

Health Medicine Center

PATIENT REGISTRATION INFORMATION

Last Name:	First Name:	Middle Name:						
Address:	City:	State: Zip:						
Home Phone:	Work Phone:	Cell Phone:						
Soc SS#:	Birth Date:	E-mail:						
Male	Female	Minor	Single	Married	Divorced	Widowed	Separated	Life Partner
Occupation:	Employer:							
Emergency Contact:	Phone:	How did you hear about us?						

PRIMARY INSURANCE CARD HOLDER INFORMATION

Card Holder Name/ Responsible Party:	Relationship to Patient:
Address:	City: State: Zip:
Home Phone:	Soc SS#: Birth Date:
Occupation:	Employer: Work Phone:
Business Address:	
Insurance Company:	Subscriber ID#: Group#:
Insurance Claim Address:	

2ND INSURANCE CARD HOLDER INFORMATION

Card Holder Name:	Relationship to Patient:
Address:	City: State: Zip:
Home Phone:	Soc SS#: Birth Date:
Occupation:	Employer: Work Phone:
Business Address:	
Insurance Company:	Subscriber ID#: Group#:
Insurance Claim Address:	

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Health Medicine Center all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance for all services rendered on my behalf or my dependants. I authorize the above doctor and/or any supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party

Date:

Health Medicine Center

Integrative Health & Well Being

CONSENT FOR CARE

I, _____ hereby grant permission to the Health Medicine Center and its practitioners to perform such examinations and therapeutic services, and so discuss modalities & options that are considered necessary or advised for my diagnosis and care. Practitioners who may treat me include, but are not limited to: medical doctors, naturopathic physicians/ ND's, acupuncturists, body workers, herbal specialists, nutritional experts, psychologists, biofeedback experts, spiritual counselors, nurses, and/or chiropractors.

I understand that a chart of my treatments will be kept confidential and will not be released to others unless they are involved in my care. I authorize Health Medicine Center staff and practitioners to keep a joint chart or record, which may be discussed by related staff and practitioners. I further understand that I may look at my medical record at any time and can request a copy of it. My records will be kept for the duration of time required by law.

I understand that the nature of the recommended treatments for my care will be explained to me. I understand that I will have the opportunity to ask of those involved in my care. I am not being forced by anyone to accept treatment.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Health Medicine Center to release any information required to process any claims to insurance companies or attorneys. I also authorize any insurance company or medical provider to release my medical records to the Health Medicine Center. This information is to be used for the purpose of processing claims for benefits due. I hereby agree that a photocopy of this document is as valid and as effective as the original copy.

PAYMENT AGREEMENT

I assume full responsibility for the timely payment of all costs, charges and expenses related to my treatment at Health Medicine Center. The amount of the bill shall be due and payable on presentation to the client, his/her agent, guardian, conservator, or third party responsible for payment.

24 HOUR APPOINTMENT CANCELLATION POLICY

I agree to change or cancel appointments at least 24 hours in advance or I will be charged the full fee for the missed appointment unless I am offered other arrangements by HMC.

Date

Signature of Patient or Legal Guardian

Date

Signature of Witness

HEALTH MEDICINE CENTER

1620 Riviera Avenue
Walnut Creek, CA 94596
(925) 935-7500

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.

The Health Medicine Center is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

“On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with the “Health Medicine Center”.

“It is our policy to provide a substitute health care provider, authorized by the Health Medicine Center to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider’s absence due to vacation, sickness, or other emergency situation.”

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

“As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Health Medicine Center and/or your individual health care provider for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received.”

Workers’ Compensation

We may disclose your health information as necessary to comply with State Workers’ Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug

Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.

We may disclose your health information to coroners or medical examiners.

Organ Donation.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing.

We may contact you for marketing purposes or fund-raising purposes, as described below: (example)

“As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.”

“It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of the Health Medicine Center sponsored fund-raising events.”

Change of Ownership.

In the event that the Health Medicine Center is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- Ø You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that the Health Medicine Center is not required to agree to the restriction that you requested.
- Ø You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- Ø You have the right to inspect and copy your health information.
- Ø You have a right to request that the Health Medicine Center amend your protected health information. Please be advised, however, that the Health Medicine Center is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- Ø You have a right to receive an accounting of disclosures of your protected health information made by the Health Medicine Center.
- Ø You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

The Health Medicine Center reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, the Health Medicine Center is required by law to comply with this Notice.

LIST OF PRACTICING HEALTH CARE PROVIDERS PRACTICING IN THIS CLINIC:

Len Saputo, MD

Trina Swerdlow, CCHT

Mitchell Corwin, DC, AK

Roseann Liu

Geoffrey Marx, NC

Nirinjan Yee, CMT

Beverly Rubik, PhD

Michael Mayer, PhD

Bonnie Maeda, RN

Masha Henzel, ACSM, ACE, MAT

Jennifer Jeha, CMT

The staff of the Health Medicine Center will take every precaution to protect your health information privacy however; there may be an “incidental disclosure” due to the following circumstances specific to our health care facility:

- We have an “open front desk” area where you may hear what our staff and/ or patients say.
- We hold Patient’s-in-Common conferences where patient information is shared between the practitioners listed in a private conference area for the purpose of optimizing your care by coordinating treatment with different modalities.
- Access to therapeutic medications, nutritional supplements, or homeopathic remedies is through the private offices of the above listed practitioners who dispense them.
- Patient health care information is kept in open and closed file areas that have been designated as “staff only “ areas. The insurance resource area, reception desk, thermography room, and work stations where patient health information may be present for the purpose of daily operations, are designated by signs accessible to staff members only.

The Health Medicine Center is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling (925) 935-7500.

Complaints

Complaints about your Privacy rights, or how the Health Medicine Center has handled your health information should be directed to our Executive Director, Sean White. Call (925) 935-7500 to make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of April 30, 2003.

Health Medicine Center

Integrative Health and Well Being

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide the Health Medicine Center with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Name (print)

Patient's Signature

Date

Authorized Facility Signature

Date

HEALTH MEDICINE CENTER
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HIPAA Policy Acknowledgment

Health Medicine Center is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

You have the right to determine whether detailed messages may be left, including any protected health information, on the phone numbers of your choice. Please provide the following numbers where we can reach you and a decision as to whether or not a message may be left.

Home Phone: _____	Confirm Appointments OK?	YES	NO
	Detailed Message OK?	YES	NO
Work Phone: _____	Confirm Appointments OK?	YES	NO
	Detailed Message OK?	YES	NO
Cell Phone: _____	Confirm Appointments OK?	YES	NO
	Detailed Message OK?	YES	NO
E-mail: _____	Confidential Information OK?	YES	NO

Other person authorized to receive messages/information: _____
Relationship to patient: _____

.....
I have received, read and understand the Notice of Privacy Practices. I understand this organization has the right to change it's Privacy Practices from time to time and that I may contact this organization and receive an updated copy at any time.

Patient's Name (print)

Patient's Signature

Date

Relationship to patient (If other than patient)

Date

Authorized Facility Signature

Date

OFFICE USE ONLY		
I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:		
Date:	Initials:	Reason: