PATIENT REGISTRATION

Last Name_____ Middle Initial_____ First Name_____

Preferred Named_____ SSN _____-____-_____ Birth Date ____/____/_____

Gender: Male / Female (circle one) Sexual Orientation _____ Gender Identity _____

Mother's Maiden Name_____ Multiple Birth (twin, triplet, etc.) **Yes or No** Birth Order ___

Mailing Address_____ City_____ State_____ Zip _____

Home Phone _____-_____-_____ Work Phone _____-_____-_____Cell _____-_____-_____

E Mail_____ Marital Status_____

Primary Language _____ Race _____ Ethnicity _____

Student Status **Yes or No** Employment Status_____ Employer_____

Emergency Contact _____ Relationship_____ Phone#_____

Primary Insurance_____ Group#_____ ID_____ Subscriber Name_____

Secondary Insurance_____ Group # _____ ID_____ Subscriber Name_____

I authorize the release of my medical information to medical professionals and insurance companies: **Yes or No**

Legal Representative _____DOB___/___/____ Relationship to the Patient_____

Whom may we thank for referring you? _____

Informed Consent

I understand that I am financially responsible for all charges whether or not paid by insurance company (ies) and their agents for the benefits payable for related services provided by Dr. Hovancsek and or his staff.

_____ _____

Signature of Patient, Parent Guardian, or Representative Date

Medical History

Please circle to indicate if you have had any of the following:

AIDS/HIV
Allergies to Anesthetics
Allergies to Medicine
Anemia
Angina
Arthritis
Artificial Heart Valves
Artificial Joints
Asthma
Back Problems
Bleeding Disorder
Cancer _____
Chemical Dependency
Chest Pain
Chronic Diarrhea
Depression/Anxiety
Diabetes Type _____

Ear Problems
Epilepsy
Eye Problems
Fainting
Foot or Leg Cramps
Gout
Headaches
Heart Disease
Hemophilia
Hepatitis or Jaundice
High Blood Pressure
High Cholesterol
Kidney Problems
Liver Disease
Neuritis
Neuropathy
Psychiatric Care

Radiation Treatment
Rashes
Reflux GERD
Respiratory Disease
Rheumatic Fever
Shortness of Breath
Sinus Problems
Stroke Year_____
Swelling in Ankles and/or Feet
Swollen Neck Glands
Tuberculosis
Ulcers – Stomach
Ulcers – Extremities
Varicose Veins
Venereal Disease
Weight Changes

Surgeries

_____

_____

Allergies

_____

Medications

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Physician _____ **Last Date Seen** _____

Pharmacy _____

Chief Complaint _____

Treatment Consent

I hereby consent and give my permission to Doctor Hovancsek D.P.M and his Medical Assistants to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____
Signature of Patient, Parent Guardian, or Representative Date

Last Name_____ Middle Initial_____ First Name_____

Has the patient received a flu vaccination for the current season? **Yes or No**

Patients 65 yrs. or older, have you had a Pneumonia Vaccination? **Yes or No**

Patients 65 yrs. or older, do you have a living will or someone to make decisions on your behalf? **Yes or No**

If no, please state why _____

Acknowledgment of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Robert L Hovancsek, D.P.M The Statement of Privacy Practice describes the type of uses of disclosure of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the Privacy Practice is also posted in the facility.

Robert L Hovancsek D.P.M. reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at that time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

_____ _____

Signature of Patient, Parent, Guardian, or Representative Date

Disclosure Authority

In addition to the allowable disclosure described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

Any Member of My Immediate Family **Yes or No**

Spouse Only **Yes or No**

Other (Please Specify): Name: _____ Phone # _____

_____ _____ _____

Print Name of Patient Signature of Patient or Personal Representative Date

Statement of Privacy Practices

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may from time to time amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and your medical care operations. Your personal health information will never be given to anyone – even other family members – without written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our office and electronic system are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality medical care, implement payment activities, conduct normal medical practice operations, and comply with the law. This may include your name, address, telephone numbers, Social Security Number, employment data and medical information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the fullest extent of the law.

Disclosure of Your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointment including voicemail messages, answering machines and postcards.

Patient Rights

You may have a right to request copies of your healthcare information, to request copies in a variety of formats, and to request a list of instances in which we, or our business associates, have disclosed your protected information for use other than stated above. All such request must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient of Robert L. Hovancsek D.P.M. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Robert L. Hovancsek D.P.M