED CONSENT

DESCRIPTION OF THERAPY AND BENEFITS:

The therapeutic goals of the chronic opioid (narcotic) therapy are to improve your ability to do daily tasks and/or to reduce chronic pain. It will be important for your provider and you to routinely assess goals and to agree on a time and a dose limit for meeting these goals. If the goals cannot be met after a reasonable period of time, the therapy will be tapered off and then stopped and another treatment offered.

PATIENT REQUIREMENTS TO PARTICIPATE:

1. Tell your provider if you have problems with alcohol or drug abuse or dependence.
Tell your provider if you are currently in treatment or have had treatment for any of these conditions.
2. Use only your provider (or covering provider if they are not available) for your opioid Prescriptions.
3. See your prescribing provider regularly to assess and re-evaluate therapy.
4. The therapy will be stopped if you:
 1. get opioid medications from other providers or prescribers (except in reasonable emergent situations).
 2. increase your dose without prior approval from your provider.
 3. use this medication to self treat any condition.
 4. give your medication to anyone else to use.
 5. change or forge prescriptions
 6. show evidence of saving up these medications
 7. show evidence of misuse or unapproved use of other controlled substances, (sleeping pills, anti-anxiety pills, stimulants, or other pain pills) or alcohol while on this therapy.
 8. use illicit (street) drugs
5. If you become pregnant during your treatment, your treatment will be discontinued.
Discuss this with your provider. If you have plans to become pregnant, please inform your provider.
6. You are responsible for lost or stolen prescriptions or medications. These may or may not Be replaced at the discretions of the provider.
7. You and your provider agree to continue the ipioid therapy until a clear reason for stopping It develops. If the medical condition for which it is prescribed resolves, the treatment will be slowed and discontinued. You and your provider will re-evaluate your therapy about every 6 months to decide id it should continue. Any increase in these dosages will be discussed and agreed upon in advance by both provider and patient.
8. I understand that drug/substance abuse screening is a routine/periodic function and if I Should test positive for drugs/substances not prescribed for me, I may be discharged from this practice. Rosedale Infectious Diseases reserves the right to discharge any patient (s) from service at any time with a 30 day written notice.

RISKS:

During this chronic opioid therapy the following things are possible:

- a. There is a small chance of becoming “psychologically dependent on this medication.
- b. It is likely that you will develop a “physical dependence” and could develop withdrawal syndrome from medication if stopped too quickly.
- c. There is a chance you will be able to think clearly on this medication. This would most likely happen during the early phase of use, and if used with other sedating drugs, (sleeping pills and/or anti-anxiety medications in particular) or alcohol.
- d. You may be able to safely drive a car or operate heavy equipment on this therapy.
- e. For females in child-bearing years: a child delivered during this therapy will most likely be physically dependent on the drug used and is likely to suffer from withdrawal syndromes after birth, just like an adult.
- f. A urine drug screen will be positive for these medications.

ALTERNATIVES:

Other alternatives may include physical therapy and/or other medications.

PATIENT’S STATEMENT OF UNDERSTANDING AND CONSENT:

I have read the above information. I have had a chance to ask for additional information about therapy, its risks, benefits, and alternatives. I am satisfied with the information I have received and have no further questions. I understand that it is my responsibility to follow the therapy as described above and by my provider. I request and consent to this therapy and agree to follow the guidelines given.

Patient’s Signature: _____ Date: _____

Provider Signature: _____

ROSEDALE INFECTIOUS DISEASES GRIEVANCE POLICY

We at Rosedale Infectious Diseases treat patients on a “need” basis. All your concerns are valid and are our highest priority as your healthcare providers. We will not discriminate or refuse care to any individual based on sexual orientation, gender, race, religious affiliation, monetary background, or age.

If you fell that any of your individual rights have been ignored or violated at any time by any member of the staff, please contact me personally and I assure you that every avenue of your grievance will be addressed.

You are entitled to one or all of the following by the practice a manger of this facility

A written response to your grievance

A personal phone call, discussing the issue and what actions need to be taken

A personal meeting with the practice manager

I assure you that everything will be done to come to satisfactory resolution of your grievance, within at least 15 days of the initial complaint. You will be informed of the decisions made by the practice manager and the actions taken to rectify the situation, wither in person or in writing.

Patient Signature

Dale J. Pierce
Practice Manger and Ryan White Coordinator
Rosedale Infectious Diseases, PLLC

Revised 1/2010