SHEA

PATIENT INFORMATION

PLEASE FILL OUT THIS FORM COMPLETELY
AND SIGN WHERE INDICATED – PLEASE PRINT

Date_____

NAME OF PATIENT _____
LAST NAME FIRST INITIAL NICKNAME

ADDRESS: _____
STREET CITY ZIP CODE

DATE OF BIRTH _____ HOME PHONE _____
MONTH DAY YEAR

EMPLOYER _____ WORK PHONE _____

SS# _____ SEX (check one) MALE ___ FEMALE ___

MARRIED ___ DIVORCED ___
SINGLE ___ SEPERATED ___
WIDOWED ___

YOUR PRIMARY PHYSICIAN: _____ WHO IS RESPONSIBLE FOR PAYMENT _____

SPOUSE, PARTENT OR GUARDIAN

NAME: _____
LAST NAME FIRST INITIAL NICKNAME

ADDRESS: _____
STREET CITY ZIP CODE

OCCUPATION _____ EMPLOYER _____

WORK PHONE _____ SOCIAL SECURITY #: _____

HOME PHONE _____ CELL PHONE: _____

WHO REFERRED THE PATIENT TO US – PLEASE NAME BELOW

_____ _____
REFERRING DOCTORS NAME REFERRING PERSONS NAME / RELATIONSHIP / PHONE #

INSURANCE INFORMATION

In order to avoid error or delay in the processing of any insurance claims, it is essential that this section be **COMPLETELY FILLED OUT**.

Do you have health insurance to cover these services? YES NO (Circle One)

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Insurance Company _____	Insurance Company _____
Ins. Co. Address _____	Ins. Co. Address _____
_____	_____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Policy Holder _____ Birth Date_____	Policy Holder _____
Social Security No. _____	Social Security No. _____
Employer _____	Employer _____
Group No. _____ ID No. _____	Group No. _____ ID No. _____

Due to the large number of insurance policies that come across our desk everyday, we cannot possibly keep up with the specifics of each one. Therefore, we rely on you to know your insurance benefits. When you come in, we will take a copy of your insurance card to assure proper billing, but you should know when you need a referral and whether or not you have a co-payment.

AUTO ACCIDENT INFORMATION

Date of Injury_____

Name of Carrier _____

Address of Carrier _____
Street

_____
City State Zip

Phone Number _____ Adjuster_____

PLEASE SIGN BY BOTH X'S

I authorize payment of medical benefits to undersigned physician or supplier for these services and all future claims.	I authorize the release of any medical information necessary to process this claim and all future claims.
X_____	X_____
Signed (Insured or Authorized Person)	Signed (Insured or Authorized Person)

Notice of Privacy Practices

Brian Shea, D.O.____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept confidential. This Act gives you, the patient, the right to understand and control how your personal health information (PHI) is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill; for your visit and/or verifying coverage prior to surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may be also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.
- We may also create and distribute de-identified health information by removing all reference to individually identifiable information.
- We may contact you, by phone or by writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosure of PHI will only be made pursuant to us receiving written authorization from you:

- Most uses and disclosure of psychotherapy notes.
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations.
- Disclosures that constitute a sale of PHI under HIPAA, and other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

We may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we do not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.
We are required by law to maintain the privacy of your Protected Health Information and provide you the notice of our legal duties and our privacy practices with respect to PHI.

This notice is effective as of January 1, 2016 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the office, the Department of Health and Human Services, and the Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer (Brian Shea, D.O. 303-447-0022) for more information, in person or in writing.

Effective Date
This notice is effective on or after 1/1/2016

Acknowledgment Form

I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

_____
Name of Patient or Personal Representative

_____
Signature of Patient or Personal Representative

Date:_____

Brian Shea, D.O.
Sussex One Building
1790 30th Street, Suite 120
Boulder, CO 80301

Dear Patient:

Physicians have always protected the confidentiality of health information by sealing medical records away in file cabinets and refusing to reveal your information. Today, state and federal laws also attempt to ensure the confidentiality of this sensitive information.

The federal government recently published regulations designed to protect the privacy of your health information. This "privacy rule" protects health information that is maintained by physicians, hospitals, other health care providers and health plans.

This new regulation protects virtually all patients regardless of where they live or where they receive their health care. Every time you see a physician, are admitted to the hospital, fill a prescription, or send a claim to a health plan, your physician, the hospital or other health care provider will need to consider the privacy rule. All health information including paper records, oral communications, and electronic formats (such as e-mail) are protected by the privacy rule.

The Notice of Privacy Practices attached to this letter explains my privacy practices. It contains very important information about how your confidential health information is handled by this office. It also describes how you can exercise your rights with regard to your protected health information.

Please let me know if you have any questions about my Notice of Privacy Practices. You may contact my Privacy Officer at 303-447-0022 or discuss any questions you have with me.

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my protected health information by Dr. Shea for the purpose of diagnosing or providing treatment to me, obtaining payment for my Health care and to conduct health care operations of Dr. Shea. I understand that diagnosis and treatment of me by Dr. Shea may be conditioned upon my consent as evidenced by my signature of this document.

I understand I have the right to request a restriction as to how my protected health information is disclosed to carry out treatment, payment or health care operations of the practice. Dr. Shea is not required to agree to the restrictions that I may request. However, if Dr. Shea agrees to a restriction that I request, the restriction is binding on Dr. Shea.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Shea has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information collected from me and created to received by my physician, another heath care provider, from my employer or a health care clearinghouse. This protected health information relates to my current or future physical or mental health or condition and identifies me, or there is a reasonable way the information may identify me.

I understand I have a right to review Dr. Shea's Notice of Privacy Procedures by signing this document. The notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of protected health information that will occur in my treatment, payment of my bills or in the practice of health care operations of Dr. Shea.

Dr. Shea reserves the right to change the privacy practices as allowed by law. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent to me or by asking for one at the time of my next appointment.

_____

Signature of Patient of Person Representative

_____

Name of Patient or Personal Representative

_____

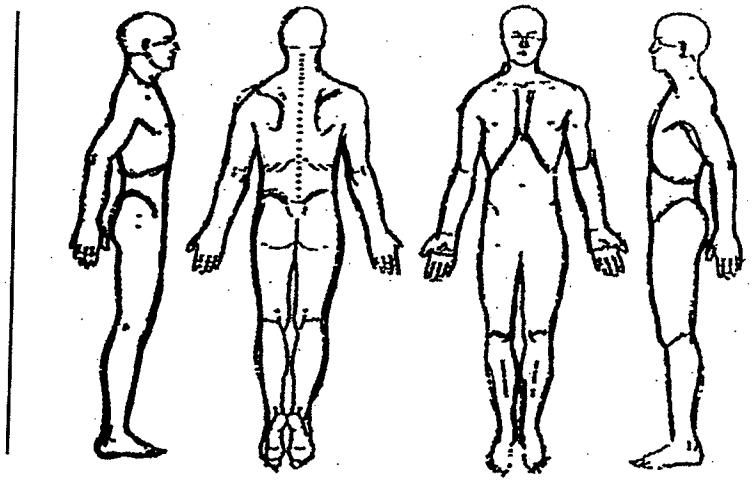
Date

NAME:_____ DATE:_____

PHYSICAL EXAM INTAKE FORM

Reason For Visit:

Mark Where It Hurts:



Allergies:

Medications:

Past Medical History: ***Please mark next to any item you have experienced problems with***

☐ Breathing	☐ Sinuses	☐ Genital	☐ Joints	☐ Diabetes	☐ Caffeine
☐ Urinary - Prostate	☐ Throat	☐ Menses	☐ Lymph	☐ Blood Pressure	☐ Smoking
☐ Headaches	☐ Neck	☐ Stomach	☐ Fatigue	☐ Sleep	☐ Alcohol
☐ Sweating	☐ Lungs	☐ Muscles	☐ Weight	☐ Cholesterol	☐ Pregnancy
☐ Eyes	☐ Heart	☐ Skin	☐ Immunity	☐ Cancer	☐ Hospitalized
☐ Ears	☐ Bleeding	☐ Nerves	☐ Thyroid	☐ Fractures	☐ Surgeries
☐ Nose	☐ Abdomen	☐ Mental	☐ Hepatitis	☐ Trauma	☐ Other
☐ Mouth	☐ Intestines	☐ Skeletal	☐ Rheumatic Fever	☐ Accidents	

Family History: ***Please mark next to any item a blood relative has experienced problems with***

☐ Epilepsy	☐ Diabetes	☐ Anemia	☐ Heart Disease	☐ Alcoholism
☐ Migraine	☐ Thyroid Disease	☐ Bleeds Easily	☐ Stroke	☐ Hepatitis
☐ Mental Illness	☐ Hayfever	☐ Osteoporosis	☐ Hypertension	☐ Cancer
☐ Glaucoma	☐ Asthma	☐ Arthritis	☐ Lipid Disorder	☐ Other

Other Medical Treatment: ***Please list all other Health Care Providers whom you are currently receiving treatment from and list the condition you are being treated for.***

Health Care Provider Name(s)	**Condition**

Food For Thought: ***A written answer is not necessary***

1) If this treatment was like a magic wand, and we could do anything for you, not just the main symptom, but anything at all, what would it be?
2) Do you see yourself as healthy? When was the last time you felt healthy?
3) What is your sense of where you are now, or where you are heading, in your overall picture of life?
4) What are you thankful for?