Dear Patient:

Our staff welcomes you to Swisher Internal Medicine. Enclosed you will find the registration forms that you will need to complete and bring in with you to your upcoming appointment. Please remember to bring your insurance cards and all bottles of medication(s) you are currently taking. Please arrive 30 minutes early for your appointment to allow us time to get all of your information entered into our computer system. Please review our office policies sheet that is included in your packet.

Our staff looks forward to meeting you and caring for all of your healthcare needs.

Sincerely,

Swisher Internal Medicine

HIPAA Release Form

Name:________________________________ Date of Birth: ____________

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse ___________________________________

[ ] Child(ren) ________________________________

[ ] Other ____________________________________

[ ] Information is NOT to be released to anyone.

The **Release of Information** remains in effect until terminated by me in writing.

Messages

Please call: [ ] Home [ ] My Work [ ] My Cell Number

If unable to reach me:

[ ] You may leave a detailed message

[ ] Please leave a message asking me to return your call

[ ] Please leave message reminding me of my appointments

Signed: ___________________________________ Date: ___/____/_____

Witness: __________________________________ Date: ___/___/_____

Patient Registration Information

Please Print and complete ALL sections below

Patients Personal Information Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed
Sex: [ ] Male [ ] Female

Name: ____________ ____________ ______
LAST NAME FIRST NAME INITIAL

Date of Birth: ___/___/___ Social Security #: ___-___-___

Home Phone: (___)________ Work Phone: (___)________ Cell: (___)________

Address: ______________________ Apt #: ________

City: ____________ State: ________ Zip: ______

Patients Responsible Party Information Relationship to patient: [ ] Self [ ] Spouse [ ] child [ ] Other

Name: ____________ ____________ ______
LAST NAME FIRST NAME INITIAL

Date of Birth: ___/___/___ Social Security #: ___-___-___

Home Phone: (___)________ Work Phone: (___)________ Cell: (___)________

Address: ______________________ Apt #: ________

City: ____________ State: ________ Zip: ______

Pharmacy Information

Name: ______________________

Address: ____________ City: ________ State: ______ Zip: ______

Phone: (___)________ Fax: (___)________

Emergency Contact

Name: ______________________ Relationship: ____________

Address: ____________ City: ________ State: ______ Zip: ______

Home: (___)________ Work: (___)________ Cell: (___)________

Assignment of Benefits- Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Swisher Internal Medicine, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fee. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as the original.

Your Signature: ______________________ Date: ________

-Please come n fasting (if appointment is before lunch) Nothing to eat or drink (except water) after midnight.

-Please arrive 30 minutes early so we can get you registered in our computer system.

-Please bring all completed paperwork on the day of your appointment.

-Please bring all bottles of medications you are currently taking.

-Please review our office policies sheet.

Please fill in the following information:

Employer: ______________________________

Email Address: ____________________________

Drivers License #: ___________

Expiration Date: ___________

How did you hear about Swisher Internal Medicine (please check):

[ ] Prior Patient [ ] Word of Mouth [ ] Internet

[ ] Hickory Daily Record [ ] Charlotte Observer

[ ] Sophie Womans Magazine [ ] Sign/Location

[ ] Sprint Yellow Pages [ ] Pages Plus Telephone Book

[ ] Doctor Referral [ ] Other

SWISHER INTERNAL MEDICINE

30 13th Avenue NW Hickory, NC 28601 Phone (828)324-0100 Fax (828-324-0101

***New Patient Medical History** - Please complete this two-sided form prior to your first appointment*

Name: ______________________ Date of Birth: ___/___/____ Age: ____ Sex: ____
How did you hear about our practice?

♦ Please briefly state in the box below the reason for your visit ♦

♦ Past Medical History ♦			
Condition / Disease	***Year Began***	***Condition / Disease***	***Year Began***
❑ Hypertension		Other(s):	
❑ High Cholesterol			
❑ Hypothyroidism (low thyroid)			
❑ COPD, Emphysema or Asthma			
❑ Diabetes			
❑ GERD/Acid Reflux			
❑ Depression or Anxiety			
❑ Heart Problems			

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦			
Operation / Surgeon	***Month / Yr***	***Operation / Surgeon***	***Month / Yr***

♦ Medication or Food Allergies or Intolerances ♦ *List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)*			
Medication / Food	***Reaction***	***Medication / Food***	***Reaction***

♦ Medications, Vitamins and Herbal Supplements ♦					
Medication	***Strength***	***Number of pills taken & frequency***	***Medication***	***Strength***	***Number of pills taken & frequency***
Example: *Tylenol*	*500 mg*	*1 - twice daily*			
What Pharmacy do you use?					

♦ Social, Educational and Work History ♦

Marital Status:	Age of children, if any:	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current/Prior Occupation:	Place of Employment:
What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
Who lives in your household with you?		
How much caffeine do you drink each day?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker, former smoker, or non-smoker?		
Number of years you smoke(d)?	How many packs per day do you smoke(d)?	
If you a former smoker, what year did you quit?		
Are you sexually active: Yes / No	How many partners have you had in the past 12 months?	Are you concerned that you may have been exposed to HIV? Yes/No

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	***Living or Deceased***	***Age or age at death***	***Cause of Death***	***Health Problems***
Father:				
Mother:				
Brother(s):				
Sister(s):				

♦ Review of Systems ♦

Please review the following symptoms and circle those items that are a problem for you

Fatigue	Runny nose	Shortness of breath	Abnormal menses	Easy bruising
Fever/chills	Nose bleeds	Heartburn	Joint pains	Hair loss
Weight loss	Dental problems	Constipation	Back pain	Cold intolerance
Weight gain	Chest pain	Diarrhea	Muscle aches	Heat intolerance
Vision problem	Palpitations	Change in stool	Dizziness	Increased thirst
Eye pain	Rapid heart rate	Genital lesions	Headaches	Other:
Hearing problem	Leg swelling	Blood in urine	Numbness/tingling	
Sinus Congestion	Cough	Vaginal bleeding	Weakness	

❑ ***Place an "X" in the box to the left if you have none of the above.***

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests

	Month/Yr		***Month/Yr***		***Month/Yr***
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Abd. Aneurysm Screen	
Gardasil Vaccine		Chest X-Ray		HIV Test	

♦ Other Physicians and Specialists ♦

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)

Swisher Internal Medicine, PLLC

Consent Form

Patient Name: ______________________________ **DOB:** ______________

Consent for Treatment:

I hereby give consent to Swisher Internal Medicine to provide whatever treatment the physician/provider may deem necessary to the patient.

Consent for Insurance Policy:

Swisher Internal Medicine will submit claims to the insurance companies that they are contracted with. I understand that I am responsible for all deductibles, copays, and charges not covered by insurance at the time of service. I also understand that I will need to bring my insurance card at each visit along with my cost that the insurance does not pay.

Authorization To Release Information:

I hereby authorize Swisher Internal Medicine to release any information acquired in the course of my treatment to any insurance company including Medicare. I also authorize the payment of claims directly to Swisher Internal Medicine.

Signature for treatment, insurance policy, and authorization to release information.

SIGNED: ________________________________ DATE: ______________

Acknowledge of Receipt of Notice of Privacy Practices:

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our practice to ask questions about our privacy practices. By signing this form, you have agreed that you have had opportunity to read our Notice of Privacy Practices.

SIGNED: ________________________________ DATE: ______________

Office Policies

Office Visits:

Please bring your insurance copay or deductible amount, insurance card, and medication bottles to every visit. Please arrive 10m minutes before your appointment time for a follow up visit and 30 minutes early if you are a new patient. **If you are late for your appointment, we will have to reschedule.**

Lab appointments:

If you are scheduled to get fasting blood work, you may (and should) drink WATER prior to the appointment so that you are not dehydrated. Do not eat anything after midnight that night before your lab appointment.

Cancelations:

If you cannot make it to your appointment, please cancel 24 hours in advance. This will allow other sick patients to be seen. There is a $30 charge for un-kept appointments.

Prescription Refills:

When you need a refill on a medication that has been previously prescribed for you, please call your pharmacy and have them fax a refill request to our office. We can then fax them a prescription. **Do not wait until you are down to your last pill; allow 24 hours for the prescription order to go through.** New prescriptions typically require an appointment in order to evaluate the appropriateness of the medication for you.

Paperwork:

There is a $20 fee for any paperwork that needs completed outside of an appointment, depending on the amount of involvement this fee may be higher.

Financial:

All copays, deductibles, and any charges not covered by insurance are due at the time of service.

All bills/invoices received by mail must be paid within 30 days of receipt inless payment arrangements have been made by the office manager.

We accept Master Card, Visa, Cash, and some checks. **We do not accept checks for amounts greater than $50.** There is a $25 service charge for returned checks.

SWISHER INTERNAL MEDICINE, PLLC
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 the Privacy Officer.
Deena Suddreth

Effective Date: April 14, 2003 **Revised: September 23,2013**

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: swishermedicine.com.

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.

- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing to Swisher Internal Medicine, Attention Deena Suddreth.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Deena Suddreth, LPN, Office Manager

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on September 23,2013.
operations. You have the right to obtain a listing of these disclosures that occurred after April 14,