



HEALTH HISTORY QUESTIONNAIRE

| | | | | | |
|---|--------|---|-----------------------------|--|------|
| Name (<i>Last, First, M.I.</i>) | | <input type="checkbox"/> M <input type="checkbox"/> F | Height: | DOB: | |
| Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | | | | | |
| Previous or Referring Doctor: | | | Date of Last Physical Exam: | | |
| Main Reason for Your Visit Today: | | | | | |
| Please list any significant medical conditions you have had, past or present: | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Surgeries | | | | | |
| Year | Reason | | Hospital | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Other Hospitalizations | | | | | |
| Year | Reason | | Hospital | | |
| | | | | | |
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| | | | | | |
| | | | | | |
| Preventative Care | | | | | |
| | Date | | Date | | Date |
| <input type="checkbox"/> Colonoscopy | | <input type="checkbox"/> Pap Smear (Women) | | <input type="checkbox"/> Cholesterol Level | |
| <input type="checkbox"/> Bone Density | | <input type="checkbox"/> Mammogram (Women) | | <input type="checkbox"/> Other | |
| Immunizations | | | | | |
| | Date | | Date | | Date |
| <input type="checkbox"/> Tetanus Td or Tdap (Circle One) | | <input type="checkbox"/> Hepatitis B | | <input type="checkbox"/> Influenza | |
| <input type="checkbox"/> Hepatitis A | | <input type="checkbox"/> HPV (Gardasil) | | <input type="checkbox"/> Shingles (Zostavax) | |
| <input type="checkbox"/> Pneumovax | | | | | |

 Last Name, First Name

HEALTH HABITS AND PERSONAL SAFETY

| | | | |
|-----------------|---|--|--|
| Exercise | Regular Exercise is any planned physical activity (e.g., brisk walking, aerobics, jogging, bicycling, swimming, rowing, etc.) performed to increase physical fitness. Such activity should be performed 4 to 5 times per week for 20-60 minutes per session. Exercise does not have to be painful to be effective but should be done at a level that increases your breathing rate and causes you to break a sweat. | | |
| | Do you do Regular Exercise according to the above definition? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Days per week: | | |
| | Minutes per session: | | |
| Diet | Are you on a special diet? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Do you eat a healthy diet? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | # of meals you eat in an average day? | | |
| Caffeine | <input type="checkbox"/> None | <input type="checkbox"/> Coffee | <input type="checkbox"/> Tea <input type="checkbox"/> Soda |
| | # of cups/cans per day? | | |
| Alcohol | Do you drink alcohol? | | |
| | If yes, what kind? | | |
| | How many drinks per week? | | |
| | Have you ever felt the need to cut down on drinking? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Have you ever been annoyed by criticism of your drinking? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Have you ever felt guilty about your drinking? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Have you ever felt the need for an eye-opener? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Have you ever experienced blackouts? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tobacco | Do you use or have you ever used tobacco? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | <input type="checkbox"/> Cigarettes - pk/day: | <input type="checkbox"/> Chew - #/day: | <input type="checkbox"/> Pipe - #/day: <input type="checkbox"/> Cigars - #/day : |
| | # of years: | Year quit: | |
| Drugs | Do you currently use recreational or street drugs? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Have you ever given yourself street drugs with a needle? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sex | Are you sexually active? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Do you have more than one partner? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Are your partner(s) <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both | | |
| | If not trying for a pregnancy, list contraceptive or barrier method used: | | |
| | Do you have any questions or concerns about sexually transmitted diseases? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Do you live alone? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Do you have frequent falls? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Do you have a vision or hearing loss? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Do you have an Advance Directive or Living Will? If you would like one, please ask your physician. | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Do you wear seatbelts? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Do you have any concerns about physical, mental or sexual abuse that you would like to discuss with the physician? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

 Last Name, First Name

FAMILY HEALTH HISTORY

| Did/do they have diabetes, high blood pressure, cancer, high cholesterol, heart disease, thyroid disease, asthma, migraines, Alzheimer's, drug or alcohol abuse, other (list) | | | | | |
|---|----------------------------|--|-----------------|-----------------------------|--|
| | Age | | Age | Significant Health Problems | |
| Father | | | Children | <input type="checkbox"/> M | |
| | | | | <input type="checkbox"/> F | |
| Mother | | | | <input type="checkbox"/> M | |
| | | | | <input type="checkbox"/> F | |
| Brothers/ Sisters | <input type="checkbox"/> M | | Grandmother | | |
| | <input type="checkbox"/> F | | <i>Maternal</i> | | |
| | <input type="checkbox"/> M | | Grandfather | | |
| | <input type="checkbox"/> F | | <i>Maternal</i> | | |
| | <input type="checkbox"/> M | | Grandmother | | |
| | <input type="checkbox"/> F | | <i>Paternal</i> | | |
| | <input type="checkbox"/> M | | Grandfather | | |
| | <input type="checkbox"/> F | | <i>Paternal</i> | | |

MENTAL HEALTH

| | | |
|--|------------------------------|-----------------------------|
| Do you feel depressed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you cry frequently? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever attempted suicide? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever seriously thought of hurting yourself? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever been to a counselor? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, for what problem? | | |

MEDICATIONS

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

| Name the Drug | Strength | Frequency Taken |
|---------------|----------|-----------------|
| | | |
| | | |
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| | | |
| | | |

Allergies to Medications

| Name the Drug | Reaction You Had |
|---------------|------------------|
| | |
| | |
| | |
| | |

Last Name, First Name

√ CHECK to the left of symptom if you have now or in the recent past:

| Constitutional | Gastrointestinal | Cardiovascular |
|--|---|---|
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Swallowing problem | <input type="checkbox"/> Chest pain or pressure |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Bloating | <input type="checkbox"/> Wake up breathless |
| <input type="checkbox"/> Significant Weight change | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Ankle swelling |
| Head Neck neuro | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Leg cramping |
| <input type="checkbox"/> Vision changes | <input type="checkbox"/> Nausea | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Cold feet or hands |
| <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Passing out |
| <input type="checkbox"/> Dizziness or vertigo | <input type="checkbox"/> Constipation | Musculoskeletal |
| Ear, Nose, Throat | <input type="checkbox"/> Bowels irregular | <input type="checkbox"/> Joint stiffness |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Black stool | <input type="checkbox"/> Joint swelling |
| <input type="checkbox"/> Sinus – Nose bleeds | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Muscle aches |
| <input type="checkbox"/> Oral lesions | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Neck or jaw pain | Genitourinary | <input type="checkbox"/> Change in moles |
| <input type="checkbox"/> Lumps in Neck | <input type="checkbox"/> Menstrual trouble | <input type="checkbox"/> Rashes-Bump-Bruises |
| Respiratory | <input type="checkbox"/> Menopause | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Sputum | <input type="checkbox"/> Urge to urinate | <input type="checkbox"/> Blood clots-Phlebitis |
| <input type="checkbox"/> Coughed up blood | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Deformity/Amputation |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Blood in urine | |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Discharge | |
| <input type="checkbox"/> Breathless with walking | <input type="checkbox"/> Awakening to urinate | |
| <input type="checkbox"/> Breathless when flat in bed | <input type="checkbox"/> Change in stream | |
| | <input type="checkbox"/> Lumps in testicles | |

ALLERGIES

| | | |
|--|------------------------------|-----------------------------|
| Do you experience any of these symptoms more than twice per year: Cough, cold, congestion, difficulty breathing, headaches, wheezing, runny nose, sore throat, itchy/irritated eyes, unexplained fatigue, sinus pain, ear pain, skin irritation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever been diagnosed with asthma or bronchitis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you experience symptoms of allergies? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| We offer allergy testing and no-shot allergy treatment at this office. Would you like to find out more about this? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

 Patient Signature

 Date

Christine Harter M.D.,PC REGISTRATION FORM

(Please Print)

| Today's date: | | | | PCP: | | | |
|--|----------------------------------|---|--|---|---|---|---|
| PATIENT INFORMATION | | | | | | | |
| Patient's last name: | | First: | Middle: | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. | <input type="checkbox"/> Miss <input type="checkbox"/> Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid | |
| Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No | If not, what is your legal name? | | (Former name): | | Birth date: / / | Age: | Sex: <input type="checkbox"/> M <input type="checkbox"/> F |
| Street address: | | | Social Security no.: XXXXXXXXXXXXXXXXXXXXXXXXXXXX | | Home phone no.: () | | |
| P.O. box: | | City: | | State: | | ZIP Code: | |
| Occupation: | | Employer: | | | Employer phone no.: () | | |
| Referred to clinic by (please check one box): | | | | <input type="checkbox"/> Dr. | | <input type="checkbox"/> Insurance Plan | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Family | <input type="checkbox"/> Friend | <input type="checkbox"/> Close to home/work | <input type="checkbox"/> Yellow Pages | | <input type="checkbox"/> Other | | |
| Other family members seen here: | | | | | | | |

| INSURANCE INFORMATION | | | | | | | |
|--|-------------------------------------|--|------------------------------------|--------------------------------|---------------------------------|-------------------------------|-------------------|
| (Please give your insurance card to the receptionist.) | | | | | | | |
| Person responsible for bill: | | Birth date: / / | Address (if different): | | | Home phone no.: () | |
| Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| Occupation: | | Employer: | Employer address: | | | Employer phone no.: () | |
| Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| Please indicate primary insurance | | <input type="checkbox"/> Medicare | <input type="checkbox"/> AHCCCS | <input type="checkbox"/> AETNA | <input type="checkbox"/> HUMANA | <input type="checkbox"/> UHC | |
| <input type="checkbox"/> BCBS | <input type="checkbox"/> STATE COMP | <input type="checkbox"/> CIGNA | <input type="checkbox"/> UNINSURED | | <input type="checkbox"/> Other | | |
| Subscriber's name: | | Subscriber's S.S. no.: XXXXXXXXXXXXXXXXXXXX | Birth date: / / | Group no.: | | Policy no.: | Co-payment: \$ |
| Patient's relationship to subscriber: | | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> Other | | |
| Pharmacy Name: | | | Address: | | | Phone: | |
| Patient's relationship to subscriber: | | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> Other | | |

| IN CASE OF EMERGENCY | | | |
|---|--|--------------------------|---------------------------|
| Name of local friend or relative (not living at same address): | | Relationship to patient: | Home phone no.: () |
| | | | Work phone no.: () |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Christine Harter M.D., PC or insurance company to release any information required to process my claims. | | | |
| _____ <i>Patient/Guardian signature</i> | | | _____ <i>Date</i> |

Referral Policy

Christine Harter M.D., PC

Our office would like you as our patient to take time and read the following information about our referral process.

A referral, also called pre-authorization, is the approval our office must obtain before admitting you to the hospital or providing or referring you for other types of specialty services. Without this approval your medical care may not be covered and you could be responsible for 100% of the bill.

Dr. Harter authorizes referrals she believes are appropriate given your health condition. Dr. Harter requires an office visit prior to authorizing a referral and can treat most conditions in our office.

You as the patient have the following responsibilities:

1. Verify the specialist is participating on your plan.
2. Schedule your appointment and provide the specialty office with your personal and insurance information.
3. Inform our office of the specialist name, date of appointment, and phone and fax number.

******WE REQUIRE SEVEN (7) DAYS ADVANCE NOTICE******

URGENT REFERRALS WILL BE EXPEDITED AT THE PHYSICIAN'S DISCRETION

Our office will:

1. Obtain and complete all referral forms.
2. Contact your insurance company to obtain authorization.
3. Fax to the specialty location your referral and pertinent medical information.
4. You will be contacted when the process is complete.

I have read and understand the practice's referral policy and I agree to be bound by its terms. I also understand and agree such terms may be amended by the practice from time to time.

Signature of Patient (or responsible party, if minor)

DATE

Printed Name of Patient

Christine Harter M.D., PC

Christine Harter M.D.

2915 W Rose Garden Lane, Suite102

Phoenix, AZ 85027

Phone: 623.748.8300 Fax: 623.748.8314

Patient Name: _____

Guardian Name (if applicable): _____

The following information will assist the physician and staff in contacting you with test results, medical information, financial and/or insurance issues.

Where is the best phone number to reach you between 8:30 a.m. and 5:00 p.m.? _____

If we cannot reach you personally, may we leave a message on:

YES

NO

_____ _____ Answering machine at home Home phone: _____

_____ _____ Voicemail at work Work phone: _____

_____ _____ Cell phone voicemail Cell phone: _____

_____ _____ _____ _____

Other person(s) i.e. family member

We will not send confidential medical information out through e-mail, since the Internet is not secure, though we will be developing a secure Internet e-mail portal, probably in 2011. To be able to update you on these new services, and to provide a medical newsletter to you no more often than quarterly, we would appreciate your e-mail address:

E-mail address: _____

Date _____ Signature _____

Date _____ Signature _____

Date _____ Signature _____

Date _____ Signature _____

Date _____ Signature _____

Christine Harter, M.D., P.C.

Notice of Privacy 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.

Christine Harter, M.D., P.C. is dedicated to maintaining the privacy of your personal health information. Each time a patient visits this office, a record is made that describes the treatments and services provided. Federal law outlines specific privacy protections and individual rights related to the information we maintain that identifies you as a patient. Protected information includes demographic data and facts about your past, present, or future physical or mental health. Our office has put in place policies and procedures to help protect your health information. We are required to provide this notice outlining our legal duties and responsibilities related to the use and disclosure of patient identifiable health information, Privacy Practices, and examples of how your information may be used or disclosed.

Practice will abide by the terms of this notice. We may revise this notice at any time. The new notice will be posted in our office in a prominent location. You can request a copy of our most current notice at any time. Revisions to the notice will be effective for all health care information this office maintains: past, present, or future.

Practice may use your individually identifiable health information for the following purposes without your authorization:

1. **Treatment:** We may use and disclose your identifiable health information to treat you and assist others in your treatment. For instance, we may send a copy of your records to another doctor so that you can be evaluated for a specific condition, or we may disclose information to others who take part in your care, such as your spouse, children, or parents.
2. **Payment:** We may use your health information to bill and collect payment for services provided. This may include providing your insurance company with the details of your treatment, sharing your payment information with other treatment providers, contacting you over the phone or through the mail about balances, or sending unpaid balances to a collection agency.
3. **Health Care Operations:** We may use and disclose health information to operate our business. For example, your health information may be used to evaluate the quality of care we provide, for state licensing, or to identify you by name when you visit the office.
4. **Appointment Reminders:** We may use and disclose your information to remind you of appointments. We may also mail you a reminder for follow-up visits.
5. **Treatment Options:** We may use your health information to inform you of treatment options or other health-related services we offer that may be of interest to you.
6. **Business Associates:** We may share your health information with other individuals or companies that perform various activities for, or on behalf of, our office such as after-hours telephone answering, billing, or quality assurance. Our Business Associates agree to protect the privacy of your information,

Practice may disclose your health information without your authorization when permitted or required to by law, including:

- For public health activities including reporting of certain communicable diseases.
- For workers' compensation or similar programs as required by law.
- To authorities when we suspect abuse, neglect, or domestic violence.
- To health oversight agencies.
- For certain judicial and administrative proceedings pursuant to an administrative order.
- For law enforcement purposes. To a medical examiner, coroner, or funeral director.
- For the facilitation of organ, eye, or tissue donation if you are an organ donor.
- For research purposes under strictly limited circumstances,
- To avert a serious threat to your health and safety or that of others.
- For governmental purposes such as military service or for national security.
- In the event of an emergency or for disaster relief.
- In any other instance required by law.

Practice may also disclose your information to family members and/or other persons involved in your care or payment for your care. Practice may leave messages for you at home or work about your visits or test results. If you do not want us to do so, please inform our Privacy Officer in writing.

All other uses and disclosures of your information to others will require a written, signed authorization from you. You have the right to revoke your authorization at any time except to the extent that we have already acted on it. Should you require your records to be released, Practice will provide you with an authorization form to complete and return to the address listed on it.

YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF PRACTICE. THE INFORMATION CONTAINED IN IT BELONGS TO YOU. BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS. WE WILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.

1. **Restrictions on Use and Disclosure:** You have the right to request restrictions on how we use and disclose your health information. This includes requests to restrict disclosure of your health information to only certain individuals, or entities, involved in your care such as family members and insurance companies. We are not required to agree with your request. If we agree, we are bound to the agreement unless disclosure is otherwise required or authorized by law.
2. **Confidential Communications:** You have the right to request that we communicate with you in a particular manner or at a certain location. For example, you may request that we only contact you at home. We will accommodate reasonable requests.
3. **Access:** You have the right to inspect or request a copy of records used to make decisions about your health care, including your medical chart and billing records. This office will schedule appointments for record inspection. We may charge a fee for providing you copies of your records. Under special circumstances, we may deny your request to inspect and/or copy your records. You may request a review of this denial.
4. **Record Amendment:** You have the right to request amendments to your health records created by and for this Practice if you feel they are incorrect or incomplete. We may accept or deny your request. If we deny your request, you have the right to provide a statement of disagreement.
5. **Accounting of Disclosures:** You have the right to receive an accounting of disclosures. This means you may request a list of certain disclosures Practice has made of your records. Upon your request, we will provide this information to you one time free during each twelve (12) month period. There may be a fee for additional copies.
6. **Copy of Notice:** You have the right to request that we provide you with a paper copy of this notice of Privacy Practices.

If you have questions about this notice, please contact Practice's Privacy Officer at Christine Harter, M.D., P.C.; or (623) 748-8300. If you feel your privacy rights have been violated, you have the right to file a written complaint with our office. You may also file a complaint with the Secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint.

I have received a copy of this office's Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed, and protected.

Printed Patient Name

Name/Relationship if Signed by Individual Other than Patient

Signature

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of this Notice of Privacy Practices but could not because:

___ Individual Refused to Sign

___ Communication Barrier

___ Care Provided was Emergent

___ Other: _____

Employee Name

Date

**AUTHORIZATION FOR RELEASE
OF PROTECTED HEALTH INFORMATION**

Patient Name: _____
Address: _____

Other Name: _____
Birth date: _____
Soc. Sec. No.: Last 4 Digits Only _____

I hereby authorize:

to release a copy of the following information:

To: Christine Harter, M.D., P.C.
2915 W. Rose Garden Lane, Suite 102
Phoenix, AZ 85027
Phone: (623) 748-8300 Fax: (623) 748-8314

- For continuity of care
- Other

Medical records may include confidential information related to HIV, communicable disease, alcohol or drug abuse, and mental health diagnosis and treatment.

I do do not authorize the release of this type of information.

I understand:

- I may revoke this authorization except to the extent that it has already been acted upon.
- Treatment will not be conditioned on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- Once this information is released it may be re-disclosed by the recipient and may no longer be protected information.
- I may have a signed copy of this authorization.

Patient or Personal Representative's Signature

Date

Description of Representative's Authority to Act for Patient

- This authorization will expire in 90 days.

CHRISTINE HARTER, M.D., P.C.

PATIENT REGISTRATION FORM

Welcome to Christine Harter, M.D., P.C. It is our pleasure to provide you with excellent health care in internal medicine and/or headache care.

Please take a few minutes to read the following policies that will help us serve you better, and make your visit more enjoyable.

1. If your address, telephone number, or Insurance Coverage changes, please notify us immediately.
2. Please arrive prior to the time of your appointment. If you are more than 15 minutes late, we may ask you to reschedule so that other patients are seen at their scheduled appointment times.
3. You may be charged \$50.00 if you miss an appointment, or do not cancel or reschedule 24-hours prior to your appointment. If you miss two appointments in a 12-month period, you may be DISCHARGED from the practice.
4. If you need a prescription refilled, please contact your pharmacy and they will contact us. Prescriptions will not be refilled after-hours or on weekends.
5. Messages left for Dr. Harter after 3:00 p.m., and on weekends, will not be returned until the next business day.
6. There is a \$25.00 charge per page for filling out any forms required by third parties, such as Disability Ins., Life Ins., Car Accidents, etc...
7. There is an administrative fee ranging from \$15 - \$50.00 if you request a copy of your medical records.
8. There will be a \$40.00 fee for all NSF checks. If your account is sent to collections for failure to pay account balance when due, you will be charged a collection fee of \$50.00 in addition to the amount you owe on your account.
9. No food or drink, other than water, is to be consumed in the waiting or exam rooms.
10. Minor children must be accompanied by a parent or legal guardian.

Thank you for your understanding, and please acknowledge your acceptance of these policies by signing and dating below.

Signature

Date: _____

Allergy History Survey

Name _____ Date _____

Occupation _____ Age _____

COMPLAINTS:

Please circle the appropriate number 1-5 according to severity: 1 = mild, 5 = very severe, 0 = no problem

| | | | |
|----------------------|-------------|---------------------------------|-------------|
| Nasal Discharge | 0 1 2 3 4 5 | Chronic Fatigue | 0 1 2 3 4 5 |
| Nasal Obstruction | 0 1 2 3 4 5 | Food Intolerance | 0 1 2 3 4 5 |
| Watery or itchy eyes | 0 1 2 3 4 5 | Frequent sinus or ear infection | 0 1 2 3 4 5 |
| Sneezing | 0 1 2 3 4 5 | Frequent colds or sore throats | 0 1 2 3 4 5 |
| Wheezing | 0 1 2 3 4 5 | Learning disability | 0 1 2 3 4 5 |
| Cough | 0 1 2 3 4 5 | Poor memory or concentration | 0 1 2 3 4 5 |
| Itching | 0 1 2 3 4 5 | Hyperactivity | 0 1 2 3 4 5 |
| Eczema | 0 1 2 3 4 5 | Abdominal gas or cramping | 0 1 2 3 4 5 |
| Hives | 0 1 2 3 4 5 | Arthritis or muscle aching | 0 1 2 3 4 5 |
| Headache | 0 1 2 3 4 5 | Asthma | 0 1 2 3 4 5 |

Other symptoms _____

Which (if any) foods cause you any problems? _____

In what year did your allergies start? _____

How many months of the year do you have allergies? _____

Have you been allergy tested before? _____ If yes, did you receive desensitization shots? _____

What prescription medications have you tried for allergies? How long did you use them?

1. _____ For how long? _____

2. _____ For how long? _____

3. _____ For how long? _____

4. _____ For how long? _____

Does any medication give you relief of symptoms? _____

List any animals you have in or around the home _____

Who else in your family has allergies? _____

How did you hear about our office? (Be specific. If a newspaper, please give name)
