HOMETOWN
PHYSICIAN SERVICES

Patient Registration Form

Patient Name: _____

Community Address: _____

Date of Birth:_____ **Social Security #:** _____

Guarantor/Power of Attorney Name (if applicable):

Phone #:_____ Email:_____

Address: _____

Case Worker Name (if applicable):

Contact #:_____ Email:_____

Medicare ID #: _____

Primary Plan Name: _____

Primary Policy & Group # (if applicable): _____

Secondary Plan Name: _____

Secondary Policy & Group # (if applicable):_____

Checklist of Registration Information:

- ☐ ***Authorization for Release of Health Information (page 2 completed)***
- ☐ ***Power of Attorney / POA Document (if applicable)***
- ☐ ***Copies of ALL Insurance Cards***
- ☐ ***Current History & Physical (H&P) from Provider (Face Sheet, Diagnosis, Current Medication List)***

I have read and agree to Hometown Physician Services Patient HIPAA Acknowledgement, Consent for Services and Insurance, and Notice of Privacy Practices (the attached pages 3-6).

Patient's Name (or legal representative) _____ **Date** _____

To Submit Enrollment, Fax to: 715-997-7044 or Email to: enrollment@hometownphysicianservics.com or go to www.hometownphysicianservices.com, & click "Patient Enrollment" to get started QUESTIONS, Please Call: 715-600-0549

Authorization for Release of Health Information

Patient Name:_____ **Date of Birth:** _____

This Form Authorizes Release of Patient Information to:

Hometown Physician Services / Medical Records
8687 Eagle Point Blvd.
Lake Elmo, MN 55042
Phone: 715-600-0549

Email: enrollment@hometownshysicianservices.com

FAX: 715-998-7044

Release Information from:

Provider Name: _____

Phone: _____

FAX: _____

Address: _____

_____

Information to be released

IMPORTANT: Indicate only the information that you are authorizing to be released

- ☐ **Specific dates / years of treatment:** _____
- ☐ **ALL HEALTH INFORMATION**

OR indicate portions of health information to be released:

☐ **History / Physical**	☐ **Surgical Report**	☐ **Care Plan**
☐ **Laboratory Reports**	☐ **Radiology Reports**	☐ **Discharge Summary**
☐ **Progress Notes**	☐ **Radiology Images**	☐ **Immunizations**
☐ **Medications**	☐ **Emergency Room**	☐ **Billing Records**

☐ **Other Information / Instructions:** (indicate specifics below)

The following information required special consent by law. Even if you indicate ALL HEALTH INFORMATION above, you must specifically request the following information in order for it to be released:

- ☐ **Chemical dependency program**
- ☐ **Psychotherapy notes (this cannot be combined with any other area listed above)**

MANDATORY: Name of professional releasing psychotherapy notes:

Health information includes written and oral information. I hereby authorize the release of my individually identifiable health information described above for treatment and payment purposes. I understand that this authorization to release information is voluntary. I understand that the information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law.

I understand that my healthcare provider will not condition treatment, payment, enrollment or eligibility for benefits on weather I sign the consent form. I understand I may request a copy of this form after I sign it. I understand that this authorization may be revoked by me by written notice to Hometown Physician Services.

This consent will end one year from the date the form is signed unless I indication and early date or event here: Date: Or specific event:

Patient or Legal Representative Signature:_____ **Date:** _____

If Legal Rep., Printed Name and Relationship to Patient: _____

Medical POA or Health Care Directive documentation must be included if signing on behalf of patient.

Hometown Physician Services

Patient HIPAA Acknowledgement, Consent for Services and Insurance

NOTICE OF PRIVACY PRACTICES: I acknowledge I have received a copy of Hometown's Physician Services Notice of Privacy Practices and I understand that I have a right to review these privacy practices before signing this consent form. I understand that Hometown Physician Services may change its privacy practices in the future. If privacy practices change, I understand that the new privacy practices will be posted on Hometown Physician Services website and that I may request a copy of the new privacy practices at any time. I also understand that I can contact Hometown Physician Services Privacy Officer with any questions I may have about the Notice of Privacy Practices.

RELEASE OF INFORMATION: I hereby permit Hometown Physician Services and the physicians or other health professionals involved to release healthcare information for purposes of treatment, payment, or healthcare operations. I also consent to the release and disclosure of my health care information to health care providers and facilities unrelated to Hometown Physician Services that may be involved in my care.

INSURANCE ASSIGNMENT & PAYMENT CONSENT: I give permission to Hometown Physician Services to release my protected health information, including paper or electronic records of my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment, to my Health Insurance Company, Health Maintenance Organization or Medical Assistance Program for the purposes of payment, treatment or health care operations. I understand that this information serves as a source of information for applying my diagnosis and treatment information to my medical bill; a verification to third party payers that I did in fact receive these health care services; and a tool for routine health care operations such as quality review of the staff performance at Hometown Physician Services.

PATIENT CENTERED MEDICAL HOME & CHRONIC CARE MANAGEMENT: I give Hometown Physician Services permission to enroll me in the Hometown Physician Services on-site primary care program. This care program includes physician/care management on-site visits, and related activities, which will be billed to my insurance with standard deductibles and copays.

This consent applies to health records that Hometown Physician Services already have about me, and information about future care I may receive from them. This consent will continue unless I cancel by giving written notice to Hometown Physician Services or it expires as required by law. If I cancel the consent, it will apply to information generated after the date when the notice to cancel is received.

Hometown Physician Services

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.

The Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (HIPAA), as amended, is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse Protected Health Information (PHI).

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your Protected Health Information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities. We may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may call your home and leave a message (either on an answering machine or with the person answering the phone) to remind you of an upcoming appointment, the need to schedule a new appointment or to call our office. We may also mail a postcard reminder to your home address. If you would prefer that we call or contact you at another telephone number or location, please let us know.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization, or Opportunity to Object unless required by law. Use and disclosures of PHI for marketing purposes, as well as disclosures that constitute a sale of PHI, require an authorization from you.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

The Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. If such information is maintained in an Electronic Health Record (EHR), your access rights include the right to a copy in an electronic format. We have the right to charge you a fee for the copying of paper records, and in the case of a request for an electronic copy of your PHI maintained in an EHR (or a summary or explanation of such information) we have the right to charge you the amount of labor costs in responding to your request. Your right to inspect and obtain a copy of your PHI extends only to your PHI contained in our Designated Record Set for you. A "Designated Record Set" is the HIPAA term for medical and billing records and any other records that we use for making health care decisions about you.

You have the right to request a restriction of your health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply. Any such request for restrictions must be in writing, be addressed to the Privacy Officer, and state the specific restriction requested and to whom you want the restriction to apply. However, we are not required to comply with your request, unless you are asking us to restrict the use and disclosure of your PHI to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full.

Your physician is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health

information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. However, we may condition this accommodation by asking you for information as to how payment will be handled or a specification of an alternate address or other method of contact. We will not request an explanation from you as to the basis for the request. Your request must be in writing, be addressed to the Privacy Officer, and state the specific alternate means or location.

You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health information contained in your Designated Record Set if you believe it is incorrect or incomplete. However, we are not required to make any such amendments. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. All of these documents will be placed in the appropriate part of your Designated Record Set. If you are requesting that we amend your records because you believe that you are a victim of medical identity theft, we will use reasonable efforts to assist you in making corrections to your record which are determined to be appropriate under the circumstances.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. Affected individuals have the right to be notified in the event of a breach of unsecured PHI.

We reserve the right to change the terms of this Notice and will keep updated version on company website. You then have the right to object or withdraw as provided in this Notice.

To exercise any of your rights above, please contact our privacy officer in writing.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint at our office and main telephone number listed below. We will not retaliate against you for filing a complaint.

This Notice was originally published and became effective on May 29, 2019.

Contact Us

If you have any questions about this Notice of Privacy Practices, please contact us at:

Email: info@hometownphysicianservices.com

Fax: 715-997-7044

Phone: 715-600-0549

Mailing Address: **Hometown Physician Services**
8687 Eagle Point Blvd.
Lake Elmo, MN 55042