INNOVARE
Health Advocates

Health care the way it ought to be…

Patient Demographic Form

Last Name____________________________ First Name__________________________________ M.I.____________

Date of Birth: ________________________ Social Security Number: _______________________ Sex: **Male/ Female**

Address__________________________________ City____________________ State______________ Zip___________

Phone: Home________________________ Mobile__________________________ Work________________________

Email ____

Spouse Information:

Last Name_______________________________ First Name________________________________ M. I.______________

Spouse Date of Birth ________________________ Spouse Social Security Number ________________________________

Spouse Employer ___________________________ Phone ______________________ Address______________________

Insurance Information:

Primary Insurance _____________________________ ID #___________________________ Subscriber_______________

Secondary Insurance ___________________________ ID #___________________________ Subscriber_______________

Emergency Contact: ______________________________

Relationship: ____________________________

Phone number: __________________________

2nd Emergency Contact: ____________________________

Relationship: _____________________________

Phone number: ___________________________

3rd Emergency Contact: _____________________________

Relationship: ____________________________

Phone Number: __________________________

Email: ____

I hereby authorize Innovare Health Advocates, its representatives, physicians, and staff, to share any and all medical and financial information with the above individual(s):

X_______________________________________ Date: _______________

Signature of patient or patient’s representative

New Patient Medical History Form

Patient Name____Date_______________________________

Prior Primary Care Provider____ Last Office Visit_____________________

Former Specialists Name/Phone____

____

Do you have an “Advanced Directive” or “Durable Power of Attorney”? ____________ If so, please provide a copy.

____

<u>Past Medical History:</u> Please check any that apply and note the date if known.

☐ Allergies
☐ Acid Reflux/Heartburn
☐ Anemia
☐ Angina/Chest Pain
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Blood Clots/Bleeding Disorders
☐ Diabetes
☐ CVA/ Stroke
☐ COPD/Emphysema
☐ Crohns’s Disease/Colitis
☐ Heart Disease/ Attack/Failure
☐ Depression
☐ Eye Disorders
☐ Hepatitis
☐ High Cholesterol
☐ High Blood Pressure
☐ Irritable Bowels
☐ Liver Disease
☐ Migraines
☐ Osteoporosis
☐ Ulcer
☐ Kidney Disease
☐ Seizures
☐ Thyroid Disease

☐ Cancer (type) __________________________ Treatment _________________________________ Year _________

☐ Other ____

<u>Past Surgical History:</u>

Procedure	Year	Procedure	Year	Procedure	Year
☐ Angioplasty		☐ Gastric Bypass		☐ Cesarean Section	
☐ Angioplasty w/ Stent		☐ Hip Replacement		☐ D and C	
☐ Appendectomy		☐ Knee Replacement		☐ Hysterectomy	
☐ Arthroscopic Knee		☐ Liver Biopsy		☐ Mastectomy	
☐ Back Surgery		☐ ORIF/ Hip Fracture		☐ Breast Biopsy	
☐ CABG/ Bypass		☐ Pacemaker		☐ Prostatectomy	
☐ Carpal Tunnel		☐ Bowel Resection		☐ Vasectomy	
☐ Cataract		☐ Thyroidectomy		☐ Other	
☐ Gall Bladder		☐ Tonsillectomy		☐ Other	
☐ Colostomy		☐ Tubal Ligation		☐ Other	

<u>Past Diagnostic History:</u>

Procedure	Date	Procedure	Date	Procedure	Date
☐ Colonoscopy		☐ Cardiac Stress Test		☐ Eye Exam	
☐ Bone Density		☐ Cardiac Catheterization		☐ Pap Smear	
☐ Mammogram		☐ Echocardiogram		☐ PSA	

Medications:

What is your preferred pharmacy? ____ Phone #____________________

Do you use a pill organizer? YES/ NO

Check here if you have NO MEDICATION ALLERGIES ☐

Please list all medication ALLERGIES.

MEDICATION	REACTION	MEDICATION	REACTION
1.		4.	
2.		5.	
3.		6.	

Please list all prescription medications and dosage amount:

Medications	Dosage and directions
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Please list all vitamins, supplements and other over the counter products:

Vitamins/OTC	Dosage and directions
1.	
2.	
3.	
4.	

Family History:

Check here if you were adopted ☐

Please check if any family member has ever had any of the following conditions. Include information even if the person is deceased.

Disease	Mother	Father	Sister	Brother	Grandparents	Other
CAD/ Heart Disease						
Heart Disease before age 50						
Cancer: Type						
Cancer: Type						
CVA/ Stroke						
Diabetes						
High Cholesterol						
High Blood Pressure						
Depression/ Anxiety						
Osteoporosis						
Glaucoma						
Macular Degeneration						

Social History:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ _______________

Number of Children: ________ In/Out of home

Children:

Name	Age	Health Status	Live Nearby?	Phone #

Employer & Occupation: ____ ☐ Current ☐ Retired Year: ________

Military Service: ☐ Yes ☐ No Combat: ☐ Yes ☐ No

Exercise: What type of exercise? _____________________________________ How many days per week? __________

Alcohol Use: ☐ Never ☐ Rarely ☐ Frequent Type of alcohol? ____

How many drinks per day? ________ Per week? ________

Tobacco Use: ☐ Never ☐ Former ☐ Current Type of tobacco used? ______________________________________

Age at onset of use? ________ Year Quit ________ Packs per day? ________

Illicit or prescription drug abuse? ☐ Never ☐ Former ☐ Current If yes, type? ____________________________

Date last used? ___________

Any history of sexually transmitted disease? ☐ Yes ☐ No ________________________________

Vaccination History:

Vaccine	Date	Vaccine	Date
☐ Hepatitis A		☐ Influenza	
☐ Hepatitis B (3 shot series)		☐ Pneumovax 23	
☐ Tetanus (Td)		☐ Prevnar 13	
☐ Tetanus & Pertussis (Tdap)		☐ Herpes Zoster/Shingles	

What are the three most important issues you'd like to discuss at your visit?

1. ____

   ____

2. ____

   ____

3. ____

   ____

Innovare Health Advocates Multiple Consent Form

Patient Name: _________________________________ Date of Birth: _______________ MRN#: __________________

Notice of Health Information Practices:

I acknowledge that I have been given a copy of the "Notice of Health Information Practices". I have read and understand the information contained on the document. I also understand that if I have any questions I may call my physician's office manager for clarification.

X ____

Signature of Patient or Patient's Representa...

Consent to Leave Messages:

I hereby authorize Innovare Health Advocates, its representatives, physicians, and staff to leave messages related to my healthcare on a recorder at the following phone number(s):

Home: ______________________________ Cell: _______________________________ Work: _____________________________

I also authorize Innovare Health Advocates, its representatives, physicians and staff, to share any and all medical and financial information with the following individual(s):

Name: ______________________________ Relationship: _______________________ Phone: __________________

Name: ______________________________ Relationship: _______________________ Phone: __________________

X ____

Signature of Patient or Patient's Representa...

Photo Consent:

This consent is for the purpose of capturing your photograph to be attached to your chart.

I understand that I may revoke this authorization at any time, by notifying Innovare Health Advocates in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Innovare Health Advocates before receiving my revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment and enrollment in a health plan or eligibility for benefits. I hereby authorize Innovare Health Advocates and their staff to capture my photograph to be attached to my chart.

X ____

Signature of Patient or Patients Representat...

Relationship to Patient___________________________________

Innovare Health Advocates Authorization for Release of Health Information

Patient Name____ **DOB**___________________________

Social Security Number____ **MRN#**__________________________

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following physician or organization is authorized to make the disclosure:
3.
   Name: ____
   Address: ____ Phone _________________ Fax ________________

4. This information may be released to and used by the following organization:
   Name: ____
   Address: ____

5. The type and amount of information to be released:
   ◯ Complete Medical Record ◯ Immunization Record ◯ Problem List
   ◯ Physician Progress Notes ◯ Lab Reports ◯ Hospital Records
   ◯ List of Allergies ◯ Medication List ◯ Diagnostic Testing Reports
   ◯ X-ray Reports ◯ EKG ◯ Most Recent 5 year History
   ◯ Problem List ◯ Consultation Reports ◯ Discharge Summary
   ◯ Other ____

6. Unless otherwise provided by law, records and information concerning the following types of diagnoses, care and treatment will be released only if I indicate my specific consent by checking the appropriate box:
   ◯ Drug/ Alcohol Abuse ◯ Mental Health Notes ◯ HIV/ AIDS ◯ Genetic Testing

7. I understand that I have a right to cancel this authorization at any time. I understand that if I wish to withdraw this authorization I must do so in writing. I must present my written cancellation to the health information management department. I understand that the authorization withdrawal will not apply to information that has already been released due to this authorization. I understand that the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise cancelled, this authorization will expire on the following date _________________. If I fail to specify an expiration date or event, this authorization will expire in six months.
8. I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I don't have to sign this form to receive treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the possibility for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact my physician's office manager. I understand that there may be a charge for costs associated with copying my health information.

X
____

Signature of Patient/ Legal Representative (Specify Relationship to Patient) Date

Health care the way it ought to be…

Notice of Health Information Practices

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.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

How to Get More Information or to Report a Problem

If you have questions and/or would like additional information, you may contact our Privacy Officer at 314-843-4794.

Innovare Health Advocates

New Patient Survey

How did you hear about us?

We are very happy that you are here with us today! Thank you for sharing with us how you learned about Innovare.

Name: ____

I learned about Innovare Health Advocates from (check as many as may apply):

A friend or family member:	_______	Name of referring patient:	____________________________
Insurance plan or broker:	_______	Name of plan:	____________________________
An Innovare employee:	_______	Name of employee:	____________________________
A referral from another physician:	_______	Name of physician:	____________________________
Online:	_______	Name of website:	____________________________

An advertisement:

KMOX radio	________
KPTS radio	________
Direct Mail	________
Post-Dispatch paper	________
Post-Dispatch website	________
Seminar	________
Other	____

Any other source not listed: ____

____

Health care the way it ought to be…

FACILITY CONTACT AUTHORIZATION

Patient Name: ______________________________

Birth Date: _________________________________

I hereby authorize Dr. Charles Willey and his healthcare team to advocate for me, review records and discuss my care with physicians and staff of any healthcare facility, including a mental health facility, while I am admitted.

X____

Signature of patient or patient's representative

Date:________________________