Your Information.
Your Rights.
Our Responsibilities.

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.**

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on the back page. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

Our Uses and Disclosures

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

WE DO NOT CREATE OR MANAGE ANY HOSPITAL DIRECTORY

WE DO NOT CREATE OR MAINTAIN PSYCHOTHERAPY NOTES AT THIS PRACTICE

WE WILL NEVER SHARE ANY SUBSTANCE ABUSE TREATMENT RECORDS WITHOUT YOUR PERMISSION

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

DR. BERNICE R. SWAIN FAMILY MEDICINE

ADDRESS- 2424 DANVILLE ROAD SUITE L
DECATUR AL. 35603

PRIVACY CONTACT - DR. SWAIN

TELEPHONE # - 256- 341- 0043

EFFECTIVE DATE - JUNE 2016

Dr. Bernice R. Swain | Family Medicine
2424 Danville RD Suite L
Decatur, AL. 35603
Phone: 256-341-0043
Fax: 256-341-0095

Patient Information

Patient Name:_____ Marital Status:_____ Date of Birth:_____

Street Address:_____ City, State, Zip:_____

Home Phone:_____ Cell Phone:_____ Social Security #:_____

Email Address: _____

Patient Employer:_____ Occupation:_____

Employer Address:_____ Employer Phone:_____

Spouse/Parent:_____ Home Phone:_____ Cell Phone:_____

Emergency Contact (other than spouse):_____ Relation:_____

Address:_____ Home Phone:_____ Cell Phone:_____

Billing information & responsible party (Payment required at the time of service unless other arrangements have been made.)

Billing Name (if different from patient):_____ Relation to patient:_____

Billing Address:_____ City, State, Zip:_____

Insurance Information

Primary Insurance:_____ Phone Number:_____ Effective Date:_____

Address:_____ Group Number:_____

Name of Insured:_____ Relationship to patient:_____

Additional Insurance:_____ Phone Number:_____ Effective Date:_____

Address:_____ Group Number:_____

Name of Insured:_____ Relationship to patient:_____

Additional Insurance:_____ Phone Number:_____ Effective Date:_____

Address:_____ Group Number:_____

Name of Insured:_____ Relationship to patient:_____

Signature:_____ Date:_____

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Authorization to Release Medical Information

Dr. Bernice R. Swain is authorized to discuss my medical information or needs with the following individuals:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient or Representative Signature:_____ Date:_____

(14 and Over)

By circling yes on this form you authorize Dr. Swain and staff to leave detailed messages regarding personal health care information on your voicemail. (Please Circle One) Yes / No

If yes, please list numbers where you may be contacted:

Cell: (___)_____

Work: (___)_____

Home: (___)_____

Parent or Guardian Signature:_____ Date:_____

(14 and Over)

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HEALTH HISTORY

(Confidential)

Name:_____ Date:_____

Age:_____ Birth Date:_____ Date of last physical examination _____

What is your reason for visit?_____

SYMPTOMS (Check all that apply)

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, Weakness, Numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITOURINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed vision
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision-Flashes
- ☐ Vision-Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN ONLY

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Sore on penis
- ☐ Other

WOMEN ONLY

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_____

Date of last Pap smear_____

Have you had a mammogram? _____

Are you pregnant?_____

Number of children_____

CONDITIONS (Check all that apply)

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◻ AIDS ◻ Alcoholism ◻ Anemia ◻ Anorexia ◻ Appendicitis ◻ Arthritis ◻ Asthma ◻ Bleeding disorder ◻ Breast lump ◻ Bronchitis ◻ Bulimia ◻ Cancer ◻ Cataracts	◻ Chemical Dependency ◻ Chicken Pox ◻ Diabetes ◻ Emphysema ◻ Epilepsy ◻ Glaucoma ◻ Golter ◻ Gonorrhea ◻ Gout ◻ Heart Disease ◻ Hepatitis ◻ Hernia ◻ Herpes	◻ High Cholesterol ◻ HIV Positive ◻ Kidney Disease ◻ Measles ◻ Migraine Headaches ◻ Miscarriage ◻ Mononucleosis ◻ Multiple Sclerosis ◻ Mumps ◻ Pacemaker ◻ Pneumonia ◻ Polio	◻ Prostate Problems ◻ Psychiatric Care ◻ Rheumatic Fever ◻ Scarlet Fever ◻ Stroke ◻ Suicide Attempt ◻ Thyroid Problems ◻ Tonsillitis ◻ Tuberculosis ◻ Typhoid Fever ◻ Ulcers ◻ Vaginal Infections ◻ Venereal Disease

MEDICATIONS (List all medications you are currently taking)	ALLERGIES (List any medicines you are allergic too)
_____ _____ _____ _____	_____ _____ _____ _____

FAMILY HISTORY (Fill in health information about your family)

Relation	Age	State of Health	Age at Death	Cause of Death			
Father							
Mother							
Brothers							
Sisters							

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HOSPITALIZATIONS			PREGNANCY HISTORY		
Year	Hospital	Reason for Hospitalization and Outcome	Year	Sex	Complications

Have you ever had a blood transfusion? Yes ☐ No ☐

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME	SOCIAL HISTORY		
			Type	Yes/No	How long?
			Do you use tobacco?		
			Do you use alcohol?		
			Do you drink caffeine?		
			Do you use illegal drugs?		
			OCCUPATIONAL CONCERNS Check if your work exposes you to the following: ☐ Stress ☐ Hazardous Substances ☐ Heavy Lifting ☐ Other		
			Your occupation:		

I certify that the information is correct to the best of my knowledge. I will not hold my Dr. Swain or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

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Signature:_____ Date:_____

Reviewed By:_____ Date:_____

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Patient Consent

Consent for treatment:

I hereby authorize the performance of any medical procedure which may be advised and/or recommended by Dr. Bernice R. Swain while I am under her care.

Authorization for release of medical information:

I authorize Dr. Bernice R. Swain and/or authorized employee to furnish any medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment for my care

Financial Policy:

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees. Financial Policy, or your responsibility. All patients must complete our *"Patient Information form"* Before receiving treatment.

I understand that I will be responsible for all charges incurred during my course of treatment in this office regardless of insurance coverage.

Adult patients: Are responsible for full payment.

Minors Accompanied by an Adult: The adult accompanying a minor, and his/her parents (or Guardian), are responsible for full payment.

Unaccompanied Minors: The parents (or guardians) are responsible for full payment. Non-emergency treatment may be denied unless charges have been pre-authorized to an approved method of payment (cash, or check).

Insurance:

If you have insurance, we will help you receive maximum benefits. If we accept your insurance, you will be responsible for your estimated co-payment amount and any unmet deductible at the time of service.

Insurance is a contract between you and your insurance company.

We are NOT a party to this contract. We file insurance claims as a COURTESY to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual, customary & reasonable" charges, etc. other than to supply factual information as necessary. You are responsible for the timely payment of your account.

Any account that we receive no payment on for 90 days will be turned over to a collection agency for collection. At that time, you will be responsible (or the balance on your account, and an additional charge of 40% of your total balance to cover the collection agency fees. Therefore, please do not let your account reach this point without trying to make satisfactory arrangements with us to keep your account current.

Missed Appointments

If you cannot make your appointment, please call at least two hours in advance to cancel. We reserve the right to charge for any non-cancelled appointment. It is our policy that three consecutive "NO SHOW" for two scheduled appointments, or a total of six cancellations and/or no shows constitute discontinuation of treatment.

Patient (Responsible Party) Signature _____ Date _____

Witness _____ Date _____

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Consent for Purposes of Treatment. Payment and Health Care Operations

I, _____, understand that as part of my health care; Dr. Bernice Swain originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Dr. Bernice Swain is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Dr. Bernice Swain reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Dr. Bernice R Swain change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to allow the following persons to have access to, use of, or disclosure of my health information:

_____
_____

I wish to have the following restrictions to the use or disclosure of my health information:

_____
_____
_____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / disclose the terms of this consent.

_____

Patient’s Signature

_____

Date

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Patient Name: _____ **Date:** _____

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

For each question in the chart below, circle the choice best describing your answer.

Questions						
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	

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Patient Name: _____ **Date:** _____

PATIENT: Over the last 2 weeks, bow often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

Little interest or pleasure in doing things	Not at all	Several days	More than half the days	Nearly every day
Feeling down, depressed, or hopeless	Not at all	Several days	More than half the days	Nearly every day
Trouble falling asleep, staying asleep, or sleeping too much	Not at all	Several days	More than half the days	Nearly every day
Feeling tired or having little energy	Not at all	Several days	More than half the days	Nearly every day
Poor appetite or overeating	Not at all	Several days	More than half the days	Nearly every day
Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down	Not at all	Several days	More than half the days	Nearly every day
Trouble concentrating on things such as reading the newspaper or watching television	Not at all	Several days	More than half the days	Nearly every day
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual	Not at all	Several days	More than half the days	Nearly every day
Thinking that you would be better off dead or that you want to hurt yourself in some way	Not at all	Several days	More than half the days	Nearly every day

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Receipt of Notice of Privacy Practices Written Acknowledgment Form

I am a patient of Dr. Bernice R. Swain. I hereby acknowledge receipt of Dr. Bernice R. Swain's Notice of Privacy Practices.

Name: _____

Signature: _____

Date: _____

or

I am a parent or legal guardian of _____ (Patient Name). I hereby acknowledge receipt of Dr. Bernice R. Swain's Notice of Privacy Practices with respect of the patient.

Name: _____

Relationship to Patient: _____ Parent _____ Legal Guardian

Signature: _____

Date: _____