Christine Harter M.D.,PC

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.: XXXXXXXXXXXXXXXXXXXXXXXXXX	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ 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? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Medicare	❑ AHCCCS	❑ AETNA	❑ HUMANA	❑ UHC

❑ BCBS	❑ STATE COMP	❑ CIGNA	❑ UNINSURED	❑ Other

Subscriber's name:	Subscriber's S.S. no.: XXXXXXXXXXXXXXXXXXX	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Pharmacy Name:	**Address:**	**Phone:**	

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ 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.

Patient/Guardian signature *Date*

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

<u>Christine Harter M.D., PC</u>

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	____

DATE: ____________________ SIGNATURE: ____

Effective Date of Notice: April 14, 2003

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

Notice of Privacy Practices

THIS NOTICE DESCIUBES 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 ofyour 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 denia1.
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. Ifwe 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 cel1ain disclosures Practice has made of your records. Upon your request, we will provide this information to you one time fi'ee 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

Form 1 64.520-A

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ____________________ Other Name: ____________________
Address: ____________________ 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.

Form 164.508-B

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

PATIENT REGISTRATION – OFFICE POLICIES

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 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.

8. No food or drink, other than water, is to be consumed in the waiting or exam rooms.

9. 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.

______________________________ Date: ____________

Signature