KEVIN L. PRITCHETT, M.D., P.C.

(PLEASE PRINT ALL INFORMATION)

PATIENT INFORMATION:

Patients Full Name: _____ **M (or) F**

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

Street Address: _____

City: _____ **State:** _____ **Zip** _____

Phone Number: _____ **Cell:** _____

Employer: _____ **Employer Phone Number:** _____

PRIMARY INSURANCE:

Insurance Name: _____

Group #: _____ **ID#** _____

Policyholders Name: _____

Relationship to Patient: _____

Policyholders Date of Birth: _____ **Policyholders Employer:** _____

SECONDARY INSURANCE:

Insurance Name: _____

Group #: _____ **ID#** _____

Policyholders Name: _____

Relationship to Patient: _____

Policyholders Date of Birth: _____ **Policyholders Employer:** _____

(IF MARRIED PLEASE GIVE SPOUSE INFORMATION BELOW:)

Spouses Name: _____ **Spouses Employer:** _____

Spouses Date of Birth: _____

SIGNATURE: _____ **DATE:** _____

(There are (4) pages to be completed.)

(IF PATIENT IS A MINOR PLEASE COMPLETE THE FOLLOWING:)

Name of Responsible Party: _____

Relationship to Minor: _____

Street Address: _____

City: _____ **State:**_____ **Zip:** _____

IN CASE OF EMERGENCY CONTACT:

Name: _____ **Relationship:**_____

Address & Phone#:_____

_____

Name: _____ **Relationship:**_____

Address & Phone#:_____

_____

I hereby assign payment of authorized medical and or surgical benefits to include major medical benefits to which I am entitled, to be made on my behalf to Kevin L. Pritchett, M.D., P.C. for any services furnished me by that physician/supplier. I authorize release of medical information needed to determine these benefits payable to related services. I understand that I am financially responsible for all charges whether or not paid by said insurance within the law. I also understand that all office copays are due at time of service. Kevin L. Pritchett, M.D., P.C. does not deny benefits or service because of or based on race, color, age, gender, disability, religious or political beliefs. If you feel that you have been discriminated against, you may file a Complaint of Discrimination of this facility. You will not suffer any penalty because you file a complaint. In addition, I agree to pay a $25.00 service fee for any returned check and any additional charges related to the cost of collection (including but not limited to collection agency fees, reasonable attorney fees and court costs), in the event that I would fail to pay my bill.

Guarantor's Signature _____ **Date** _____

KEVIN L. PRITCHETT, M.D., P.C.

Authorization to Release Information to Specified Family Members And Close Friends

PATIENT NAME: _____ **D.O.B.**_____

Authorization to Release Health Information to Family Members & Close Friends

I authorize **Kevin L. Pritchett, M.D., P.C.** to disclose health and/or financial information to the following family members and/or close friends to the extent necessary to help with your healthcare or financial information.

Name	Relationship	D.O.B or S.S.N
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please indicate whether we may leave messages on your voicemail and/or answering machine regarding appointments, test results, medication instructions, or other healthcare information.
Please circle: (YES or NO)

_____ _____
Signature of Patient/Guardian/Parent **Date**

_____
Relationship of Patient Representative to Patient

KEVIN L. PRITCHETT, M.D., P. C.

Acknowledgement of Receipt of Notice of Privacy Practices

Acknowledgement of Receipt

Kevin L. Pritchett, M.D., P.C. reserves the right to modify the privacy practices outlined in the notice.

Signature
I have received a copy of the Notice of Privacy Practices for **Kevin L. Pritchett, M.D., P.C.**

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient

Inability to Obtain Acknowledgement of Receipt

Attempt to Obtain Acknowledgement
An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices on _____. The acknowledgement was not obtained because:

- ☐ The patient was undergoing emergency treatment
- ☐ The patient declined to sign the acknowledgement
- ☐ Other _____

Signature

_____
Name of Patient (Print or Type)

_____
Name of Staff Member

_____
Date

KEVIN L. PRITCHETT, 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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of **Kevin L. Pritchett, M.D., P.C.** For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

Fund raising. Unless you request us not to, we will use your name and address to support our fund-raising efforts.

KEVIN L. PRITCHETT, M.D., P. C.

Individual Rights
You have certain rights under the federal privacy standards. These include:

- ☐ the right to request restrictions on the use and disclosure of your protected health information
- ☐ the right to receive confidential communications concerning your medical condition and treatment
- ☐ the right to inspect and copy your protected health information
- ☐ the right to amend or submit corrections to your protected health information
- ☐ the right to receive an accounting of how and to whom your protected health information has been disclosed
- ☐ The right to receive a printed copy of this notice

Kevin L. Pritchett, M.D., P.C. Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the **Privacy Officer.** Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
Brenda Erlinger
100 Springfield Court
O'Fallon, Illinois 62269

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is:

Privacy Officer
Brenda Erlinger
100 Springfield Court
O'Fallon, Illinois 62269
618-632-3565

Effective Date
This Notice is effective on or after **April 13, 2003.**