

## Patient Questionnaire

Patient's Name (First, Middle, Last)			Patient's Date of Birth		Patient's Age
Patient's Street Address		City	State	Zip	Patient's Sex
Patient's Home Phone Number		Allergies to Medications			
Who Can We Thank for This Referral?		Patient's Pediatrician/or Family Doctor, Phone Number and Address			
Dentist Name, Phone Number and Address			Orthodontist Name, Phone Number and Address		
Reason For Exam:	Extraction	Pediatric Craniofacial	Orthognathic Surgery (Corrective Jaw Surgery)		
Other: _____				Patient's Social Security Number	
Name and Relationship of Family Members Seen Here					
Patient's Employer		Spouse's Name		Spouse's Date of Birth	
Patient's Work Phone (Area Code and Extension)		Spouse's Social Security Number		Spouse's Employer	
Emergency Contact (Name, Phone Number, Relationship to Patient)			Spouse's Work Number		Fax Number
Primary Insurance/Policy Holder Name/Employer		Insurance Company Address		ID #	Group#
Secondary Insurance/Policy Holder /Employer		Insurance Company Address		ID#	Group#
<b>FOR MINORS:</b>					
Mother's Name (or Legal Guardian)			Father's Name		
Mother's Employer			Father's Employer		
Work Phone (Area Code and Extension)			Work Phone (Area Code and Extension)		
Mother's Social Security Number		Mother's Date of Birth	Father's Social Security Number		Father's Date of Birth
Name(s) and Ages of Patient's Siblings (Children Only)					

### Medical Records Release of Payment Authorization

I understand that payment of all medical care is due and payable at the time of service, and that it is my responsibility to pay any deductible, coinsurance or any other balance not paid by my insurance company. I understand that I am responsible for any cost incurred in the collection of patients' accounts in case of default, including reasonable attorney fees, court cost, and hereby waive presentment for payment, protection and notice of protection, and non-payment of outstanding account.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient and/or Legal Guardian

# HEALTH HISTORY

Patient's Name: \_\_\_\_\_ Current Height: \_\_\_\_\_ Weight (For Peds) Birth Weight: \_\_\_\_\_

Have you had or do you currently have ...	YES	NO	Notes	Have you had or do you currently have ...	YES	NO	Notes
Cancer?				Swollen ankles, arthritis or joint disease?			
Radiation therapy/chemotherapy?				Stomach ulcers?			
Rheumatic fever?				Contagious diseases?			
Heart murmur/Heart disease?				HIV, AIDS?			
High blood pressure?				Problems of the immune system?			
Chest pain, angina?				Mental health problems/psychiatric treatment?			
Heart attack(s)?				Drugs (marijuana, cocaine)?			
Bronchitis, chronic cough, pneumonia?				Alcoholic beverages?			
Asthma, hay fever, or sinus problems?				Eye disease/glaucoma?			
Tuberculosis?				Are you pregnant?			
Difficulty breathing, emphysema?				Pain or clicking of jaws when eating?			
Do you smoke?				TMJ problems?			
Bleeding tendency (abnormal bleed)?				Snoring or sleep disturbance?			
Jaundice, hepatitis or liver disease?				Hearing loss?			
Frequent headaches?				Anemia/sickle cell?			
Convulsions, epilepsy, seizures?				Problems with anesthesia?			
Stroke?				Malignant hyperthermia?			
Thyroid trouble?				Cerebral palsy?			
Diabetes?				Delayed development?			
Are you on dialysis?				Osteoporosis/Osteopenia?			
Kidney trouble?				Other problems not listed?			
Allergies (food/medicine)?				Surgery?			
Please List				Please List			

Medications? Please List: \_\_\_\_\_

**Birth History:**

1. Did the child's mother have any problems during pregnancy? \_\_\_\_\_
2. Was the baby delivered via cesarean section? If so, why? \_\_\_\_\_
3. Was your child premature? How many weeks? \_\_\_\_\_
4. Did your child have to stay in ICU? How long? \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

# FLORIDA CRANIOFACIAL INSTITUTE

## Patient Disclosure Instructions

In general, The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home.

Please list below how you would like to receive information from our office:

Cell Phone \_\_\_\_\_

House phone \_\_\_\_\_

Email \_\_\_\_\_

List any person (E.G. Mom, Dad, Grandmother, Grandfather) whom you would want to give access to records.

\_\_\_\_\_  
\_\_\_\_\_

### Special instructions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Print Name

## **Notice of Privacy Practices for Protected Health Information**

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!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information (PHI) is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

### **Example of uses of your health information for treatment purposes:**

A nurse obtains treatment information about you and records it in a health record. During the course of your treatment the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

### **Example of use of your health information for payment purposes:**

We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

### **Example of Use of Your Information for Health Care Operations:**

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

### **Your Health Information Rights**

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full—we must comply with this request;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office; appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office
- Elect to opt out of receiving further fundraising communications from the office/hospital
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.
- If you want to exercise any of the above rights, please contact **Peter Kemp**, in person or in writing, during normal hours. We will provide you with assistance on the steps to take to exercise your rights.

### **Our Responsibilities**

The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you abided by the terms of this Notice
- Notify you if we cannot accommodate a requested restriction or request;
- Accommodate your reasonable requests regarding methods to communicate health information with you, and
- Notify you if you are affected by a breach of unsecured PHI

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

### **To Request Information or File a Complaint**

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact [insert name, title, and telephone number of internal contact person].

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Peter Kemp. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address and e-mail address is

850-245-4444 [health@flhealth.gov](mailto:health@flhealth.gov)

#### **Mailing Address**

Florida Health  
4052 Bald Cypress Way  
Tallahassee, FL 32399

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

### **Other Disclosures and Uses**

#### **Notification**

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death

#### **Communication with Family**

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

## **Food and Drug Administration (FDA)**

We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

## **Workers Compensation**

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

## **Public Health**

As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

## **Abuse & Neglect**

We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

## **Correctional Institutions**

If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

## **Law Enforcement**

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

## **Health Oversight**

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

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Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

## **Judicial/Administrative Proceedings**

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

## **Other Uses**

Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

## **Website**

If we maintain a website that provides information about our entity, this Notice will be on the website.

I \_\_\_\_\_, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

## **OPTIONAL/ADDITIONAL Uses and Disclosures**

The following are segments of the Notice of Privacy Practices that may not be used by the general OMS practice. If your Notice of Privacy would need to incorporate any of these items, we have provided model language. An example would be: If your practice participates with drug research, then you would need to include the first item listed below in your Notice of Privacy Practices.

### **Research**

- We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

### **Disaster Relief**

- We may use and disclose your protected health information to assist in disaster relief efforts

### **Funeral Directors/Coroners**

- We may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.

### **Organ Procurement Organizations**

- Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

### **Marketing**

- We may contact you to provide you with information about treatment alternatives, or with information about other health-related benefits and service? that may be of interest to you.

### **For Specialized Governmental Functions**

- We may disclose your protected health information for specialized government functions as authorized by law, such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

**FLORIDA CRANIOFACIAL INSTITUTE - PHOTO RELEASE FORM**

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

\_\_\_\_\_  
Date of Birth

Parent/Legal Guardian (if Patient is a Minor): \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**SECTION A: AUTHORIZATION**

By signing this Photo Release Form ("Authorization"), I hereby grant to the Florida Craniofacial Institute ("FCI") permission and limited license to use my pre-op and post-op photographs ("Photos) and any comments I voluntarily include in the Testimonial section below ("Testimonial") for marketing purposes in connection with (1) the website currently hosted at <http://www.flcranio.com> (the "Website"); and (2) other advertising, marketing, informational and educational publications for FCI, or any other publication FCI may deem useful and appropriate, including electronic and print media (i.e. CD-ROM, video, pamphlets, mailings, etc.) and I expressly authorize the FCI to disclose my Photos and Testimonial (together, my "Materials") in the foregoing materials. I understand that this means that my Materials may be disclosed to any person viewing the Website or advertising, marketing, informational, educational or other publications.

I agree and confirm that I am providing this Authorization and any Materials to FCI voluntarily and without any expectation of receiving compensation of any kind in exchange. I hereby confirm that no one has made any offer, promise or representation of compensation of any kind to me in exchange for my Authorization and my Materials.

I represent that I am of legal age, or if the patient is a minor, that I am the parent or legal guardian of the patient. I further represent that my Testimonial (if any) is truthful and accurate.

I understand that information disclosed by reason of this Authorization may be subject to re-disclosure by the recipient and therefore may no longer be protected under state or federal law.

I agree and grant permission to FCI to edit or summarize my Materials for display, or otherwise create derivative works from my Materials for display. I waive the right of prior approval. I agree to be contacted by FCI in the event of any questions regarding my Materials and/or this Authorization, including for verification and authentication purposes.

I understand and acknowledge that FCI is not required to use my Materials, in whole in in part. I further understand and agree that FCI may elect not to use my Materials at this time, but may do so at its own discretion at a later date,

I understand and acknowledge that FCI may remove any or all of my Materials from the Website or other publications at any time without notice and for any reason at FCI's sole discretion.

I understand and acknowledge that signing this Authorization is not a condition for continued treatment, payment, enrollment, or eligibility for health plan benefits.

By signing below in Section C, and to the fullest extent permitted by law, I hereby release FCI from any and all claims or damages of any kind based on the use of any of my Materials as specified herein.



**SECTION B. REVOCATION/EXPERATION/SIGNATURE**

I understand that, without exception, I may revoke this Authorization at any time by notifying FCI in writing at the address below. I understand that such revocation by me will not affect any action that FCI took in reliance upon this Authorization before receiving my revocation.

Florida Craniofacial Institute

4200 N Armenia Ave., Suite 3

Tampa, FL 33607

I understand that this Authorization, if unrevoked by me, will remain effective until ten (10) years after the date of execution, unless I specify a different Expiration Date below.

**Expiration Date:** \_\_\_\_\_

I understand that I can request to receive a copy of this Authorization for my personal records at no cost.

I HAVE READ AND UNDERSTOOD THE AUTHORIZATION AND I AGREE TO ALL OF ITS TERMS.

\_\_\_\_\_  
Patent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name