PERSONAL HEALTH HISTORY

NOTE: Please complete all information on this record. All information is treated in confidence and will not be released unless you grant permission.

Name____Today's Date___________________________________

Age*________________________Birth Date_____________________________Last Physical Exam Date______________________________

***Patients under the age of 18 must be accompanied by parent or guardian on the first visit.**

ACTIVE AND INACTIVE PROBLEMS:

Check (✓) all items either yes or no and give approximate date if past.	No	Yes Now	Yes Past	If Past, Date	Check (✓) all items either yes or no and give approximate date if past.	No	Yes Now	Yes Past	If Past, Date
Asthma					Rheumatic Fever				
Abnormal Electrocardiogram					Rectal Trouble				
Angina					Recurrent Boils				
Anemia (Type)					Stroke				
Arthritis					Stomach or Duodenal Ulcer				
Blindness Either Eye					Syphilis				
Broken Bones					Skin Disease				
Cataracts					Serious Depression				
Chronic Bronchitis/Lung Disease					Serious Emotional Problems				
Cirrhosis of Liver					Tuberculosis				
Colon or Bowel Trouble					Thyroid (overactive)				
Deafness					Thyroid (underactive)				
Dysentery					Varicose Veins				
Diabetes					**Men**				
Ear Infections					Prostate Problems				
Emphysema					**Women**				
Enlarged Heart					Menstrual Difficulties				
Glaucoma					Cystitis				
Gall Stones					Mastitis				
Gout					Ovarian Cyst				
Goiter					Breast Cancer				
Gonorrhea					Other Breast Disease*				
Hay fever					Other Gynecological Problems*				
Heart Murmur as Adult					Still Menstruating (circle)	YES	NO		
Heart Attack					Age Period Started				
High Blood Pressure					Age Periods Stopped				
Hepatitis					Why Periods Stopped				
Hemorrhoids					Number of Pregnancies				
Kidney Infection					Number of Children				
Kidney Stones					Number of Miscarriages				
Nervous Breakdown					*Explain				
Poor Blood Clotting									
Polio									
Phlebitis									

SURGERIES:

	Yes	**No**	**Date**		**Yes**	**No**	**Date**
Tonsils				Hernia			
Appendix				Breast (women)			
Gall Bladder				Uterus (women)			
Stomach				Ovaries (women)			
Kidney				Prostate (men)			
Colon				Other – Specify			
Thyroid							

CURRENT PRESCRIPTION MEDICATIONS (list name, strength and dosage for all meds):

CURRENT NON-PRESCRIPTION MEDICATIONS (list name, strength and dosage for all meds):

Allergies to Medications? Yes No If yes, to what? ____

NOTE: Allow no less than 48 hours for prescription refills.

Name____DOB ________________________________

FAMILY RECORD:

Check (✓) condition(s) and relationship of any blood relative who has or has had any of the conditions listed below.	Father	Mother	Brother	Sister	Son	Daughter
Alcoholism						
Allergies						
Anemia						
Arthritis						
Asthma						
Birth Defects						
Bleeding Tendency						
Cancer, Tumor						
Colitis						
Congenital Heart						
Diabetes						
Emphysema						
Epilepsy						
Glaucoma						
Goiter						
Hay Fever						
Heart Attack						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Leukemia						
Liver Disease						
Mental Illness						
Migraine						
Nervous Breakdown						
Obesity						
Rheumatism						
Rheumatic Fever						
Sickle-cell Anemia						
Stomach Ulcer						
Stroke						
Suicide						
Tuberculosis						

Name____DOB ___________________________

FAMILY MEMBERS:

	Living				Deceased	
	Age	Health Good	Fair	Poor	Age at Death	Cause of Death
Father						
Mother						
Brother(s)						
Sister(s)						

Tobacco Use: [ ] No [ ] Yes [ ] Former Packs/Day___________ How Long ________yrs Date Quit ____________

Alcohol Use: [ ] No [ ] Yes Beers/Day _______ Hard Liquor Drinks/Day _______

Former Alcohol Use: How many years? _______________ Date Quit __________________

Do you drink coffee? No Yes How many per day?

HOSPITALIZATIONS/REASONS: **DATE(S)**

____

____

____

Do you wear artificial devices? Yes No

Please list ____

____

IMMUNIZATIONS:

	Yes	No	Date
Pneumonia			
Tetanus			
Booster			
Measles			
Influenza			
German Measles/Mumps			
Other (specify)			

X-RAYS:

	Yes	No	Date
When was your last mammogram?			
Back			
Chest			
Colon			
Extremities			
Gall Bladder			
Kidney			
Stomach			
Treatments			
Other (specify)			

Name____DOB ____________________________

New Patient Information

Patient Name: ____
Last First Middle Initial

Address:____E-Mail: ________________
Street City State Zip

Telephone (home)______________________(cell) ____________________

Date of Birth:______/_____/_____* Gender: M F Marital Status: S M D W SS#: ________________________

Race________________[may decline] Ethnicity____________[may decline] Language _________________________

Emergency Contact:__________________________________ Relationship: _________________________________

Phone 1:_____________________________________ Phone 2: ____

Patient's Employer:__________________________________ Occupation: ___________________________________

Employer's Address: ____
Street City State Zip

Work Phone (______)_____________________________ Employed: Full Time Part Time

Are you a student? YES NO If yes: FULL TIME PART TIME

Primary Insurance Company: ____

Primary Insured's Name:____ Date of Birth: ________________

Member ID:______________________Group #:__________________ Relationship to Patient: ___________________

Secondary Insurance Company: ____

Insured's Name:____ Date of Birth: ____________________

Member ID:______________________Group #:__________________ Relationship to Patient ____________________

Whom may we thank for referring you? ____

Preferred Pharmacy: ____
Name Location Phone

NOTE: YOU MUST ALLOW NO LESS THAN 48 HOURS FOR MEDICATION REFILLS. PATIENTS ARE ASSESSED $50 FOR AN APPOINTMENT NOT CANCELED AT LEAST 24 HOURS IN ADVANCE.

I hereby assign all medical benefits, including major medical to which I am entitled, Medicare, and other government-sponsored programs, private insurance and any other health plan to Mauck Medical Clinic, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I hereby authorize assignee to release all information to secure the payment.

____ _______________________________
Patient, Parent or Guarantor Signature Date

*Patients under the age of 18 must be accompanied by parent or guardian on the first visit.

COMPLETE THIS FORM ONLY IF YOU ARE ASKING US TO GET YOUR PAST MEDICAL RECORDS FROM ANOTHER DOCTOR.

Authorization for Disclosure of Health Information

Patient's Name	DOB	SSN	Phone Number

Street Address	City	State	Zip

Authorizes (Doctor from Whom You Wish Us to Get Your Records):

Name	Street Address	City	State	Zip	Phone/Fax

To Release Protected Health Information To:

Mauck Medical Clinic, LLC
917 Pine Ave Ste D
Hoxie, KS67740
Fax (785)677-3931 Phone (785)677-3930

Information to be Released:

[ ] Entire Medical Record
[ ] Medical History, Examination, Report
[ ] Surgical Reports
[ ] Treatment or Tests
[ ] Hospital Records, Including Reports
[ ] Allergy Records
[ ] Immunizations
[ ] Prescriptions
[ ] X-ray Reports
[ ] Billing & Payment Information
[ ] Consultations
[ ] Laboratory Reports
[ ] Other (Specify)____
[ ] Only for the Following Dates ________________________________

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

[ ] Yes, I consent to the release of this information.
[ ] No, I do not consent to the release of this information.

Purpose for Need of Disclosure (Check Applicable Categories):

[ ] Further Medical Care
[ ] Personal = At the Request of the Individual
[ ] Insurance Eligibility/Benefits
[ ] Changing Physicians
[ ] Legal Investigation or Action
[ ] Other (Specify):

Date Records Are Needed: ________________________________

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:________________________________. If I fail to specify an expiration date, event or condition, this authorization will expire in six months. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Office Manager of Mauck Medical Clinic, LLC.

Signature of Patient or Legal Representative	Date

Relationship to Patient (If Legal Representative)	Witness

AUTHORIZATIONS

Authorization for Disclosure of Health Information
(As defined by HIPAA, a separate authorization must be used for psychotherapy notes.)

Patient Name:____ Date of Birth: ______________________________

I authorize Mauck Medical Clinic, LLC., to release my records or information relating to my health care to the following individuals:

Name:____ Relationship: ______________________________

Name:____ Relationship: ______________________________

Name:____ Relationship: ______________________________

Information to be Released:

[ ] Entire Medical Record
[ ] Treatment or Tests
[ ] Immunizations
[ ] Billing & Payment Information
[ ] Medical History, Examination, Report
[ ] Hospital Records, Including Reports
[ ] Prescriptions
[ ] Consultations
[ ] Surgical Reports
[ ] Allergy Records
[ ] X-ray Reports
[ ] Laboratory Reports
[ ] Other (Specify)____
[ ] For All Dates [ ] Only for the Following Dates ____

We have no control over the person(s) you have listed as your personal representative(s). Therefore, your PHI disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Mauck Medical Clinic, LLC.

Disclosure of Protected Health Information Via Alternative Means

I consent to receive calls from Mauck Medical Clinic, LLC., regarding my protected healthcare and other services at the phone number(s) below, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated notification system.

[ ] Home ________________________ [ ] Cell _______________________ [ ] Work ____________________

These authorizations will remain in effect until terminated by the patient, the patient's personal representative, or another individual legally authorized to do so by court order. The patient has the right to revoke or terminate these authorizations by submitting a written request to: Mauck Medical Clinic, LLC. 917 Pine Ave Ste D. Hoxie, KS 67740

Patient Signature____ Date ____________________________

Witness Signature____ Date ____________________________

Mauck Medical Clinic, LLC.

Notice of Privacy Practices

We are required by law to maintain the privacy of our patients with respect to protected health information. Our Notice of Privacy Practices is enclosed. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

____
Print Name

____ ____________________
Patient/Guardian Signature Date

____ ____________________
Witness Signature Date

Mauck Medical Clinic, LLC. NOTICE OF PRIVACY PRACTICES

Protected health information about you is obtained as a record of your contacts or visits for healthcare services with Mauck Medical Clinic, LLC.. This information is called protected health information. Specifically, "Protected Health Information" is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.
Mauck Medical Clinic, LLC. is required to follow specific rules on maintaining the confidentiality of your protected health information, how our staff uses your information, and how we disclose or share this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow those rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law. If you have any questions about this Notice, please contact our Office Manager at 785-677-3930. **Your Rights Under The Privacy Rule**

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our staff. You have the right to receive and we are required to provide you with a copy of this Notice of Privacy Practices. We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. You have the right to authorize other use and disclosure. This means you have the right to authorize or deny any other use or disclosure of protected health information not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to designate a personal representative - This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health information.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record. In certain cases we may deny your request.

You have the right to request a restriction of your protected health information. This means you may ask us, in writing, 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 protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases we may deny your request for a restriction.

You may have the right to have us amend your protected health information. This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

You have the right to request disclosure accountability. This means that you may request a listing of your protected health information disclosures we have made to entities or persons outside of our office.

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 Office Manager of your complaint.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

For Treatment - We may 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 that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other physicians who may be involved in your care and treatment.

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 contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. And, we may contact you to provide information about health related benefits and services offered by our office. For Payment - Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations - We may use or disclose, as needed, your protected health information in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, and auditing functions. It also includes Education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally, it includes business administrative activities such as customer service and compliance with privacy requirements.

Other Permitted and Required Uses and Disclosures - We may also use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

As Required By Law - We may use or disclose your protected health information to the extent that law requires the use or disclosure.

For Public Health - We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

For Communicable Diseases - We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

For Health Oversight - We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

In Cases of Abuse or Neglect - We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

To The Food and Drug Administration - We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

For Legal Proceedings - We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

To Law Enforcement - We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes.

To Coroners, Funeral Directors, and Organ Donation - We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. Protected health information may be used and disclosed for cadaver organ, eye or tissue donation purposes.

In Cases of Criminal Activity - Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

For Military Activity and National Security - When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services.

GENERAL

- **Patients under the age of 18 must be accompanied by parent or guardian on the first visit.**

MEDICATIONS

- Patients are asked to bring their current medications or a list thereof to each visit.
- Medication refills are not given to patients who do not keep their follow-up appointments.
- Medications will not be prescribed for illness unless the patient sees the physician first.
- Patients must allow no less than 48 hours for prescription refills.
- The physician "on-call" does not prescribe or refill medications.

______________________________________ ______________________________

Patient or Guarantor Signature Date

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a provider and other health care providers or the designees as deemed necessary to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

______________________________________	_____________________
Printed Name of Patient or Personal Representative	Relationship to Patient
______________________________________	_____________________
Witnessed By	Date
______________________________________	_____________________
Signature of Patient or Personal Representative	Date