

**EMMAUS MED-SURG CLINIC**

GENERAL PRACTICE & SURGERY  
BERT B. OUBRE, M.D., F.A.C.S.  
669 Barr Rd., Lexington, SC 29072

Phone: (803) 359-0164

Fax: (803) 359-0255

**PATIENT INFORMATION:**

Patient's Full Name \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_ Gender \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home# \_\_\_\_\_

Employer/School \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_

Ethnicity \_\_\_\_\_ Race \_\_\_\_\_ Primary Language \_\_\_\_\_

Email \_\_\_\_\_ Marital Status \_\_\_\_\_ Spouse Name \_\_\_\_\_ Contact# \_\_\_\_\_

Spouse/Parent Employer \_\_\_\_\_ Work# \_\_\_\_\_

Parent/Guardian, if under 18: \_\_\_\_\_ Contact# \_\_\_\_\_

Emergency contact (not living with you) \_\_\_\_\_ Relationship \_\_\_\_\_ Contact# \_\_\_\_\_

Allergies \_\_\_\_\_ How were you referred to our office? \_\_\_\_\_

**INSURANCE INFORMATION/GUARANTOR:**

**Primary Insurance** \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Policy Holder's DOB \_\_\_\_\_ SSN \_\_\_\_\_ Employer \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ Name of Policy holder \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Policy Holder's DOB \_\_\_\_\_ SSN \_\_\_\_\_ Employer \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**RELEASE OF INFORMATION:**

I authorize release of any information concerning myself or my child's health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand that I am responsible for any amount not covered by my insurance. I understand that I must pay any amount owed at the time of services. I authorize the release of my medical records to Bert B. Oubre, MD, FACS and permit a copy or fax of this authorization to be legally used as the original.

I give Dr Oubre and/or his staff permission to leave messages regarding my Protected Health Information to the following people listed below:

Name \_\_\_\_\_ Contact # \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Contact # \_\_\_\_\_ Relationship \_\_\_\_\_

I also authorize Emmaus Med-Surg Clinic the release of my Protected Health Information via voicemail on my:

(Home) \_\_\_\_\_ Yes \_\_\_\_\_ No (cell) \_\_\_\_\_ Yes \_\_\_\_\_ No (work) \_\_\_\_\_ Yes \_\_\_\_\_ No

Information that can be released: Results \_\_\_\_\_ Appts \_\_\_\_\_ Diagnosis \_\_\_\_\_ Referrals \_\_\_\_\_ All info \_\_\_\_\_

PATIENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Name \_\_\_\_\_

I have received a copy of the Notice of Privacy Practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Patient Name \_\_\_\_\_

Birthdate \_\_\_\_\_

**Medical History** Please Check all that apply to you:

- Anxiety
  - Arthritis
  - Asthma
  - Blood/bleeding disorder
  - Depression
  - Diabetes
  - Gastrointestinal problems
  - Gynecological problems
  - Heart disease
  - Hepatitis
  - High blood pressure
  - HIV/AIDS
  - Kidney/bladder problems
  - Liver disease
  - Lung problems
  - Prostate problems
  - Seizures/epilepsy
  - Skin disorder
  - Shingles
  - Stroke
  - Thyroid problems
  - Tuberculosis
  - Ulcers
  - Abdominal Pain
  - Ankle/leg swelling
  - Balance problems
  - Black/bloody stools
  - Blood in the urine
  - Bone pain
  - Change in bowel habits
  - Change in vision
  - Chest Pain
  - Cough
  - Coughing blood
  - Difficulty Swallowing
  - Dizziness
  - Easy Bruising
  - Fatigue
  - Fevers, chills, night sweats
  - Fingers turn blue in the cold
  - Frequent nausea/vomiting
  - Headaches
  - Hoarse voice
  - Involuntary weight loss
  - Nose or gum bleeding
  - Numbness – location \_\_\_\_\_
  - Palpitations
  - Problems Urinating
  - Shortness of breath
  - Substance abuse
  - Tinnitus (ringing in ears)
  - Vomiting Blood
  - Weakness
- Smoking: N/A \_\_\_\_ packs per day \_\_\_\_\_       Alcohol use: N/A \_\_\_\_ drinks per day \_\_\_\_\_

**Menstrual History**

Age of onset \_\_\_\_\_

Date of last Period \_\_\_\_\_

Post-menopausal bleeding     Yes     No

Date of last Pap test \_\_\_\_\_ Results     Pos     Neg

Have you ever taken birth control pills or estrogen replacement?     Yes     No

Pregnancies # \_\_\_\_\_ Abortions/miscarriages # \_\_\_\_\_

Children born alive # \_\_\_\_\_

Your age when last child was born \_\_\_\_\_

**Surgical History** (please include all cancer-related procedures)

<i>Type of surgery</i>	<i>Date</i>	<i>Type of Surgery</i>	<i>Date</i>



Patient Name \_\_\_\_\_

Birthdate \_\_\_\_\_

**Allergies**

Reactions

Reactions

- Penicillin \_\_\_\_\_
- Sulfa \_\_\_\_\_
- Morphine \_\_\_\_\_
- Latex \_\_\_\_\_

- CT dye \_\_\_\_\_
- Aspirin \_\_\_\_\_
- Tape \_\_\_\_\_

**Other Allergies**

<i>Allergies</i>	<i>Reactions</i>

**Family History**

Have any of your relatives had a chronic illness (for example, cancer, heart disease, diabetes)?

Relative	Specify chronic illness(es)	Living	Deceased
Biological Mother _____		<input type="checkbox"/>	<input type="checkbox"/>
Biological Father _____		<input type="checkbox"/>	<input type="checkbox"/>
Maternal Grandmother _____		<input type="checkbox"/>	<input type="checkbox"/>
Maternal Grandfather _____		<input type="checkbox"/>	<input type="checkbox"/>
Paternal Grandmother _____		<input type="checkbox"/>	<input type="checkbox"/>
Paternal Grandfather _____		<input type="checkbox"/>	<input type="checkbox"/>
Siblings _____		<input type="checkbox"/>	<input type="checkbox"/>
Aunt(s) _____		<input type="checkbox"/>	<input type="checkbox"/>
Uncle(s) _____		<input type="checkbox"/>	<input type="checkbox"/>

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### NOTICE OF PRIVACY PRACTICES

Effective as of April 14, 2003.

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

#### Understanding Your Protected Health Information (PHI)

Each time you visit Emmaus Med/Surg Clinic (EMSC) a record of your visit is made. We are legally required to protect the privacy of this record containing your PHI. **We collect or receive this information about your past, present or future health condition, to provide health care to you, to receive payment for this health care, or to operate the clinic.**

#### HOW WE MAY USE AND RELEASE YOUR PROTECTED HEALTH INFORMATION (PHI)

A. The following uses do NOT require your authorization, except where required by SC law:

1. **For treatment** - Your PHI may be discussed by caregivers to determine your plan of care. The physicians, nurses, and other health care personnel may share PHI in order to coordinate the services you may need.
2. **To obtain payment** - We may use and disclose PHI to obtain payment for our services from you, an insurance company or a third party.
3. **For health care operations** - We may use and disclose PHI for hospital and/or clinic operations. For example we may use the information to review our treatment and services and to evaluate the performance of our staff in caring for you.
4. **For public health activities** - We report to public health authorities as required by law, information regarding births, deaths, various diseases, reactions to medications and medical products.
5. **Victims of abuse, neglect, domestic violence** - Your PHI may be released as required by law, to the South Carolina Department of Social Services when cases of abuse and neglect are suspected.
6. **Health oversight activities** - We will release information for federal or state audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary actions, as required by law.
7. **Judicial and administrative proceedings** - Your PHI may be released in response to a subpoena or court order.
8. **Law enforcement or national security purposes.**
9. **Uses and disclosures about patients who have died** - We provide coroners, medical examiners and funeral directors necessary information relating to an individual's death.
10. **For purposes of organ donation** - As required by law, we will notify organ procurement organizations to assist them in organ, eye or tissue donation and transplants.
11. **Research** - We may use your PHI if the Institutional Review Board (IRB) or Privacy Board reviews for research, approves and establishes safeguards to ensure privacy.
12. **To avoid harm** - In order to avoid a serious threat to the health or safety of a person or the public, we may release limited information to law enforcement personnel or persons able to prevent or lessen such harm.
13. **For worker's compensation purposes** - We may release your PHI to comply with worker's compensation laws.
14. **Marketing** - We may send you information on the latest treatment, support groups and other resources affecting your health.
15. **Fundraising activities** - We may use your PHI to communicate with you to raise funds to support health care services and educational programs we provide to the community.
16. **Appointment reminders and health-related benefits and services** - We may contact you with a reminder that you have an appointment for check-up or treatment. *We must receive notice of all appointment cancellations 24 hours prior to your scheduled appointment or a minimum of \$50 may be charged to your account.*

#### B. You may object to the following uses of PHI:

1. **Hospital directories** - Unless you object, we may include your name, location, general condition and religious affiliation in our patient directory for use by clergy and visitors who ask for you by name.
2. **Information shared with family, friends or others** - Unless you object, we may release your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care.

#### C. Your prior written authorization is required (to release your PHI) in the following situations:

1. Any uses or disclosures beyond treatment, payment or healthcare operations and not specified in parts A & B above.
2. Psychotherapy notes.

## **WHAT RIGHTS YOU HAVE REGARDING YOUR PHI**

Although your health record is the physical property of EMSC, the information belongs to you, and you have the following rights with respect to your PHI:

### **A. The Right to Request Limits on How We Use and Release Your PHI.**

You have the right to ask that we limit how we use and release your PHI. We will consider your request but we are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. Your request must be in writing and state (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse; and (4) an expiration date.

### **B. The Right to Choose How We Communicate PHI to You.**

You have the right to request that we communicate with you about PHI in a certain way or at a certain location (for example, sending information to your work address rather than your home address). You must make your request in writing and specify how and where you wish to be contacted.

### **C. The Right to See and Get Copies of Your PHI.**

You have the right to inspect and receive a copy of your PHI, which is contained in a designated record set, that may be used to make decisions about your care. You must submit your request in writing. If you request a copy of the information, we may charge a fee for copying, mailing or other costs associated with your request. We may deny your request to inspect and receive a copy in certain very limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed.

### **D. The Right to Get a List of Instances of When and to Whom We Have Disclosed Your PHI.**

This list **may not** include uses such as those made for treatment, payment, or health care operations, directly to you, to your family, or in our facility directory as described above in this Notice of Privacy Practices. This list also **may not** include uses for which a signed authorization has been received or disclosures made before April 14, 2003.

### **E. The Right to Amend Your PHI.**

If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we amend the existing information or add the missing information. You must provide the request and your reason for the request in writing. We may deny your request in writing if the PHI is correct and complete or another facility's report.

### **F. The Right to Receive a Paper Copy of This Notice:**

You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Please contact the Privacy Officer at the address listed at the end of this statement.

### **G. The Right to Revoke an Authorization.**

If you choose to sign an authorization to release your PHI, you can later revoke that authorization in writing. This will stop any future release of your health information except as allowed or required by law.

## **HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES**

If you think your privacy rights may have been violated, or you disagree with a decision we made about access to your PHI, you may file a complaint with the office listed in the next section of this Notice. **Please be assured that you will not be penalized and there will be no retaliation for voicing a concern or filing a complaint. We are committed to the delivery of quality health care in an environment that is confidential and private.**

## **CHANGES TO THIS NOTICE**

We reserve the right to change the terms of this Notice at any time. We also reserve the right to make the revised or changed Notice effective for PHI we already have about you as well as any information we receive in the future. The Notice will always contain the effective date.

## **PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES**

If you have any questions about this Notice or any complaints about our privacy practices please call:

Virginia Shenk  
803-359-0164