WARMINSTER MEDICAL ASSOCIATES
350 WEST STREET RD.
WARMINSTER, PA 18974
(215) 674-2440

Privacy Officer: Robert Topkis, D.O. **Effective Date:** April 1, 2003

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.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.

Medical History

Date ____________

Name: ______________________________ Birthdate: ____________ Sex: Male Female
Address: ______________________________ Home Phone: ____________
______________________________ Work Phone: ____________
______________________________ Cell Phone: ____________
Emergency Contact: ____________________ Phone Number: ________________
Social Security #: ____________
Marital Status: Single Married Divorced Widowed Separated
If married, spouse's name: ______________________________
Children's names and ages: ______________________________________
Insurance Name: ____________________ Holder of insurance: ____________
Insurance ID#: ____________________ Holder's Birthdate: ____________
Insurance Group#: ____________________

Allergies to Medications, X-Ray Dyes, or Other Substances: Yes or No
(If yes, please list name of medicines and type of reaction.)

____
____
____

Past Medical History and Review of Systems

Please check off if you have had any problems with or are presently experiencing any of the following:

__High Blood Pressure	__ Bronchitis	__Change in bowel habits	__Arthritis
__Diabetes	__ Pneumonia	__Unexplained weight gain/loss	__Low back problems
__Cancer	__ Persistent Cough	__Hemorrhoids	__Skin diseases
__Heart Disease	__ T.B.	__Gall Bladder disease	__Blood disorders
__Chest pain/chest Tightness	__ Hay fever	__Colitis	__Venereal Diseases
__Shortness of breath	__Abdominal discomfort	__Hepatitis or jaundice	__Anxiety
__Swollen ankles	__ Indigestion	__Thyroid disease	__Depression
__Palpitations	__Nausea	__Head or neck radiation	__Anemia
__Lightheadedness	__Vomiting	__Headache	__Alcohol abuse
__Frequent urination	__Constipation	__Kidney disease	__Drug abuse
__Rheumatic fever	__Diarrhea	__Kidney Stones	__Gout
__Asthma	__Blood in stool	__Difficulty urinating	__Impotence or Erectile Dysfunction
	__ Ulcers		__Other

____
____
____

Gynecologic and Obstetric History

Age at onset of periods ____________ Frequency ____________ Length of period ____________
Pregnancies ____________ Births ____________ Miscarriages ____________
Prolonged or abnormal bleeding No or Yes (please describe) ____________________
Leakage of urine No or Yes (please describe) ____________________
Pelvic pain No or Yes (please describe) ____________________
Abnormal discharge No or Yes (please describe) ____________________
History of abnormal Pap smear No or Yes (please describe ____________________
Method of birth control? ______________________________

Medical History (continued)

Please List and Supply the Dates of:

Operations: ______________ ______________ ______________

______________ ______________ ______________

Hospitalizations other than for surgery: ______________ ______________

______________ ______________ ______________

Immunization history - have you had:

Hepatitis B? No or Yes When? ______

Other? No or Yes When? ______

Pneumovax Immunization? No or Yes When? ______

Flu Immunization No or Yes When? ______

Tetanus Immunization No or Yes When? ______

When was your last:

Pap Smear? ______ Breast Exam? ______ Stool check for blood? ______

Mammogram? ______ Cholesterol check? ______ Prostate Exam? ______

Family History Has any member of your family ever had the following:
(including, parents, grandparents and siblings)

Illness	Which family members?	Age when diagnosed?
Cancer (describe type)		
Hypertention (high blood pressure)		
Heart Disease		
Diabetes		
Strokes		
Mental Disease(anxiety.depression.etc)		
Drug or alcohol addiction		
Glaucoma		
Bleeding diseases		
Other ______		

Medications (Prescriptions, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name Dose	Drug Name Dose	Drug Name Dose

Prevention

Do you wear seat belts? Yes or No If no. why not? ______

Do you wear a bike helmet? Yes or No or N/A

Do you exercise regularly? Yes or No If yes. type. duration. and number of times per Week? ______

Do you smoke? Yes or No If yes. how many packs per day? ______

Do you drink alcoholic beverages? Yes or No If yes. how much per week? ______

Do you drink coffee? Yes or No If yes. how many cups per day? ______

Do you drink tea? Yes or No If yes. how many cups per day? ______

If there is a gun in your home. do you keep it unloaded and out of children's reach? Yes or No or N/A

Do you use drugs? (marijuana.cocaine.crack.etc) Yes or No If yes. explain: ______

Have you ever engaged in any activity which has put you at risk of getting AIDS? Yes or No If yes. explain: ______

Do you wish to be tested for AIDS? Yes or No

Have you ever worked with chemicals. paints. asbestos. or other hazardous materials? Yes or No If yes. explain: ______

Are you in a relationship in which you have been physically hurt (e.g. slapped. kicked. punched. bruised) by your partner? Yes or No

Do you ever feel afraid of your partner? Yes or No or N/A

Do you have a "living will"? Yes or No

Do you have a donor card? Yes or No

This information is for use by your physician as part of your confidential medical record.
The above information is true and correct to the best of my knowledge.

Signature ______________ Date ______________