NSU
NOVA SOUTHEASTERN UNIVERSITY
Dr. Kiran C. Patel College of Osteopathic Medicine

PATIENT REGISTRATION FORM

Today's Date: _____ NSU ID: N_____ College: _____

Patient's Last Name: _____ First Name: _____ Middle Name:_____

Birth Date: _____/_____/_____ Gender: ☐ Male ☐ Female

Address: _____City: _____State: _____ ZIP Code: _____

Home Phone: _____ Cell Phone: _____

Patient Portal (sign up with your email): _____

Race:

___ American Indian Or Alaska Native ___ Black or African American ___Hispanic Or Latino (All Races)
___ Asian ___Multiracial ___ Native Hawaiian or Other Pacific Islander
___White ___Patient declined to state

Ethnicity:

___ Hispanic or Latino ___Not Hispanic or Latino ___Patient decline to state
___Unknown/Not Reported

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Partner

Spouse/Partner's Name: _____

☐ Visually Impaired ☐ Hearing Impaired Primary Language: _____

Parent / Guardian name if patient is a minor:

Last Name:_____ First Name:_____ Middle Name:_____

Address if different: _____City: _____State: _____ ZIP Code: _____

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship: _____ Phone: _____

Name:_____ Relationship: _____ Phone: _____

Do you have an Advanced Directive (Living Will)? ❑ Yes ❑ No (*If yes, please provide a copy for your medical records)*

PREFERRED PHARMACY INFORMATION

Pharmacy name:_____Phone: _____ Fax:_____

Address: _____City: _____State: _____ ZIP Code: _____

MRN # _____

WHO IS FINANCIALLY RESPONSIBLE FOR THE PATIENT (GUARANTOR)

Patient: ☐ Yes ☐ No if no, please provide details below.

Last Name:_____ First Name:_____ Middle Name:_____

Address: _____City: _____State: _____ ZIP Code: _____

Birth Date: ____/____/_____ Gender: ☐ Male ☐ Female Social Security Number: _____-____-_____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Ext: _____ E-mail Address: _____

Guarantor's Employer: _____

Patient's Relationship to Guarantor: _____

PRIMARY INSURANCE INFORMATION

Primary Insurance Company Name: _____

Insurance ID # _____ Group # _____

Customer Service or Benefits Phone:_____

Authorization or Certification Phone: _____

Is the Patient the primary policy holder: ☐ Yes ☐ No

Is the Guarantor the primary policy holder: ☐ Yes ☐ No

If both answers are no, please complete the information below regarding the primary policy holder.

Last Name:_____ First Name:_____ Middle Name:_____

Birth Date: ___/____/_____ Patient's Relationship to Insured: _____

Address: _____City: _____State: _____ ZIP Code: _____

Home Phone: _____ Mobile Phone: _____

Employer: _____

Work Phone: _____ Ext: _____

SECONDARY INSURANCE INFORMATION

Do you have secondary insurance? Yes ☐ No ☐

If yes, please complete the information below regarding the primary policy holder on the secondary insurance.

Secondary Insurance Company Name: _____

Insurance ID #: _____ Group #: _____

Customer Service or Benefits Phone:_____

Authorization or Certification Phone: _____

Is the Patient the primary policy holder: ☐ Yes ☐ No

Is the Guarantor the primary policy holder: ☐ Yes ☐ No

If both answers are no, please complete the information below regarding the primary policy holder.

Last Name: _____ First Name: _____ Middle Name:_____

Birth Date: ___/_____/_____ Patient's Relationship to Insured: _____

Address: _____City: _____State: _____ ZIP Code: _____

Home Phone: _____ Mobile Phone: _____

Employer: _____

Work Phone: _____ Ext: _____

I certify that the above information is my personal information and has not been fraudulently derived. I understand that it is my responsibility to notify NSU Medical Center of any changes to the above instructions.

_____ _____

Signature of Patient or Patient's Authorized Representative Date

If signed by the Patient's Representative, please print name and describe relationship to patient or other authority to act:

_____ _____

Name Relationship to Patient

NSU NOVA SOUTHEASTERN UNIVERSITY

HIPAA NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of the Nova Southeastern University Medicine Health Care Centers HIPAA Notice of Privacy Practices.

_____ _____

Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below.

_____ _____

Personal Representative Name (Print) Personal Representative Signature

_____

Relationship

FOR OFFICE USE ONLY

I have made a good faith effort to obtain a written acknowledgement of receipt of the NSU Notice of Privacy Practices. However, an acknowledgement was not obtained because:

- ❑ Patient refused to sign.
- ❑ Patient was unable to sign or initial because: _____
- ❑ Due to an emergency situation it was not possible to obtain an acknowledgment.
- ❑ Other: _____

_____ _____

Employee Signature Date

Date: April 2003

Revision: May 2014 File in Patient Chart

NSU NOVA SOUTHEASTERN UNIVERSITY

HIPAA 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.

Purpose of this Notice

We are required by law to maintain the privacy of your protected health information. This notice applies to all records of the health care and services you received at Nova Southeastern University ("NSU"). This notice will tell you about the ways in which we may use and disclose your protected health information. This notice also describes your rights and certain obligations we have regarding the use and disclosure of your protected health information.

I. Uses and Disclosures of Protected Health Information

NSU may use and disclose your health information, that is, information that constitutes protected health information ("PHI") as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for the purposes of providing treatment, obtaining payment for treatment and conducting health care operations. The following categories describe different ways that we use and disclose your PHI. For each category of uses or disclosures we will explain what we mean and give you some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information fall within the categories below.

A. Treatment. We will use and disclose your PHI 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 treatment purposes. For example, we may disclose your PHI to a pharmacy to fulfill a prescription, to a laboratory to order a blood test, or to a home health agency that is providing care in your home. We may also disclose PHI to other health care providers who may be treating you or consulting with your health care provider with respect to your care. In some cases, we may also disclose your PHI to an outside health care provider for purposes of the treatment activities of the other provider.

B. Payment. Your PHI will be used, as needed, to bill and collect payment for your health care services. Your PHI 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. In addition, uses of PHI for payment purposes may also include certain communications to your health insurer to get approval for the treatment that we recommend. For example, if a hospital admission is recommended, we may need to disclose information to your health insurer to get prior approval for the hospitalization. We may also disclose protected information to your insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for your services, we may also need to disclose your PHI to your insurance company to demonstrate the medical necessity of the services, or as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your case for the other provider's payment activities. We may release information to an outside agency for collection purposes.

C. Operations. We may use or disclose your PHI, as necessary, for our own health case operations in order to facilitate the function of NSU and to provide quality care to our patients. Health care operations include such activities as

- Quality assessment and improvement activities;
- Employee review activities;
- Training programs including those in which students, trainees, or practitioners in health care learn under supervision;
- Accreditation, certification, licensing, or credentialing activities;
- Review and auditing, including compliance reviews, medical reviews, legal services, and maintaining compliance programs; and
- Business management and general administrative activities.

In certain situations, we may also disclose patient information to another health care provider or health plan for their health care operations.

D. Other Uses and Disclosures. As part of treatment, payment, and health care operations, we may also use or disclose your PHI for the following purposes:

- To remind you of an appointment (appointment reminders may be communicated by mail or by leaving a message on the answering machine of a telephone number that you have provided);
- To inform you of potential treatment alternatives or options;
- To inform you of health-related benefits or services that may be of interest to you; and
- To provide refill reminders or otherwise communicate about a drug or biologic that is prescribed to you (our costs for sending these prescription-related communications may be subsidized by third parties).

E. To Business Associates. Sometimes it is necessary for us to hire outside parties (business associates) to help us carry out certain health care operations or services. These services are provided in our organization through contracts with the business associates. Examples include computer maintenance by outside companies, consultants and transcription of medical records. When these services are contracted, we may disclose your PHI to our business associates so that they can perform the job we've asked them to do. Similarly, there are departments of NSU that provide services to us, and may need access to your PHI to do their jobs. We

require business associates and other NSU departments to appropriately safeguard your information.

II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object

Federal privacy rules allow us to use or disclose your PHI without your permission or authorization for a number of reasons including the following:

A. When Legally Required. We will use or disclose your PHI when we are required to do so by any Federal, State or local law. Any use or disclosure under this section will comply with and be limited to the relevant requirements of any such law.

B. When There Are Risks to Public Health. We may disclose your PHI for public health activities and purposes. For example, public health activities generally include:

- To prevent, or control, disease, injury, or disability as permitted by law;
- To report disease, injury and vital events such as birth or death as permitted or required by law;
- To conduct public health surveillance, investigations, and interventions as permitted or required by law;
- To collect or report adverse events and product defects or problems; to track FDA-regulated products; to enable product recalls, repairs, replacements, or look back to the FDA and to conduct post-marketing surveillance;
- To notify patients of recalls of products they may be using;
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease or condition, as authorized by law;
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required, to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury; and
- To report to a school about an individual who is a student or prospective student of the school if the PHI disclosed is limited to proof of immunization and the school is required by State or other law to have such proof of immunization prior to admitting the individual.

C. To Report Abuse, Neglect, or Domestic Violence. We may notify government authorities, including a social service or protective services agency, if we reasonably believe that a patient is the victim of abuse, neglect, or domestic violence. Although every person has a responsibility to report suspected abuse or neglect, certain occupations are required to do so. These occupations are considered "professionally mandatory reporters," for example, health professionals and mental health professionals. It is the responsibility of the professionally mandatory reporters to alert the proper authorities in the event a minor, elderly, or vulnerable adult patient is identified as a victim of alleged or suspected neglect or abuse including sexual abuse, and to comply with proper procedures for the reporting as required or authorized by law.

D. To Conduct Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law such as audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

E. In Connection with Judicial and Administrative Proceedings. We may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process if we receive satisfactory assurance from the party seeking the information that either reasonable efforts have been made to ensure that you have been given notice of the request, or reasonable efforts have been made to obtain an order protecting the information requested.

F. For Law Enforcement Purposes. We may disclose your PHI to a law enforcement official for certain law enforcement purposes including:

- As required by law for reporting of a gunshot wound or other physical or life-threatening injury indicating an act of violence;
- Pursuant to court order, court-ordered warrant, subpoena, summons or similar process;
- For the purpose of identifying or locating a suspect, fugitive, material witness, or missing person;
- Under certain limited circumstances, when you are or are suspected to be the victim of a crime;
- To a law enforcement official if NSU has a suspicion that your death was the result of criminal conduct;
- To report a crime in an emergency situation; and
- In the event a minor, elderly, or vulnerable adult patient is identified as a victim of alleged or suspected neglect or abuse including sexual abuse.

G. To Coroners, Funeral Directors, and for Organ Donation. We may disclose PHI to a coroner or medical examiner for identification purposes, to determine cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorize by law, in order to permit the funeral director to carry out his or her duties. PHI may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.

H. For Research Purposes. Under certain circumstances, we may use and disclose your PHI for research purposes. We also may retain samples from tissue, teeth or blood and other similar fluids normally discarded after a medical procedure for later use in research projects. All these research projects, however, are subject to a special review and approval process, by the institutional review board ("IRB"). This process evaluates a proposed research project and its use of PHI, trying to balance the research needs with patients' need for privacy of their PHI. Before we use or disclose PHI for research, the project will have been approved through this research approval process. In some cases, your authorization would be required. In other cases it may not, where the review process determines that the project creates no more than a minimal risk to privacy, obtaining your authorization would not be practical and the researchers show they have a plan to protect the information from any improper use or disclosure. We may also disclose your PHI to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the health care center. If a research project can be done using health information from which all the information that identifies you (such as your name, social security number and medical record number) has been removed, we may use or release the data without special

approval. We also may use or disclose data for research with a few identifiers retained—dates of birth, treatment, and general information about the area where you live (not your address), without special approval. However, in this case we will have those who receive the data sign an agreement to appropriately protect it. In the event that you participate in a research project that involves treatment, your right to access health information related to that treatment may be denied during the research project so that the integrity of the research can be preserved. Your right to access the information will be reinstated upon completion of the project.

I. In the Event of a Serious Threat to Health or Safety. We may, consistent with applicable law and ethical standards of conduct, use or disclose your PHI if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

J. For Specified Government Functions. In certain circumstances, the Federal regulations authorize NSU to use or disclose your PHI to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and other law enforcement custodial situations.

K. For Worker's Compensation. We may release your health information to comply with worker's compensation laws or similar programs.

L. Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official under specific circumstances such as (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

III. Uses and Disclosures Permitted Without Authorization, but with Opportunity to Object

We may disclose your PHI to your family member(s), a close personal friend, or any other person identified by you, if the disclosure is directly relevant to the person's involvement in your care or payment related to your care. We can also disclose your information in connection with trying to locate or notify family member(s) or others involved in your care concerning your location, condition, or death.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your PHI as described.

IV. Uses and Disclosures Which You Authorize

Other than as stated above, we will not disclose your health information other than with your written authorization. We will apply special protections to psychotherapy notes and will not release such notes without your signed authorization unless they are being used by your treating provider, by mental health students under supervision of your treating provider or by NSU to defend a legal action.

We cannot use your information for marketing or sell your protected health information without your specific authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

V. Your Rights

You have the following rights regarding your health information:

A. The Right to Inspect and Copy Your PHI. You may inspect and obtain a copy of your PHI that is contained in a designated record set for as long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that are used to make decisions about you.

To the extent electronic records are implemented, you do not have the right to actually inspect or access the electronic medical record system. If you request access to part of a designated record set that is maintained in electronic format the information will be printed on paper or downloaded to a compact disk ("CD") or other electronic format upon your request provided that we are able to readily produce the requested format.

Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to a law under which, you may not have the right to have a denial for access reviewed.

We may deny your request to inspect or copy your PHI if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, that it is likely to cause substantial harm to another person reference within the information, or that the request was made by your personal representative and it is determined that the personal representative is reasonably likely to cause substantial harm to your or another person. You have the right to request a review of this decision.

To inspect or copy your medical information, you must submit a written request to the NSU Health Care Center/Clinic where you received services and direct the correspondence to the HIPAA Liaison. The contact information for that NSU Health Care Center/Clinic is attached to the notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other costs incurred by us in complying with your request.

Please contact our Privacy Officer if you have questions about access to your medical record.

B. The Right to Request a Restriction on Uses and Disclosures of Your PHI. You may ask us, in writing, not to use or disclose certain parts of your PHI for the purposes of treatment, payment, or health care operations. You may also request, in writing, that we do not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

NSU is not required to agree to a restriction that you may request. We will notify you in writing if we deny your request to a restriction.

Although NSU is not required to agree to most restrictions, if you pay for health care services out of pocket in full and do not wish the services to be counted toward an insurance deductible you may request that the information related to these services not be included in any disclosures to a health plan. There may be circumstances where NSU has a legal requirement to submit a bill to health

plan and will be unable to provide services to you consistent with this request.

If NSU does agree to a requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. If one health care center/clinic agrees to a restriction, the restriction applies only to the facility that agreed, unless you submit the request to and receive written agreement to the restriction from the other health care centers/clinics at NSU. Under certain circumstances, we may terminate a restriction. You may request, in writing, a restriction by contacting the HIPAA Liaison at the NSU Health Care Center/Clinic where you received services.

C. The Right to Request to Receive Confidential Communications from Us by Alternative Means or at an Alternative Location. You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made, in writing, to the HIPAA Liaison at the NSU Health Care Center/Clinic where you received services.

D. The Right to Request Amendment of Your PHI. You may request an amendment of PHI about you in a designated record set for as long as we maintain this information. If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or add to the record. In this written request, you must also provide a reason to support the requested amendment. We will respond within 60 days of receiving your request. We may deny the request in writing, if we determine that the PHI is: (1) correct and complete; (2) not created by us and/or not part of our records, or; (3) not permitted to be disclosed or inspected. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If we approve the request for amendment, we will change the PHI and so inform you. Requests for amendment must be directed to the HIPAA Liaison at the NSU Health Care Center/Clinic where you received services.

E. The Right to Receive an Accounting. You have the right to request, in writing, an accounting of certain disclosures of your PHI made by NSU. This right applies to disclosures for purposes other than treatment, payment, or health care operations as described in this Notice of Privacy Practices. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a facility directory, disclosures to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made, in writing, to the HIPAA Liaison at the NSU Health Care Center/Clinic where you received services. The request should specify the time period sought for the accounting. Accounting requests may not be made for periods of time dating more than six years prior to the date of the request. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

F. The Right to Obtain a Paper Copy of This Notice. Upon request, we will provide a separate copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically.

G. Right to Receive Notice of Breach. We will give you written notice in the event we learn of a breach of unsecured protected health information. We will notify you as soon as reasonably possible but not later than sixty (60) days after the breach has been discovered.

VI. Our Duties

NSU is required by law to maintain the privacy of your health information and to provide you with this Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI that we maintain. We will post a copy of the current Notice of Privacy Practices in each of our health care centers/clinics. The Notice of Privacy Practices will contain under Section VIII the effective date. In addition, each time you register for services at NSU for treatment or health care services, you may request a copy of the current notice in effect.

VII. Complaints

You have the right to express complaints to NSU and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may file a complaint with NSU by contacting, in writing, the HIPAA Liaison at the NSU Health Care Center/Clinic where you received services. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

VIII. Effective Date.

This Notice was originally effective April 14, 2003.
Last updated May 2014.

Nova Southeastern University
Medicine Health Care Centers
HIPAA Notice of Privacy Practices—Contact Persons

Contact Persons

NSU's contact person for all issues regarding patient privacy and your rights under the Federal privacy standards is the NSU Medicine Health Care Centers HIPAA Liaison. Information regarding matters covered by this Notice can be requested by contacting the HIPAA Liaison in writing. Complaints against NSU can be mailed to the HIPAA Liaison by sending it to:

HIPAA Liaison

Dr. Edward Packer
Nova Southeastern University
College of Osteopathic Medicine
3200 South University Drive
Fort Lauderdale-Davie, Florida 33328
Telephone: (954) 262-1702

In addition, complaints against NSU may also be mailed to the Privacy Officer by sending it to:

Robin Supler
Nova Southeastern University
3200 S. University Drive
Fort Lauderdale - Davie, FL 33328
Tel: (954) 262-1922
Fax: (954) 262-4043

NOVA SOUTHEASTERN UNIVERSITY HEALTH CARE CENTER
PATIENT HISTORY FORM

Patient's Name: _____ Today's Date: _____

Social Security Number: _____ Date of Birth: _____

Past Medical History

Previous Physician's name: _____ Date of last exam: _____

Have you ever been hospitalized? ☐Yes ☐No If yes, what for? _____

Have you ever been tested for hepatitis A, B or C? ☐Yes ☐No Which hepatitis virus? _____

Have you been vaccinated for hepatitis B? ☐Yes ☐No If yes, date vaccine series completed _____

Have you been vaccinated for hepatitis A? ☐Yes ☐No If yes, date vaccine series completed _____

Last Tuberculosis (TB) Screening? _____ Result of TB screening: ☐Positive ☐Negative

If positive TB screen, date of last chest x-ray: _____ Result of chest x-ray: ☐Positive ☐Negative

Have you had a sexually transmitted disease? ☐Yes ☐No Diagnosis: _____

Which of the following conditions are you currently being treated or have been treated for in the past (please check)

☐Heart disease / Murmur / Angina	☐Shortness of breathe	☐Eye disorder / Glaucoma	☐Diabetes
☐High cholesterol	☐Asthma	☐Seizures	☐Kidney / Bladder problems
☐High blood pressure	☐Lung problems / cough	☐Stroke	☐Liver problems / Hepatitis
☐Low blood pressure	☐Sinus problems	☐Headaches / Migraines	☐Arthritis
☐Heartburn (reflux)	☐Seasonal allergies	☐Neurological problems	☐Cancer
☐Anemia or blood problems	☐Tonsillitis	☐Depression / Anxiety	☐Ulcers/colitis
☐Swollen ankles	☐Ear problems	☐Psychiatric care	☐Thyroid problems

Please describe any current or past medical treatment not listed above

_____

_____

Please list your past surgeries

_____

_____

Allergies

Are you allergic to penicillin or any other drugs? ☐Yes ☐No

Please list: _____

Medications

Please list: _____

_____

PLEASE COMPLETE REVERSE SIDE →

Social and Preventive History

Do you currently smoke or chew tobacco? ☐Yes ☐No If no, have you in the past? ☐Yes ☐No
How many packs per day? _____

Do you drink alcohol, beer, or wine? ☐Yes ☐No If no, have you in the past? ☐Yes ☐No
How many drinks per week? _____

Do you currently drink coffee and/or tea? ☐Yes ☐No If yes, how many cups per day? _____

Do you exercise daily/weekly? ☐Yes ☐No

Do you use seatbelts while driving? ☐Yes ☐No Do you wear a helmet while riding a bike? ☐Yes ☐No

Family History

	Living	Age (or age at death)	List serious illnesses
Mother	☐Yes ☐No	_____	_____
Father	☐Yes ☐No	_____	_____
Sisters	☐Yes ☐No	_____	_____
	☐Yes ☐No	_____	_____
	☐Yes ☐No	_____	_____
Brothers	☐Yes ☐No	_____	_____
	☐Yes ☐No	_____	_____
	☐Yes ☐No	_____	_____

Has any member of your family (including children and parents) had any of the following illnesses:

Illness	Which family member?
Anemia or Blood disease	_____
Cancer	_____
Diabetes	_____
Glaucoma	_____
Heart disease	_____
High blood pressure	_____
HIV disease / AIDS	_____
Mental Illness / Depression	_____
Stroke	_____
Other serious illness	_____

Females: Gynecological History

How many times have you been pregnant? _____ Date of last Pap Smear: _____

Have you had an abnormal Pap Smear? ☐Yes ☐No Diagnosis: _____ Follow up: _____

Have you had a sexually transmitted disease? ☐Yes ☐No Diagnosis: _____
Date of last mammogram: _____ Mammogram results: _____

Have you ever had a breast biopsy? ☐Yes ☐No Biopsy results: _____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature _____ **Date** _____

NOVA SOUTHEASTERN UNIVERSITY
Health Professions Divisions
Student Medical Center

CONSENT AND AGREEMENT FOR TREATMENT AND RELEASE OF INFORMATION FOR TREATMENT AND HEALTH CARE OPERATIONS
Please read the following information carefully. After you have read this Consent and Agreement for Treatment ("Agreement") please sign your name below to accept the terms of this agreement.

1. **Authorization for Routine Medical Treatment:** I hereby consent to such medical treatment for myself or my child which in the judgment of my health care provider may be considered necessary or advisable while a patient at Nova Southeastern University Inc., and it's health care providers, employees and agents ("NSU").

2. **Teaching Facilities:** I am aware that the NSU Health Care Centers are teaching facilities, and as a result, medical residents, medical students, and other medical career students will be involved in my care and treatment under appropriate supervision of clinical faculty.

   I am aware that the NSU Student Medical Center does not involve medical residents, medical students, and other medical career students in my care and treatment. In addition, I am aware that should I access care and treatment at any other NSU Health Care Center for any reason that medical residents, medical students, and other medical career students will be involved in my care and treatment under appropriate supervision of clinical faculty.

3. **Appointments and Cancellation Policy:** The clinic time of the medical resident and clinical faculty is scheduled by appointment. It is essential, that all appointments be kept promptly. When an appointment cannot be kept, the clinic must be notified at least 24 hours in advance. Patients that miss THREE (3) scheduled appointments may be DISMISSED from the NSU Health Care Centers. In the event that you are dismissed, the NSU Health Care Centers will be available for emergencies during the normal hours of operation for a period of 30 days from the date of the third missed appointment to provide you with ample opportunity to select a medical provider of your choice.

Patient/Representative's Initials _____

4. **Right to Discontinue Treatment:** The NSU Health Care Centers have the right to discontinue treatment. In such cases, the patient or patient's representative agrees to accept full responsibility for pursuing alternate professional medical care. A letter will be sent informing the patient or patient's representative that treatment is being discontinued. All records pertaining to the treatment and diagnosis of patients are the property of the NSU Health Care Centers. Records and X-rays will be duplicated upon written request with reasonable charge to the patient.

5. **Financial Agreement:** I hereby agree to pay usual and customary charges for all services provided by NSU to the patient, except those covered by insurance (which includes all commercial and government third party payors). I understand that I am personally responsible for payment for any non-covered services, health insurance deductibles and co-insurance. In the event that I fail to fulfill any of the obligations in this section, I agree to pay any and all collection costs incurred by NSU in the enforcement of this section.

6. **Risks of Treatment:** The students and/or residents under the appropriate supervision of clinical faculty at the NSU Medicine Health Care Centers are available to answer any questions concerning the potential risks and complications involved with specific procedures, and reasonable alternatives to the proposed treatment. In the Student Medical Center clinical faculty are available to answer any questions concerning potential risks and complications involved with specific procedures, and reasonable alternatives to the proposed treatment. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of my treatment.

7. **Laboratory Bills:** I understand the outside reference laboratory ("laboratory") will bill me directly for all laboratory tests performed by said laboratory. I understand that the fee schedule and/or cost for laboratory tests performed by NSU shall be available to the patient upon request.

8. **Patient Records:** I understand that all original records and diagnostic aids, such as x-rays, are the property of the NSU Health Care Centers. I understand that the NSU Health Care Centers will own the original records. I also understand that I may obtain copies of the records at a reasonable cost, upon written request, based upon established policies of the NSU Health Care Centers.

Patient/Representative's Initials _____

9. **Consent to Photograph:** I understand that photography, video recordings, other imaging and audio recordings ("images and/or recordings") may be recorded to document my care and treatment. I understand that the NSU Health Care Centers will own these images and/or recordings. I also understand that I may obtain copies of the images and/or recordings at a reasonable cost, upon written request, based upon established policies of the NSU Health Care Centers.

10. **Release of Information for Payment:** I hereby authorize and consent to NSU to release medical information to obtain payment as described in the NSU Privacy Notice. This authorization will include where applicable psychiatric, alcohol, drug abuse, and laboratory results of HIV Infection (Human Immune Deficiency Virus) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS). I authorize NSU to provide necessary information to the patient's insurance carrier or other payer for payment purposes, and I authorize my insurance company/payer to pay NSU for services filed on my behalf. This assignment remains effective until I revoke it in writing.

11. **Change of Student/Resident/Clinical Faculty:** I understand that at the time of the treatment, unforeseen circumstances may require changing which individual clinical faculty member and/or student(s) or resident(s) actually are involved in performing the care and treatment. In addition, I understand at the Student Medical Center that at the time of the treatment, unforeseen circumstances may require changing which individual clinical faculty member is involved in performing the care and treatment.

12. **Information for Female Patients:** I have informed my doctor about my use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing conception and pregnancy. I have been advised that in addition to using my regular birth control pills that I will need to use and an additional alternative method of birth control while taking medications prescribed during my care and treatment.

13. **Medical History and Follow up:** I acknowledge that I have provided an accurate and complete medical and personal history, including antibiotics, drugs, or other medications I am currently taking as well as those to which I am allergic. I will follow any and all treatment and post treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including x-rays.

Patient/Representative's Initials _____

14. **Assignment of Benefits:** I hereby irrevocably assign and transfer to NSU all right, title and interest in any benefits payable to which I may be entitled from all insurance companies, employee benefit plans, third party administrators and/or other person or entities financially responsible for my medical care and treatment rendered to me, my dependent or the insured by NSU. Where Medicare benefits are applicable, I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct and request that said payment of authorized benefits be made on my behalf to NSU. Where Medicaid benefits are applicable, I certify that I am a recipient of Medicaid benefits and request that said payment of authorized benefits be made on my behalf to NSU.

Patient/Representative's Initials _____

Release of Information for Treatment and Health Care Operations

By signing this form, I am consenting to the use and disclosure of my Protected Health Information ("PHI") for treatment and Nova Southeastern University's health care operations purposes for myself or for the patient for whom I am the parent or legally authorized representative. I understand that the Nova Southeastern University Medicine Health Care Centers ("NSU") will share patient PHI according to the federal and state law for treatment, payment, and operations, as well as in accordance with its Notice of Privacy Practices.

NSU's Notice of Privacy Practices provides a more complete description of these uses and disclosures. I agree that I have the right to review the Notice of Privacy Practices prior to signing this consent. I acknowledge that I have done so. NSU reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained at the NSU Medicine Health Care Centers.

I acknowledge and agree that the PHI that may be disclosed for treatment and health care operations purposes may include any or all of the following information concerning the patient: (i) any psychiatric or psychological information related to treatment of physical and/or mental illness; (ii) any information regarding drug abuse, chemical dependency or alcohol abuse; or (iii) any information regarding testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome ("AIDS"); human immunodeficiency virus ("HIV"); Sexually Transmitted Disease("STD"); Tuberculosis; Hepatitis; or other information as may be required for my treatment and health care operations.

I also consent to the release of any information to any and all business associates, regulatory and/or accrediting organizations as necessary to maintain licensure and accredited status. In addition, I consent to the release of any information to county, state or federal public health agencies, as required by law.

I understand that I have the right to request that NSU restrict how it uses or discloses the patient's PHI to carry out treatment and health care operations. However, I understand that NSU is not required to agree to the requested restrictions, but if it does, it is bound by such agreement.

I understand that I may revoke this consent in writing except to the extent that NSU has already made disclosures in reliance upon it. If I do not sign this consent, or if I later revoke it, NSU may decline to provide treatment to the patient.

Patient/Representative's Initials _____

I certify that I have read and understand the preceding Consent and Agreement for Treatment, and/or have asked and had answered to my satisfaction, any and all questions that I may have about same, by my treating student/resident or clinical faculty physician.

Patient or Patient Representative Signature

Date

Print Name of Patient or Patient Representative

Patient Date of Birth

Description of Patient Representative's Authority

Confirmation of interpretation to Patient (if applicable)
If the patient does not read/understand English, it is the responsibility of the person who is authorized by him/her to ensure that the content of this consent form has been duly explained to him/her before he/she signs the form.

- The Patient does not read or understand English.
- I confirm that I understand the content of the consent form and I have interpreted and explained the content of the form to the patient so that he/se clearly understood what it meant before signing it.

Print Name of Interpreter

Relationship to Patient

Signature of Interpreter

Medicare Secondary Payer Form

DATE_____ PATIENT NAME_____

Dear Medicare Patient:

As a direct result of mandated Medicare Secondary Payer (MSP) regulations, we are required to gather the following information to determine if Medicare is your primary insurance.

1. Is the illness/injury due to an automobile accident, liability accident or Workman's Compensation? ☐Yes ☐No

2. Is illness covered by the Black Lung Program or Veterans Administration program? ☐Yes ☐No

3. If under 65, are you a renal dialysis patient in your first 30 months of Medicare entitlement? ☐Yes ☐No

4a. If under age 65, is your Medicare coverage due to disability? ☐Yes ☐No

4b. Is patient covered by a large group health plan through patient's employer or spouse's current employer? ☐Yes ☐No

5. If 65 and over, is patient covered by Employer Group Health Plan through patient's or spouse's current employer? ☐Yes ☐No

Registrar Notes:

A. If patient responds "no" to questions 1-5, Medicare is primary.
B. If patient responds "yes" to any questions, Medicare is secondary and primary insurance information must be obtained.

Name of Insurance Company _____

Address of Insurance Company _____

_____

Name of Policy Holder _____

Policy Number _____

Policy Holder's Employer Name _____

Policy Holder's Employer Address _____

Date of Accident (if applicable) _____

Patient's Signature _____

Form A-1