Certified Patient Services, LLC

NEW CLIENT INFORMATION

Full legal name: _____ How you prefer to be addressed: _____

Date of birth: _____ Biological gender: M F Height: _____ Weight: _____ Marital status: _____

Name of spouse: _____ Spouse's overall health: _____ Ages of children: _____

Mailing address: _____ Social Security number: _____

City, State, ZIP: _____ Primary phone number: _____

Email address: _____ Alternate phone number: _____

Emergency contact name: _____ Phone number: _____

Medical POA holder (**Durable** / **Springing**): _____ Phone number: _____

Financial POA holder (**Durable** / **Springing**): _____ Phone number: _____

List any other friends or family members with whom we may discuss your case.

Name: _____ Relation: _____ Phone number: _____

Name: _____ Relation: _____ Phone number: _____

Name: _____ Relation: _____ Phone number: _____

Name: _____ Relation: _____ Phone number: _____

Ethnicity: _____ Cultural beliefs affecting healthcare: _____

Religion: _____ Spiritual beliefs affecting healthcare: _____

Other treatment considerations: _____

Financial status: _____ Health insurance: _____

Military / education / educational pursuits: _____

Occupation / employer / vocational pursuits: _____

Describe your home environment: _____

_____

Describe your work environment: _____

_____

NEW CLIENT INFORMATION (page 2)

Family history of serious illness: Diabetes, Heart, Cancer, Other: _____

Past accidents / injuries: _____

Regularly use: Caffeine, Tobacco, Alcohol, Other Describe: _____

Describe your physical strengths and abilities: _____

_____

_____

_____

Describe your physical weaknesses and disabilities: _____

_____

_____

_____

Describe your mental, social, and/or behavioral strengths and abilities: _____

_____

_____

_____

Describe your mental, social, and/or behavioral weaknesses and disabilities: _____

_____

_____

_____

List any activities that you participate in regularly: _____

_____

List any other hobbies and recreational / leisure pursuits: _____

_____

NEW CLIENT INFORMATION (page 3)

Diagnosed Medical Condition	Doctor / Facility	Date	Prognosis	Treatment Received	Status / Comments
					☐ Resolved ☐ Ongoing
					☐ Resolved ☐ Ongoing
					☐ Resolved ☐ Ongoing
					☐ Resolved ☐ Ongoing
					☐ Resolved ☐ Ongoing
					☐ Resolved ☐ Ongoing
					☐ Resolved ☐ Ongoing
					☐ Resolved ☐ Ongoing
					☐ Resolved ☐ Ongoing
					☐ Resolved ☐ Ongoing

Medical Conditions and Concerns Not Yet Formally Diagnosed

NEW CLIENT INFORMATION (page 4)

Current Medications – prescription and over-the-counter

Current Vitamins and Supplements

Current Exercise Regimen (if applicable)

Special Diet (if applicable)

Sleep Habits and Patterns

NEW CLIENT ASSESSMENT (page 5)

– continued on next page, if necessary --

Doctor	Practice Name, Address, Phone	Specialty	Last Visit Date
		Primary Care / Family Physician	

Other Providers	Address, Phone	Service(s) Provided	Last Visit Date

Labs / Testing	Address, Phone	Type of Test(s) Performed	Last Visit Date

NEW CLIENT ASSESSMENT (page 6)

Doctor	Practice Name, Address, Phone	Specialty	Last Visit Date

Other Providers	Address, Phone	Service(s) Provided	Last Visit Date

Labs / Testing	Address, Phone	Type of Test(s) Performed	Last Visit Date

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for authorization of the use and disclosure of protected health information in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I. My Authorization

I authorize the following using or disclosing party:

_____

to use or disclose the following health information:

☐ All of my health information

☐ My health information relating to the following treatment or condition:

_____

☐ My health information covering the period of healthcare

from (date) _____ to (date) _____

☐ Other: _____

The above party may disclose this health information to the following recipient:

Any authorized agent of **Certified Patient Services, LLC**
[Coming soon!]
Reading, PA 19607
Phone: [Coming soon!]
Fax: [Coming soon!]
Email: office@certserv.net

The purpose of this authorization is (check all that apply):

☐ At my request

☐ Other: _____

☐ To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.

☐ To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.

This authorization ends:

☐ On (date)_____

☐ When the following event occurs: _____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____

If the patient is a minor or unable to sign please complete the following:

☐ Patient is a minor: _____ years of age

☐ Patient is unable to sign because: _____

Signature of Authorized Representative:

_____ Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:

☐ Parent ☐ Legal Guardian ☐ Court Order

☐ Other: _____

III. Additional Consent for Certain Conditions

The protected health information covered by this request may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

☐ I consent to have the above information released.

☐ I do not consent to have the above information released.

Signature of Patient or Authorized Representative:

_____ Date: _____ Time: _____

IV. Additional Consent for HIV/AIDS

The protected health information covered by this request may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

☐ I consent to have the above information released.

☐ I do not consent to have the above information released.

Signature of Patient or Authorized Representative:

_____ Date: _____ Time: _____

Medicare

Beneficiary Services:1-800-MEDICARE (1-800-633-4227)
TTY/ TDD:1-877-486-2048

This form is used to advise Medicare of the person or persons you have chosen to have access to your personal health information.

Where to Return Your Completed Authorization Forms:
After you complete and sign the authorization form, return it to the address below:

Medicare CCO, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

For New York Medicare Beneficiaries ONLY
The New York State Public Health Law protects information that reasonably could identify someone as having HIV symptoms or infection, and information regarding a person's contacts. Because of New York's laws protecting the privacy of information related to alcohol and drug abuse, mental health treatment, and HIV, there are special instructions for how you, as a New York resident, should complete this form.

- For question 2A, check the box for *Limited Information*, even if you want to authorize Medicare to release any and all of your personal health information.

- **Then proceed to question 2B.** You may also check any of the remaining boxes and include any additional limitations in the space provided. For example, you could write "payment information".

Instructions for Completing Section 2C of the Authorization Form:
Please select one of the following options.

- **Option 1** To **include** all information, check the box: "All information, including information about alcohol and drug abuse, mental health treatment, and HIV". Proceed with the rest of the form.

- **Option 2** To **exclude** the information listed above, check the box "Exclude information about alcohol and drug abuse, mental health treatment, and HIV". Then proceed with the rest of the form.

If you have any questions or need additional assistance, please feel free to call us at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Sincerely,

1-800-MEDICARE
Customer Service Representative

Encl.

Form Approved
OMB No. 0938-0930
Expiration Date: 7/31/2021

Information to Help You Fill Out the "1-800-MEDICARE Authorization to Disclose Personal Health Information" Form

By law, Medicare must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that isn't set out in the privacy notice contained in the Medicare & You handbook. You may take back ("revoke") your written permission at any time, except if Medicare has already acted based on your permission.

If you want 1-800-MEDICARE to give your personal health information to someone other than you, you need to let Medicare know in writing.

If you are requesting personal health information for a deceased beneficiary, please include a copy of the legal documentation which indicates your authority to make a request for information. (For example: Executor/Executrix papers, next of kin attested by court documents with a court stamp and a judge's signature, a Letter of Testamentary or Administration with a court stamp and judge's signature, or personal representative papers with a court stamp and judge's signature.) Also, please explain your relationship to the beneficiary.

Please use this step by step instruction sheet when completing your "1-800-MEDICARE Authorization to Disclose Personal Health Information" Form. Be sure to complete all sections of the form to ensure timely processing.

1. Print the name of the person with Medicare.

Print the Medicare number exactly as it is shown on the red, white, and blue Medicare card.

Print the birthday in month, day, and year (mm/dd/yyyy) of the person with Medicare.

2. This section tells Medicare what personal health information to give out. Please check a box in 2A to indicate how much information Medicare can disclose. If you only want Medicare to give out limited information (for example, Medicare eligibility), also check the box(es) in 2B that apply to the type of information you want Medicare to give out. Box 2C must be completed by **New York Residents**.

3. This section tells Medicare when to start and/or when to stop giving out your personal health information. Check the box that applies and fill in dates, if necessary.

4. This section tells Medicare the reason for disclosure.

5. Medicare will give your personal health information to the person(s) or organization(s) you fill in here. You may fill in more than one person or organization.

If you designate an organization, you must also identify one or more individuals in that organization to whom Medicare may disclose your personal health information.

Form Approved
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Expiration Date: 7/31/2021

6. The person with Medicare or personal representative must sign their name, fill in the date, and provide the phone number and address of the person with Medicare.

If you are a personal representative of the person with Medicare, check the box, provide your address and phone number, and attach a copy of the paperwork that shows you can act for that person (for example, Power of Attorney).

7. Send your completed, signed authorization to Medicare at the address shown here on your authorization form.

8. If you change your mind and don't want Medicare to give out your personal health information, write to the address shown under number seven on the authorization form and tell Medicare. Your letter will revoke your authorization and Medicare will no longer give out your personal health information (except for the personal health information Medicare has already given out based on your permission).

You should make a copy of your signed authorization for your records before mailing it to Medicare.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit CMS.gov/about-cms/agency-information/aboutwebsite/cmsnondiscriminationnotice.html, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

Form Approved
OMB No. 0938-0930
Expiration Date: 7/31/2021

1-800-MEDICARE Authorization to Disclose Personal Health Information

Use this form if you want 1-800-MEDICARE to give your personal health information to someone other than you.

1. Print Name (First and last name of the person with Medicare) _____

Medicare Number (Exactly as shown on the Medicare Card) _____

Date of Birth (mm/dd/yyyy) _____

2. Medicare will only disclose the personal health information you want disclosed.

2A: Check only <u>one</u> box below to tell Medicare the specific personal health information you want disclosed:

Limited Information (go to question 2b)

Any Information (go to question 3)

2B: Complete <u>only</u> if you selected "limited information". Check all that apply:

Information about your Medicare eligibility

Information about your Medicare claims

Information about plan enrollment (e.g. drug or MA Plan)

Information about premium payments

Other Specific Information (please write below; for example, payment information)

_____

_____

2C: NY Residents Only, this section must be completed.
Please select one of the following options: (Please check only one box.)

Include all information. This includes information about alcohol and drug abuse, mental health treatment, and HIV.

OR

Exclude information about alcohol and drug abuse, mental health treatment, and HIV.

Form Approved
OMB No. 0938-0930
Expiration Date: 7/31/2021

3. **Check only one box below indicating how long Medicare can use this authorization to disclose your personal health information** (subject to applicable law—for example, your State may limit how long Medicare may give out your personal health information):

   Disclose my personal health information indefinitely

   Disclose my personal health information for a specified period only

   beginning: _____(mm/dd/yyyy) and ending: _____(mm/dd/yyyy)

4. **Fill in the reason for the disclosure (you may write "at my request"):**

   _____

   _____

5. **Fill in the name and address of the person or organization to whom you want Medicare to disclose your personal health information. Please provide the specific name of the person for any organization you list below. If you would like to authorize any additional individuals or organizations, please add those to the back of this form.**

   Name _____

   Address _____

   Name _____

   Address _____

Form Approved
OMB No. 0938-0930
Expiration Date: 7/31/2021

Note: You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. To revoke authorization, send a written request to the address noted below. Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Medicare pays for the health services you receive.

6. **I authorize 1-800-MEDICARE to disclose my personal health information listed above to the person(s) or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and may no longer be protected by law.**

_____ _____ _____

Signature | Telephone Number | Date (mm/dd/yyyy)

Print the address of the person with Medicare (Street Address, City, State, and ZIP)

Check here if you are signing as a personal representative and complete below.
Please attach the appropriate documentation (for example, Power of Attorney). This only applies if someone other than the person with Medicare signed above.

Print the Personal Representative's Address (Street Address, City, State, and ZIP)

Telephone Number of Personal Representative: _____

Personal Representative's Relationship to the Beneficiary: _____

Form Approved
OMB No. 0938-0930
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7. **Send the completed, signed authorization to**:

Medicare CCO, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

Note: You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. If you would like to revoke authorization, send a written request to the address noted above.

Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Medicare pays for the health services you receive.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0930. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit CMS.gov/about-cms/agency-information/aboutwebsite/cmsnondiscriminationnotice.html, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.