DR. MARYANNE FREEMAN BRNDJAR, D.O., P.C.
4 WEST MAIN STREET • MACUNGIE, PA 18062 • 610-820-0575 • Fax 610-965-6211

PATIENT INFORMATION:

Patient's Full Name:_____

Date of Birth:_____ Age:_____ Social Security Number:_____

Address:_____ City:_____ State:_____ Zip:_____

□Home Phone:_____ □Cell Phone:_____ □Work Phone:_____
(please enter number and check preferred method of communication) Place of Employment_____

Marital Status: (circle one) Single Married Divorced Widowed Separated Other

Emergency Contact Name:_____ Relationship to you:_____
Phone:_____

Name of Primary Care Physician:_____ Address:_____
Phone:_____

Please Identify Your Race: African American/Black Asian Caucasian Hispanic Indian Other_____
(circle all that apply)
Please Identify Your Ethnicity: Not Hispanic or Latino Hispanic or Latino

INSURANCE INFORMATION

Name of Medical Insurance:_____ Address:_____

If you are not the primary policy holder (i.e. you are covered under your husband, fiancé, or parent's plan) we will need the following information to process the claim with the insurance company; otherwise you will have to pay for the visit on the day of service.

Name of Policy Holder:_____ Date of Birth:_____ Social Security #:_____

MEDICAL INFORMATION

Number of Pregnancies:_____ Miscarriages:_____ Terminations:_____ Living Children:_____
First Day of Last Menses:_____ Are you a smoker? _____yes _____no

Current Problems or Concerns:

_____

_____

Past Surgical and Chronic Illness History: (please list all and the dates)

_____

_____

_____

Allergies: (please list type and reaction)

_____

_____

_____

_____

Medications: (please list OTC as well as all prescriptions)

_____

_____

_____

_____

_____

Signature Date

COMMUNICATION CONSENT

DR. MARYANNE FREEMAN BRNDJAR, D.O., P.C.
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It is the office policy of Dr. Maryanne Freeman Brndjar, D.O., P.C. and staff not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence, with the exception of appointment confirmation calls. Also, information will not be left with an unauthorized person who may answer the telephone.

I authorize Dr. Maryanne Freeman Brndjar, D.O., P.C. and/or her staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

A. Home Telephone_____ _____yes _____no
B. Answering Machine_____ _____yes _____no
C. Work Telephone_____ _____yes _____no
D. Voice Mail_____ _____yes _____no
E. Cell Phone_____ _____yes _____no
F. Mail_____ _____yes _____no
G. Fax medical records_____ _____yes _____no
to another entity

If you would like to have information released to someone other than yourself please complete the following:

Please list names of authorized people:

Spouse: _____ _____yes _____no
Parent: _____ _____yes _____no

Other names of authorized people:
(please list relationship such as boyfriend, fiancé, friend, sibling, etc.) _____yes _____no

_____ _____
_____ _____
_____ _____
_____ _____

PRINTED NAME_____
Date of Birth_____

Patient/Guardian Signature_____
Date:_____

AUTHORIZATION TO RELEASE INFORMATION

RESPONSIBILITY OF INSURANCE BALANCES

DELIQUENT ACCOUNTS

1. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIMS.

2. I AUTHORIZE THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO DR. MARYANNE FREEMAN BRNDJAR, D.O., P.C.

3. I UNDERSTAND THAT DR. MARYANNE FREEMAN BRNDJAR, D.O., P.C. DOES NOT PARTICIPATE WITH ALL INSURANCE COMPANIES AND THAT I AM RESPONSIBLE FOR THE CHARGES NOT COVERED BY MY PARTICULAR COVERAGE.

4. IF MY ACCOUNT BECOMES DELIQUENT, I AM AWARE THAT I AM RESPONSIBLE FOR ANY COLLECTION FEES AND INTEREST ACCRUED ON THAT ACCOUNT.

5. IF I GIVE A PICTURE OF A NEWBORN, CHILD, OR OTHER, I ALLOW IT TO BE DISPLAYED ON THE BABY BOARD IN THE OFFICE. I AM AWARE OTHER PATIENTS WILL BE ABLE TO VIEW THIS IN THE WAITING ROOM AREA.

SIGNATURE:_____

DATE:_____

NOTICE OF PRIVACY

This notice describes how medical information about you may be used and disclosed (shared) and how you get access to this information.
PLEASE REVIEW IT CAREFULLY.

Dr. Maryanne Freeman Brndjar, D.O. and all employees, staff, and other personnel are legally required to follow these policies in this notice. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI.) PHI includes information that can be used to identify you. We collect or receive this information about your past, present, or future health condition, to provide health care to you, or to receive payment for this health care. We must provide you with this notice that explains how, when, and why we use and share your PHI.

WE MAY USE AND SHARE YOUR PROTECTED HEALTH INFORMATION for many different reasons. Below, we describe the different categories of when we use and share your PHI. All of the ways we are permitted to use and share information will fall within one of the categories.

- **For treatment.** We may share your PHI with physicians, nurses, medical students, and other health care personnel and agencies that provide or are involved in your healthcare.
- **To obtain payment for treatment.** We may share your PHI in order to bill and collect payment for the services provided to you. It is important that you provide us with up-to-date and correct PHI. We may share your PHI with our billing service and your health insurance to get paid for the health care services we provided to you.
- **To run our health care business.** There are some services that we contract with as business associates. We may share your information with them. However, we require our business associates to protect your PHI through contracted agreements.
- **When government or law enforcement agencies request your PHI.** We share your PHI when a law or law enforcement agency requires that we report information about victims of abuse, neglect, domestic violence or in response to a court order, subpoena, warrant, summons, or similar request.
- **For public health activities.** We report information about births, deaths, and various diseases to government officials and agencies such as the CDC and FDA.
- **For Health Oversight Activities.** We share your PHI with health oversight agencies as authorized by the law.
- **For Military and veterans, National and Intelligence Activities, Protective Services for the President and others.** We may share your information as required by military command authorities, authorized federal officials for lawful intelligence, counterintelligence, and national security activities, or other authorized persons as required by law.
- **For research.** We may share your PHI with researchers only when an Institutional Review Board (IRB) has approved the research. We will ask for specific permission to be included in any such research.
- **For Worker's Compensation purposes.** We are required to share your PHI to comply with worker's compensation laws.
- **For appointment reminders and health-related benefits and services.** We may use your name, address, and phone number to contact you as a reminder that you have an appointment.

Your prior written consent is required in other situations. In situations not described above, we will ask for your specific consent before using or sharing any of your PHI. If you choose to sign a specific consent to share your PHI, you can cancel that consent later in writing.

YOUR RIGHTS REGARDING YOUR PHI

A. **You have the right to require limits on how we use and share your PHI.** If we accept your request, we will put your limits in writing and follow them except in an emergency situation. You may not limit PHI that we are legally required or allowed to share.
B. **You have the right to choose how we communicate PHI to you.** All of our communications to you are considered confidential. You have the right to ask and we will send information to you at another address (for example, work instead of home) or by other means such as email instead of regular mail. You will be billed for any additional cost.
C. **You have the right to see and get copies of your PHI.** You must request to see your PHI in writing. We will respond to you within 30 days after receiving your written request. If you request copies of your PHI, we will quote and charge you the current rate for each page.
D. **You have the right to get a list of when and to whom we have shared your PHI.** This list will not include uses to which you have already consented. We will respond within 60 days of receiving your request.
E. **Please forward all request for information in writing to:**

Privacy Officer
Maryanne Freeman Brndjar, D.O.
4 West Main Street
Macungie, PA 18062

CHANGES TO THIS NOTICE

We may change the terms of this notice and our privacy policies at any time. Any changes to this notice will apply to the PHI that we already have. Before we make any change to our policies, we will promptly change this notice and post a new notice in our patient waiting area. You may request a copy of this notice from the Privacy Officer at any time.

HOW TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may send a written complaint to the person listed at the end of the notice. You may also send a written complaint to the Secretary of the Department of Health and Human Services.
You will not be penalized for filing a complaint.

PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES

HIPAA Privacy Officer
Maryanne Freeman Brndjar, D.O.
4 West Main Street
Macungie, PA 18062
(610) 820-0575

With my signature below I certify that I have read, or had read to me, the above information, that it has been fully explained to me, and that I understand its contents.

_____

Signature of Patient **Date**

_____

Signature of Authorized Representative

Relationship:

_____

_____

Witness to signature **Date**

	Self	Family		Self	Family		Self	Family
Abnormal Pap			Diabetes			Hypertension		
AIDS/HIV			Eating Disorder			Kidney Dx		
Alcoholism						Kidney Stones		
Anemia			Emphysema			Migraine		
Arthritis			Endometriosis			Mono		
Asthma			Epilepsy			Multiple Sclerosis		
Back Disorder			Gallstones			Osteoporosis/ Osteopenia		
Bleeding Dx			GERD			Phlebitis		
Breast Lump			Glaucoma			Psych Care		
Bronchitis			GC/CHLAM			Stroke		
Cancer			Heart Dx			Suicide Attempt		
Colitis			Heart Murmur			Thyroid Dx		
Cataracts			Hepatitis			Ulcer		
Chemical Dependency			Herpes			Other		
Chicken Pox			High Chol.			Other		

Hospitalizations / Surgeries

Current Medications

MEDICATION ALLERGIES: _____

REFERRING / INVOLVED PHYSICIANS _____

FORM REVIEWED AND UPDATED

Changes Provider Signature Date

NAME: _____ DOB _____ DATE _____