**Patient Name:______________________** **DOB: ____________**

# HIPPA Privacy Authorization Form

**Authorization for use or disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) **

**1. Authorization**

I authorize Trident Health Center to use and disclose the protected health information described below to

________________________________________(the company or name of individual seeking the information).

↑ **Name of a person who can call, schedule & obtain your medical records on your behalf.**

**2. Effective Period**

This authorization for release of information covers the period of healthcare from:

a. □ __________________ to __________________.

**** OR ****

b. □ All past, present and future periods.

**3. Extent of Authorization**

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable disease, HIV or AIDS, and treatment of alcohol or drug abuse).

**** OR ****

b. □ I authorize the release of my complete health record with the exceptions indicated below.

□ Mental Health Records
□ Communicable disease: (including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Other (please specify): ____________________________________________.

**Patient Name:______________________** **DOB: ____________**

4. This medical information may be used by the person I authorized to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until ____________ (date or event). At which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not affective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will be conditioned on whether I sign this authorization.

8. I understand that information used or disclose pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Name of patient:

____________________________________________

Signature of patient or personal representative (please include relationship):

____________________________________________

Date: ___________________________

**Patient Name:______________________** **DOB: ____________**

## Policies and Agreements Form

We appreciate you for choosing Trident Health Center as your primary care provider! Certain guidelines are put in place to ensure that we can give our patients outstanding medical care. Please take note of the following:

**Payment Policy:**

Payment is required when services are rendered. This allows us to offer quality medical care while keeping costs under control. You may pay by cash, Visa, Master Card, American Express, Apple Pay or Personal Check. We do not accept post-dated checks. In the event of a returned check, a $25 penalty fee will be charged. Insurance co-payments and outstanding balances (if any) must be paid at the time of service. In emergency situations where patient needs to have the co-payment billed at a later time, a $10 processing/handling fee will be added.

**No Show appointments / Same Day Cancellation:**

Please be mindful of the appointment that we have reserved for you. **We charge a $40 "No-Show" fee and a $30 fee for "Same Day Cancellation".**

Co-payments Under contractual obligations, we are required to always collect copay from patients. A copay does NOT guarantee full payment of service from your insurance carrier, it is your responsibility to know your insurance benefits. We only verify primary insurance as courtesy to our patients.

**Denial of Insurance Coverage:**

If Trident Health Center is given incorrect patient and insurance information resulting to a denial of coverage, then patient (or whoever is the responsible financial party) will be responsible for the full payment of denied coverage.

**Advanced Beneficiary/Agreement:**

For patients insured under Medicare, please note that your insurance does not pay for all of your health care cost. When you receive an item or service that is not a Medicare benefit, you are responsible to pay for it personally or through any other insurance that you may have.

**Times of Service Discount:**

For those patients and insurances that choose to pay the entire cost of the office visit (not including laboratory and/ or radiology costs) at the time of the visit, a time of service discount will be provided to tile patient. Please refer to self-Pay for further information.

**Changes to Office Policies and Agreements:**

Trident Health Center reserves the right to change the contents of this Policies and Agreements Form at any time. As our patient, you agree to abide by the most recent version of this form and you may ask for the revised copy from our front office staff.

Name: ______________________________________ Date: ________________

Signature: ___________________________________

**Patient Name:______________________** **DOB: ____________**

## Trident Health History Questionnaire

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any questions, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: ________________________________________________________________________

### ALLERGIES

**List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.**

| ALLERGY | REACTION |
| --- | --- |
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |

### MEDICATIONS

**Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.**

| DRUG NAME | STRENGTH | FREQUENCY TAKEN |
| --- | --- | --- |
| __________________ | _____________________ | ________________ |
| __________________ | _____________________ | ________________ |
| __________________ | _____________________ | ________________ |
| __________________ | _____________________ | ________________ |
| __________________ | _____________________ | ________________ |
| __________________ | _____________________ | ________________ |
| __________________ | _____________________ | ________________ |
| __________________ | _____________________ | ________________ |
| __________________ | _____________________ | ________________ |
| __________________ | _____________________ | ________________ |

### IMMUNIZATION HISTORY

**Immunizations and most recent date:**

- COVID Date: ___________
- Flu Shot Date: ___________
- Tetanus Date: ___________
- Pneumonia Date: ____________
- Zostavax Date: ____________
- Other: _________ Date: ____________

### PREVENTATIVE HEALTH SCREENING

**Screenings/Date:**

□ Colonoscopy Screening: _____________
□ Diabetic Eye Exam: ____________
□ Dexa / Bone Density: ____________
□ Mammogram: ______________

**OB/GYN History (women only):**

□ Last Pap Smear: ______________
□ Last Menstrual Period: ______________
□ Age of Menopause: ______________
□ Cesarean section. If yes, number: ______________

**Patient Name:_______________________** **DOB: ____________**

## PAST MEDICAL HISTORY

**Please check all that apply:**

☐ Anxiety Disorder
☐ Asthma
☐ Blood Clots (Deep Vein Thrombosis or Pulmonary Embolism)
☐ Cancer (If so, type: _______________)
☐ Coronary Artery Disease
☐ Diabetes (If so, type 1 or 2: _______________)
☐ Diverticulitis
☐ Fibromyalgia
☐ Gout
☐ Heart Attack

☐ Reflux Disease (GERD)
☐ HIV or AIDS
☐ High Cholesterol
☐ High Blood Pressure
☐ Thyroid Disease
☐ Kidney Disease
☐ Liver Disease
☐ Osteoporosis
☐ Stroke
☐ Tuberculosis

☐ COVID-19:
☐ Other: _____________

## PAST SURGICAL HISTORY

| Surgery | Reason | Year |
|---|---|---|
| _________________________ | _____________________ | _______________ |
| _________________________ | _____________________ | _______________ |
| _________________________ | _____________________ | _______________ |
| _________________________ | _____________________ | _______________ |
| _________________________ | _____________________ | _______________ |

## FAMILY HEALTH HISTORY

**RELATION:**

**SIGNIFICANT HEALTH PROBLEMS:**

**Grandmother** ☐ Maternal ☐ Paternal
☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Attack ☐ Stroke ☐ Asthma
☐ Depression ☐ Thyroid Problems ☐ Anxiety ☐ Cancer: _________ ☐ Other: __________

**Grandfather** ☐ Maternal ☐ Paternal
☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Attack ☐ Stroke ☐ Asthma
☐ Depression ☐ Thyroid Problems ☐ Anxiety ☐ Cancer: _________☐ Other: __________

**Grandmother** ☐ Maternal ☐ Paternal
☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Attack ☐ Stroke ☐ Asthma
☐ Depression ☐ Thyroid Problems ☐ Anxiety ☐ Cancer: _________ ☐ Other: __________

**Grandfather** ☐ Maternal ☐ Paternal
☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Attack ☐ Stroke ☐ Asthma
☐ Depression ☐ Thyroid Problems ☐ Anxiety ☐ Cancer: _________☐ Other: __________

**Mother**
→ → →
☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Attack ☐ Stroke ☐ Asthma
☐ Depression ☐ Thyroid Problems ☐ Anxiety ☐ Cancer: _________ ☐ Other: __________

**Father**
→ → →
☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Attack ☐ Stroke ☐ Asthma
☐ Depression ☐ Thyroid Problems ☐ Anxiety ☐ Cancer: _________☐ Other: __________

**Brother(s)**
→ → →
☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Attack ☐ Stroke ☐ Asthma
☐ Depression ☐ Thyroid Problems ☐ Anxiety ☐ Cancer: _________☐ Other: __________

**Sister(s)**
→ → →
☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Attack ☐ Stroke ☐ Asthma
☐ Depression ☐ Thyroid Problems ☐ Anxiety ☐ Cancer: _________☐ Other: __________

**Child(ren)**
→ → →
☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Attack ☐ Stroke ☐ Asthma
☐ Depression ☐ Thyroid Problems ☐ Anxiety ☐ Cancer: _________☐ Other: __________

**Patient Name:**______________________ **DOB:** ____________

## SOCIAL HISTORY

**Marital Status:**
□ Married □ Single □ Divorced
□ Separated □ Widowed
□ Domestic Partner

**Tobacco:**
□ Current □ Past □ Never
Cigarettes per day: _____
Chew per day: _____
Year(s) quit: ______

**Drugs (Recreational/Street):**
□ Current □ Past □ Never
Type of drug: __________
Year(s) quit: _______

**Alcohol:**
□ Current □ Past □ Never
If so, how often? ______
If so, Type? _________
Year(s) quit: ______

## MISCELLANEOUS:

**Local Pharmacy you would like prescription(s) sent to:**

______________________________________________________________________________

**Mail Order Pharmacy you would like prescription(s) sent to:**

______________________________________________________________________________

**Laboratory you would like us to use:**

______________________________________________________________________________

**Imaging Facility you would like us to use:**

______________________________________________________________________________