FOOTHILL PAIN MANAGEMENT

CHRISTOPHER J. CHARBONNET, M.D.

1530 east Chevy Chase Drive Suite 204
Glendale, CA 91206
PHONE: (818) 241-7246

1701 East Cesar Chavez, Suite 307
Los Angeles, CA 90033
FAX: (818) 241-1639

Date: _____

Patient Name:_____**Gender: M F : Race:** _____
Last First Middle

Ethnic Group: _____**DOB:** _____ **SSN:** _____ **DL#:** _____

Address: _____
Street City State Zip Code

Marital Status: Single: : ☐ **Married:** ☐ **Divorced:** ☐ **Separated:** ☐ **Widowed:** ☐

Preferred Contact Method: Home Phone: ☐ **Cell Phone:** ☐ **Work Phone:** ☐ **By Mail:** ☐

Phone (Home): _____ **Phone (Work/Cell/Other):**_____

Employer: _____ **Occupation:** _____

Primary Care Physician:

Name: _____ **Telephone :** _____

Address: _____

Referring Physician:

Name _____ **Telephone :** _____

Address: _____

Primary Insurance Company:

Name: _____ **Insured:** _____

I.D. #: _____

Secondary Insurance Company:

Name: _____ **Insured:** _____

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Authorization for how disclosures are to be made Regarding Protected Health Information (PHI)

HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of PHI. The individual is also provided the right to request confidential communications of PHI by alternate means, such as sending correspondence to the individuals' office or other place instead of home.
I wish to be contacted in the following manner (check all that applies)

TELEPHONE

- ☐ Home Telephone _____
- ☐ OK to leave a message with detailed information with person answering the phone or on my machine
- ☐ Leave message with call-back number only with person answering the phone or on my machine.

WRITTEN COMMUNICATION

- ☐ OK to mail to my home address
- ☐ OK to mail to my work/ office address
- ☐ OK to fax to this number _____

ALTERNATIVE PHONE OR ADDRESS

- ☐ ONLY LEAVE MESSAGES ON THE PHONE OR MAIL TO THIS ADDRESS
- ☐ PHONE NUMBER _____
- ☐ ADDRESS _____
- ☐ OK to leave or send detailed message.
- ☐ Leave or send only call back number

I hereby authorize Foothill Pain Management to disclose Protected Health Information to the following individuals:

Name: _____ Date of Birth: _____

Name:_____ Date of Birth: _____

Signature: _____ Date: _____

I understand that it is my responsibility to inform Foothill Pain Management in writing of any changes to this authorization.

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Summary of the HIPAA Privacy Policy

The Privacy Rule is intended to:

- Protect and enhance rights of consumers by providing them
  - Access to their health information
  - Control over PHI uses and disclosures
- Improve healthcare quality by restoring public trust and willingness to share information.
- Improve efficiency and effectiveness by creating uniform nationwide privacy framework.
- Covers electronic, paper and oral information.
- Requires contracts with business associates to protect health information
- Emphasized "minimum necessary" access
  - Standards apply to "protected health information": all individually identifiable health information in any form.
- General Rule: Protected health information may not be used or disclosed for reasons other than treatment, payment or healthcare operations without specific patient authorization
- Patients must received written notice or provider's information practices; practice must make good faith effort to obtain acknowledge of receipt
- Patients my inspect their own health information and obtain a copy
- Patients may request amendment to health information
- Patients may receive an accounting of disclosures of health information be restricted
- Patients must be provided means to report a privacy complaint
- Providers can release PHI without authorization for treatment, payment or healthcare operations, or:
  - When required by law
  - Public Health Activities
  - For victims of abuse, neglect, or domestic violence
  - Health Oversight
  - Judicial Proceedings
  - Specific law enforcement activities
- Providers must obtain a written Patient Authorization before releasing PHI for purposes other that Treating, Payment, and Health Care Operations, such as:
  - Marketing
  - Medical Research
  - Fund-Raising
- Authorization generally address a specific need and circumstances or span of time
- Authorizations are required before psychotherapy notes can be released
- Providers must identify all Business Associates that have access to or use/ disclose protected health information of patients.
  - Business Associate contract must be established to ensure that Business Associates' practice support HIPPA's requirements; sanctions must be applied for non-compliance by Business Associates
- Providers may release patient's location, condition, or death when needed to family, friends, others involved in the care of the patient
- Providers may make other disclosures to family and other involved when in the patient's best interest

Name:_____ _____

Please Print Signature

Date:_____

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OFFICE PAYMENT POLICY

I am committed to providing you with the best possible care. Your clear understanding of my payment policyis important to our professional relationship. I therefore encourage you to speak to me regarding any questions you may have about my fees and you financial obligation.

It is important you understand that your health insurance and/or your managed care plan are a contract between you and the insurance carrier. I am not a party to this contract. I provide services to you the patient, not to the insurance company. The insurance company is responsible to you, the patient, and you are responsible to me, the physician.

If your insurance carrier does not pay the account within three months after I have rendered services, you will be responsible for the payment in full. If you have not met your deductible, YOU ARE RESPONSIBLE FOR THE DEDUCTIBLE PAYMENT AMOUNT.

Please inform my staff of the type of insurance you have. ALWAYS bring your insurance card with you to your scheduled visit. If your insurance policy is in your spouse's name, please inform me.

If you are an HMO/PPO participant, it is YOUR responsibility to bring in the authorization or referral form. YOU ARE RESPONSIBLE FOR THE CO-PAYMENT AMOUNT.

If you have MEDICARE, you are responsible for the deductible as well as the co-payment. If you have a senior care supplement coverage plan, I will file the claim with your insurance carrier.
We accept cash, personal checks, and credit cards (Visa, MasterCard, Discover, American Express).
Dr. Charbonnet is on staff at Glendale Adventist Medical Center.

THIS RELEASE AUTHORIZES CHRISTOPHER J. CHARBONNET, M.D. TO RELEASE ANY INFORMATION REQUEST TO MY INSURANCE CARRIER.

I HEARBY AUTHORIZE PAYMENT DIRECTLY TO CHRISTOPHER J. CHARBONNET, M.D. FOR THE MEDICAL BENEFITS FOR SERVICE PROVIDED.

I HEARBY AUTHORIZE PAYMENT DIRECTLY TO CHRISTOPHER J. CHARBONNET, M.D. FOR THE MEDICAL BENEFITS FOR SERVICES PROVIDED.

I HEARBY AUTHORIZE PHOTOCOPIES OF THIS FORM TO BE AS VALID AS THE ORIGINAL.

Insured/Authorized Person's Signature: _____

Date:_____

Revised August 09, 2012