

Options Medical
Blair T. Butterfield, D.O.

PATIENT DATA SHEET / INSURANCE VERIFICATION

PATIENT INFORMATION									
Name (Last, First Middle)				Date of Birth		SSN		Preferred Language	
Marital Status	Single	Divorced	Separated	Sex	Female	Employment	Full Time	Retired	Unemployed
	Married	Partner			Male		Part Time	Disabled	Student
Race		American Indian / Alaskan		Asian		Hawaiian / Pacific Islander			
		White		Black / African American		Hispanic			
Address				City			State		Zip
Home Phone				Cell Phone			Work Phone		
Occupation				E-Mail Address			Other Phone		
Employer				Employer Address					
Emergency Contact					Phone Number			Relationship to Patient	
Who referred you to our office?				Parent/Guardian (if patient is a minor)					

PRIMARY INSURANCE		Insurance Holders Information			Self	Spouse	Parent		
Insurance Name / Plan					Policy/Claim/Member #				
Group #				Employer Name					
Name (Last, First Middle)			Date of Birth		SSN		Sex		
Address				City			State		Zip
Cell Phone				Home Phone			Work Phone		

SECONDARY INSURANCE		Insurance Holders Information			Self	Spouse	Parent		
Insurance Name / Network					Policy/Claim/Member #				
Group #				Employer Name					
Name (Last, First Middle)			Date of Birth		SSN		Sex		
Address				City			State		Zip
Cell Phone				Home Phone			Work Phone		

Signature:

Date:

Options Medical

Minor Child Policy's and Consents

It is the policy of Options Medical that any new patient under the age of 18 must be seen in the presence of their parent/guardian for their first visit.

Options Medical requires the parent/guardian, or authorized adult accompany a minor child to each and every office visit.

Options Medical follows Arizona guidelines regarding Minor's Consent to health care.

Patient's name: _____ Date of birth: _____

Parent(s)/guardian name: _____

Parent/guardian signature: _____ Date: _____

Consent to Accompany A Minor Child

To authorize another adult, written consent must be given prior to the office visit and photo Id shown. Written permission may be provided in two ways:

1. A completing this form
2. A signed letter including the following:
 - a. Date the release is written and expires
 - b. Child's name and date of birth
 - c. Emergency contact information for parent/guardian
 - d. Person authorized to accompany your child, please note their relationship to the patient.

I _____ give permission to _____
(Name of guardian) (Name of adult)

(Additional adults)
to accompany my child _____ and authorize treatment in accordance with the office policy of Options Medical.

I agree to be financially responsible for all copays and coinsurance.

Expiration of this consent: _____

Parent/guardian signature: _____ Date: _____

Notice of Privacy Practices

Blair T. Butterfield, D.O., P.C. dba Options Medical

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests 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, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: Treatment, Payment and Health Care Operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis and customer service. An example of this would be new patient survey cards.

The practice may also be required or permitted to disclose your PHI for law enforcement or other legitimate reasons. In all situations we will do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information. We may contact you, by phone, e-mail, text message or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following uses and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket," in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of November 5, 2014 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer at (480)751-3091 for more information or in person or in writing at 4135 S. Power Rd., Suite 129 Mesa, AZ 85212.

Options Medical
Blair T. Butterfield, D.O., P.C.
4135 S. Power Rd. Ste 129
Mesa, AZ 85212

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Options Medical P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare options (TPO). Please request a copy of Options Medicals' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Options Medical, P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by requesting a copy through the office or by forwarding a written request to the Privacy Officer at 4135 S. Power Rd. Ste 129, Mesa, AZ 85212.

With my consent, Options Medical, P.C. may call my home or other designated location and may leave messages on voice mail or in person in reference to any items that assist our office in carrying out TPO, such as appointment reminders, insurance items and calls pertaining to my clinical care, including laboratory results.

I wish to be contacted in the following manner (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Home Phone Number _____ | <input type="checkbox"/> Written Communication |
| <input type="checkbox"/> O.K. to leave message with detailed information | <input type="checkbox"/> O. K. to mail to my home address |
| <input type="checkbox"/> O. K. to leave detailed message with person | <input type="checkbox"/> O. K. to mail to my work office |
| <input type="checkbox"/> Leave message with call back number only | <input type="checkbox"/> O. K. to fax this number _____ |
| <input type="checkbox"/> Cell Phone Number _____ | <input type="checkbox"/> Persons we are able to give detailed information to |
| <input type="checkbox"/> O. K. to leave message with detailed information | _____ |
| <input type="checkbox"/> Leave message with call back number only | _____ |
| <input type="checkbox"/> Persons we are NOT able to give PHI | |
| _____ | |
| _____ | |

I have the right to request that Options Medical restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound to this agreement.

By signing this form, I am consenting to Options Medical, P. C. to use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except in the extent that the practice has already made disclosures in reliance upon my prior consent. If you do not sign this consent, Options Medical, P. C. may decline to provide treatment to me.

Signature of Patient / Legal Guardian

Date

Print Name of Patient

Options Medical
Blair T. Butterfield, D.O., P.C.
4135 S. Power Rd. Ste. 129
Mesa, AZ 85212

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent to **Blair T. Butterfield, D.O.** to provide medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical condition.
(Patient's printed name)

Patient/Guardian/Responsible Party Signature _____ Date _____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION:

I authorize **Blair T. Butterfield, D.O.** to release to my insurance company any medical information necessary to process claims for treatment that I receive under their care in order to secure payment. I authorize payment of any insurance benefits for medical services be paid directly to Blair T. Butterfield, D.O., P.C..

Patient/Guardian/Responsible Party Signature _____ Date _____

Privacy Practices: By initialing here, I acknowledge that I have received a copy of Blair T. Butterfield, D.O.'s Notice of Privacy Practices and have been provided an opportunity to review it.

(initial here)

FINANCIAL POLICY/NOTIFICATION OF PATIENT RESPONSIBILITY:

Blair T. Butterfield, D.O. will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when services are rendered. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event your insurance company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining. If any payment is made directly to you for services billed, you recognize an obligation to promptly submit same to Blair T. Butterfield, D.O., P.C..

Your insurance company requires us to collect your co-payments, co-insurances, and/or any unmet deductible amounts from you at the time of service. If we do not collect these amounts, we could be in violation of our contract with your insurance company and risk being denied reimbursement for your treatment. In the event that a check is returned for Non-Sufficient Funds, a \$25.00 service fee will be charged to you.

(initial here)

We have verified your medical benefits with your insurance company, based on the information provided by you. Please be advised that your insurance company has the disclaimer that this is a verification of benefits only, and not a guarantee of payment. Benefits/payments are determined once the claim is received.

Please Note: Any remaining balance due will be billed to you after additional information is received from your insurance company.

Please verify that you understand your financial responsibility by signing and dating this form:

I understand and agree that if I fail to make any of the payments I am responsible for in a timely manner, I will be responsible for all costs of collecting monies owed, including but not limited to court costs, collection agency fees and attorney fees.

Patient/Guardian/Responsible Party Signature _____ Date _____

Notice of Health Information Practices

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you to get better care?

In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure and timely manner.

What health information is available through Health Current?

The following types of health information may be available:

- Hospital records
- Medical history
- Medications
- Allergies
- Lab test results
- Radiology reports
- Clinic and doctor visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment

Who can view your health information through Health Current and when can it be shared?

People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, transition of care planning and population health services.

You may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form. Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted-use.

Does Health Current receive behavioral health information and if so, who can access it?

Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from federally-assisted substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the rest of your health information. Health Current will only share the substance abuse treatment records it receives from these programs in two cases.

One, medical personnel may access this information in a medical emergency.

Two, you may sign a consent form giving your healthcare provider or others access to this information.

How is your health information protected?

Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.

Your Rights Regarding Secure Electronic Information Sharing

You have the right to:

1. Ask for a copy of your health information that is available through HealthCurrent. Contact your healthcare provider and you can get a copy within 30 days.
2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.
3. Ask for a list of people who have viewed your information through HealthCurrent. Contact your healthcare provider and you can get a copy within 30 days. Please let your healthcare provider know if you think someone has viewed your information who should not have.

You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current:

1. You may “opt out” of having your information available for sharing through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. After you submit the form, your information will not be available for sharing through Health Current.
Caution: If you opt out, your health information will NOT be available to your healthcare providers even in an emergency.
2. You may exclude some information from being shared. For example, if you see a doctor and you do not want that information shared with others, you can prevent it. On the Opt Out Form, fill in the name of the healthcare provider for the information that you do not want shared with others.
Caution: If that healthcare provider works for an organization (like a hospital or a group of physicians), all your information from that hospital or group of physicians may be blocked from view.
3. If you opt out today, you can change your mind at any time by completing an Opt Back In Form that you can obtain from your healthcare provider.
4. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

IF YOU DO NOTHING, YOUR INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider’s participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.”

Signature _____ **Date** _____

Please Bring to your Appointment

Picture ID i.e. Drivers License

Insurance Card

ALL Medications