www.reddingendocrinology.com
www.akmanmd.com

MITCHELL S. AKMAN, MD, F.A.C.E.
CERTIFIED IN ENDOCRINOLOGY AND METABOLISM
FELLOW AMERICAN COLLEGE OF ENDOCRINOLOGY
CERTIFIED IN INTERNAL MEDICINE

Explanation of Forms

1) *Insurance Company Information*-explains how insurance companies behave.

2) *Patient Demographics*-your personal, non-medical information.

3) *Notice of Privacy Practices*-an explanation of how this office treats your personal information.

4) *Patient Partnership Plan*-an explanation of how both the physician and the patient need to work together to achieve your best healthcare.

5) *Medical Questionnaire*-describes your medical and family history.

6) *Acknowledgement of Receipt of Notice of Privacy Practices*-confirms that you received the Notice of Privacy Practices.

7) *Authorization for Use or Disclosure of Protected Health Information*-this form grants this office permission to release the information you specify to the people you specify (i.e. spouse/parent/child/friend/etc.). If nobody is listed we cannot release any information (not even something as simple as your next appointment time) about you to <u>anyone</u>.

8) *Credit Card Authorization Form*-only fill this out if you think you may wish to make credit card payments at some time. We still need your express permission every time you want to use a credit card. This form simply authorizes us to tell the credit card company your billing information without violating HIPAA (Federal privacy rules).

1555 East Street, Suite 300, Redding, California, 96001
Telephone: **Reception**: (530) 229-1844 **Medical Assistant**: (530) 242-4688 **Billing:** (530) 244-6715 **Fax:** (530) 243-6397

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INSURANCE COMPANY INFORMATION
PLEASE NOTE

My objective when seeing you as a patient is to provide you with the highest quality care possible. The doctor-patient relationship is a sacred one and it is unfortunate that many insurance companies try to disrupt this special relationship.

I am a participating provider with several different insurance plans. As a participating provider I have agreed to accept a specific contracted rate for various services that I provide. With these plans, patients are typically only responsible for co-payments and deductibles as well as non-covered services.

Many insurance companies do not have contracted rates. They simply agree to pay a percentage of charges. However, you may note on your explanation of benefits, the terms "reasonable and customary" or "usual and customary" or something similar. You should know that this is a term that insurance companies have made up. There is no such thing as usual, reasonable, or customary charges. This is simply a way for insurance companies to pay less. If your insurance company excludes a portion of the billed charge for these reasons, it is up to you to inform them that this is unacceptable and that they should be responsible for their percentage of the **full** amount. You would not accept it from your automobile or home insurance company. You have a contract with your health insurance company and they have agreed to accept your money every month in exchange for paying your medical bills. Make them stick to their part of the bargain.

If I am not a participating provider with your insurance company, then you will be responsible for anything that your insurance company has not paid for.

If you have any questions about your bill, please direct them towards my billing staff.

Thank You,

Mitchell S. Akman, MD, FRCPC, F.A.C.E.

I have read the above. Please initial _____

Mitchell S. Akman, MD, Inc
1555 East Street, Redding CA 96001

Thank you for choosing our office. In order to serve you properly, we will need the following information. All information will be strictly confidential. (PLEASE PRINT)

Patient's Last name_____ First Name_____ MI____

Birth date_____ Age _____ M / F Social Security #_____

Mailing Address_____ City_____

State_____ Zip Code _____Home #_____ Cell #_____ Marital status: S M O

Occupation _____ Business Phone # _____

Email _____

Employer _____ Address _____

Do you have private medical insurance? Yes No

Primary Insurance Company Name_____

Address_____

City_____ State_____ Zip_____ Group #_____ Policy #_____

Subscriber Name_____ Birthdate _____ Social Security #_____

Employer _____ Address _____

Secondary Insurance Company Name_____

Address_____

City_____ State_____ Zip_____ Group #_____ Policy #_____

Subscriber Name_____ Birthdate _____ Social Security #_____

Employer _____ Address _____

Person financially responsible for this account: Self Other

If other, Name _____

Address_____

City_____ State_____ Zip_____

Nearest friend or relative not residing with you?_____ Relationship to Patient?_____

Preferred Language _____

Race (Circle one): Caucasian, African American, Asian American, Native American, Native Alaskan, Native Hawaiian, other

I authorize this office to receive and to release any information necessary to the named insurance company (or companies) to expedite insurance payment, and to keep my signature on file for billing purposes. I understand that I am responsible for all charges (including handling fees for late payments), regardless of insurance coverage (unless the physician is contracted with your insurance company (including Medicare) for a covered service while your policy is in force). I agree to be responsible for payment when any necessary insurance authorization has not been obtained. I agree to pay for services or supplies that Medicare or any other insurance carrier may deem to be "medically unnecessary" or are otherwise not covered services by my insurance carrier(s).*

***The current handling fee for late payments is 1.5%/month, minimum charge $2.00. This will apply 30 days after the statement which shows what your insurance company paid, and shows <u>your</u> outstanding balance.*

Signature _____ Today's Date _____

MITCHELL S. AKMAN, MD, F.A.C.E.

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FELLOW AMERICAN COLLEGE OF ENDOCRINOLOGY

Privacy Officer

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Effective Date: September 19, 2013

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **Treatment.** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. **Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. **Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population- based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts
4. **Optional: Appointment Reminders**. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. **Sign In Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. **Notification and Communication with Family**. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that

they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. **Marketing**. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in,
   We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.
8. **Sale of Health Information**. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. **Required by Law**. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. **Public Health.** We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult 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. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. **Health Oversight Activities**. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
12. **Judicial and Administrative Proceedings**. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. **Law Enforcement**. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. **Coroners**. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. **Organ or Tissue Donation**. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. **Public Safety**. We may, and are sometimes required by law, 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 the general public.
17. **Proof of Immunization**. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agree to the disclosure on behalf of yourself or your dependent.
18. **Specialized Government Functions**. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
19. **Worker's Compensation**. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. **Change of Ownership**. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
21. **Breach Notification**. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to another person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice.

After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

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

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

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Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and illness. I understand I will need to complete these recommended health screenings. **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

_____ _____
Patient Signature Date

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Please answer the following questions. All information provided is strictly confidential. ***Use the space at the end or this form to write more details as needed.*** **THERE ARE 3 PAGES.**

Name:

Date:_____ Date of birth: _____ Age:_____

What is the purpose of your visit today?_____

Who referred you? _____

Personal and Family Medical History: *Check problems that have been diagnosed by a physician or other health professional in* ***you or your parents, grandparents, brothers, sisters or children only.*** *(If family, list who).*

High blood cholesterol	□Self	□Family_____
Diabetes	□Self	□Family_____
Heart attack or angina	□Self	□Family_____
Heart surgery or catheterization	□Self	□Family_____
Obesity	□Self	□Family_____
Other blood vessel disease/surgery	□Self	□Family_____
High blood pressure	□Self	□Family_____
Stroke or TIAs	□Self	□Family_____
Thyroid disease	□Self	□Family_____
Other Illnesses (list)	□Self	□Family_____

_____
_____
_____
_____
_____

Operations: *Including inpatient and outpatient procedures, and age or year performed (****Self only****).*

_____
_____
_____
_____
_____
_____
_____

Medications: *Include prescription and nonprescription drugs, including aspirin, Tylenol, vitamin supplements, herbs, antacids, laxatives, etc.* ***Explain dose, how taken and how often****.*

_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: *To drugs, or other substances. List reaction to each.*

_____	_____	_____
_____	_____	_____

Family history:

Father living? □ Yes □ No Age at time of death:_____ Cause of death: _____

Mother living? □ Yes □ No Age at time of death:_____ Cause of death: _____

Total number of brothers_____ Are any deceased? □Yes □No. Ages(s) at time of death: _____
Cause(s) of death: _____

Total number of sisters _____ Are any deceased? □Yes □No. Ages(s) at time of death: _____
Cause(s) of death: _____

Social History:

Marital status: □Married □Single □Widowed □Divorced or separated

Your Living arrangement: □With family □With friends □Alone □Other:_____

Number of children: _____ Ages_____

Number of persons in household (total): _____

Education: □Less than H.S. □High school □College □Graduate or professional school

Present or former
Occupation(s):_____

Do you currently use: □Tobacco □Alcohol □Caffeine?

If so, please give details:

_____

If no to the above, have you ever used: □Tobacco □Alcohol □Caffeine?

If so, please give details:

_____

Do you eat a special or restricted diet? □ Yes □ No. If so, what kind? _____

Do you exercise? □ Yes □ No.

If so, what kind of exercise and how much, and how often? _____

Do you have now or have you ever had any of the following? *Please check "No", "Current", Or "Past" for each item. If in the past, please list when.*

Unexplained weight gain?	□NO	□Current	□Past(when?)_____
Unexplained weight loss?	□NO	□Current	□Past(when?)_____
Fatigue?	□NO	□Current	□Past(when?)_____
Sleep disturbance?	□NO	□Current	□Past(when?)_____
Cancer (Including skin cancer)?	□NO	□Current	□Past(when?)_____
Rash or other skin condition?	□NO	□Current	□Past(when?)_____
Sinus problems?	□NO	□Current	□Past(when?)_____
Eye problems?	□NO	□Current	□Past(when?)_____
Loss of vision?	□NO	□Current	□Past(when?)_____
Chest pain?	□NO	□Current	□Past(when?)_____
Shortness of breath?	□NO	□Current	□Past(when?)_____
Leg discomfort when walking?	□NO	□Current	□Past(when?)_____

Leg Swelling?	□NO	□Current	□Past(when?)_____
Heart palpitations or irregular heart beat?	□NO	□Current	□Past(when?)_____
Dizziness or Lightheadedness?	□NO	□Current	□Past(when?)_____
Fainting/passing out?	□NO	□Current	□Past(when?)_____
Cough?	□NO	□Current	□Past(when?)_____
Heart murmur?	□NO	□Current	□Past(when?)_____
Other heart condition?	□NO	□Current	□Past(when?)_____
Abdominal pain?	□NO	□Current	□Past(when?)_____
Stomach ulcers?	□NO	□Current	□Past(when?)_____
Heartburn?	□NO	□Current	□Past(when?)_____
Hiatal hernia?	□NO	□Current	□Past(when?)_____
Trouble swallowing?	□NO	□Current	□Past(when?)_____
Chronic or recurrent nausea and/or vomiting?	□NO	□Current	□Past(when?)_____
Diarrhea?	□NO	□Current	□Past(when?)_____
Constipation?	□NO	□Current	□Past(when?)_____
Rectal or other gastrointestinal bleeding?	□NO	□Current	□Past(when?)_____
Jaundice?	□NO	□Current	□Past(when?)_____
Liver disease?	□NO	□Current	□Past(when?)_____
Problems with urination?	□NO	□Current	□Past(when?)_____
Blood in urine?	□NO	□Current	□Past(when?)_____
Kidney disease/failure?	□NO	□Current	□Past(when?)_____
Kidney stones?	□NO	□Current	□Past(when?)_____
Arthritis?	□NO	□Current	□Past(when?)_____
Joint pains?	□NO	□Current	□Past(when?)_____
Muscle pains?	□NO	□Current	□Past(when?)_____
Gout?	□NO	□Current	□Past(when?)_____
Diabetes?	□NO	□Current	□Past(when?)_____
Thyroid disease?	□NO	□Current	□Past(when?)_____
Other hormone disease?	□NO	□Current	□Past(when?)_____
Anemia?	□NO	□Current	□Past(when?)_____
History of blood transfusion?	□NO	□Current	□Past(when?)_____
Other blood problem?	□NO	□Current	□Past(when?)_____
Seizures?	□NO	□Current	□Past(when?)_____
Serious brain injury?	□NO	□Current	□Past(when?)_____
Stroke?	□NO	□Current	□Past(when?)_____
Numbness/tingling/weakness in extremities?	□NO	□Current	□Past(when?)_____
Depression?	□NO	□Current	□Past(when?)_____
Anxiety and/or panic attacks?	□NO	□Current	□Past(when?)_____
Psychiatrist or psychologist care (ever)?	□NO	□Current	□Past(when?)_____

_____ _____

PATIENT SIGNATURE DATE

_____ _____

PHYSICIAN REVIEW DATE

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MITCHELL S. AKMAN, MD, F.A.C.E.

CERTIFIED IN ENDOCRINOLOGY AND METABOLISM
FELLOW AMERICAN COLLEGE OF ENDOCRINOLOGY
CERTIFIED IN INTERNAL MEDICINE

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorize this medical practice to use and disclose health information concerning (*insert patient name and address*)

_____
_____ as follows:

Health information to be used or disclosed (check *only one box*): *

☐ Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below:

_____

_____

_____

☐ All psychotherapy notes may be released, except as specifically provided below:

_____

_____

_____

This health information may be disclosed to:

_____
(*Name and address of person(s) to use or receive the health information*)

The information may be used only for the following purposes (if you do not want to explain the purpose, write "At the request of the individual":

_____

_____

I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (CONTINUED)

I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

Effect of Refusal to Sign Authorization

I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.

This authorization is effective now and will remain in effect until _____ (*Expiration event or date*).

I understand that I have the right to receive a copy of this authorization.

Signed: _____ Dated: _____

Print Name: _____

If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of minor patient (to the extent minor could not have consented to the care)
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient ******
- ☐ spouse or person financially responsible (where information solely for purpose of processing application for dependant health care coverage)

*****Signed: _____ Dated: _____
Treating Physician

****** *For the release of records (1) protected by the Lanterman-Petris-Short Act (LPS) or (2) containing HIV test results, a separate authorization is required for each separate disclosure. Further, the LPS Act often requires that both the patient's treating physician and the patient sign the authorization form before information may be released. Under HIPAA, an authorization for release of psychotherapy notes may not be combined with an authorization involving any other type of health information (except other psychotherapy notes).*
******* *It is unclear whether the beneficiary or personal representative of a deceased patient can obtain and disclose certain records containing HIV test results.*

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IMPORTANT: SHOULD YOU EVER WISH TO PAY USING A CREDIT CARD, YOUR PAYMENT CANNOT BE PROCESSED WITHOUT THIS FORM.

AUTHORIZATION TO DISCLOSE BILIING INFORMATION UNDER PHI PROTECTION

Section A: To the individual: Please read the following carefully

- Purpose of this Authorization:

By signing form, you will authorize the disclosure and use of your billing information as it pertains to your credit card transaction.

- Effect of Declining this Authorization:

This authorization is a condition of your ability to pay your bill or copayment via credit or check card transactions. If you decide not to sign this authorization, we may decline your ability to use credit cards as a form of payment.

- Effect of Granting this Authorization:

The billing information as it relates to the protected health information (PHI) below may be disclosed to and/or received by persons or organizations that are not subject to federal health information privacy laws. These persons will use this information for identity verification only.

Section B: The use and/or disclosure being authorized:

- The credit card or check card being presented for payment.
- The expiration date imprinted on your card.
- The name on the card.
- Your billing address (To be used when verifying your identity only).

Section C: Expiration and revocation

- Expiration:

This authorization will expire upon written authorization by the patient.

- Right to Revoke:

You may revoke this authorization at any time by giving written notice of revocation to this office. Revocation of this authorization will not affect any action we took in reliance on this authorization before we received your written notice of revocation or if you are currently in a credit card dispute with this office. Revocation of this authorization may also mean that we may disallow this payment option.

Section D: Individual authorizing use and/or disclosure: (Applicant if age 18 or over, Parent or Guardian if applicant less than 18)

NAME	BILLING ADDRESS	PHONE	DATE OF BIRTH

I have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and you disclosure of my billing information as described in this form.

Applicant/Parent/Guardian signature

SIGNATURE	DATE

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