Dr. Deana Brooksher/ A Garden for Wellness

PATIENT

Patients Full Name:______________________________ SS#: ______________
Address:______________________________ City: ______________
State:______ Zip:__________ Home Ph:( ) ______________ Wk Phone:( ) ______________
Date of Birth:__________ Sex: Male Female Marital Status: S M D W Other Ph:( ) ______________

SPOUSE,GUARDIAN OR RESPONSIBLE PARTY

Responsible Party's Name: ______________________________ Relationship to Patient:______________
Address:______________________________ City:______________
State:______ Zip:__________ Home Ph: ( ) ______________ Other Ph: ( ) ______________
Date of Birth:__________ Sex: Male Female SS#:______________

PRIMARY INSURANCE INFORMATION

Primary Insurance Company:______________________________ Insured Member Name:______________
Members Address:______________________________ SS#______________
City:______________ State:______________ Member's DOB:______________
Member's ID#:______________________________ Group#:______________
Member's Employer:______________ Relationship to Patient:______________

ADDITIONAL OR SECONDARY INSURANCE INFORMATION

Additional Insurance Company:______________________________ Insured Member Name:______________
Members Address:______________________________ SS#______________
City:______________ State:______________ Member's DOB:______________
Member's ID#:______________________________ Group#:______________
Member's Employer:______________ Relationship to Patient:______________

I authorize the release of any medical or other information necessary to process all claims performed by any of the above said physicians. I also requst payment of government and/or private benefits to myself or to the party who accepts assignment on this and all future claims. We are filing your insurance as a courtesy to you, therefore if your insurance fails to pay for *any* treatment on your behalf, you will be responsible for the balance due. By signing below, you agree to the above terms and conditions.

Signature of Patient or Responsible Party: ______________________________ Date:______________
(if patient is under the age of 18 yrs)

Notice of Privacy Practices

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act (HIPAA). This notice describes how health related information about you may be used and disclosed, and how you can get access to this inormation. We are required by law to maintain confidentiality of health information that identifies you as well as your health status. Your Protected Health Information or PHI can be usec for treatment, payment, and health care operations. Other use and disclosure of your PHI in certain circumstances to include required by law, publi health, communicable diseases, health oversight, abuse or neglect, food and drug administration, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, and inmates. Our practic will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorizatior you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization except to the extent that your physician or the practice has taken action in reliance on the use or disclosure indicated in the authorization. Upon written request, you have the right to request that our practice communicate with you about your health and related issues in a particular manner. You may also request us, in writing, to amend your health insurance information if you believe it to be incorrect or incomplete. You have the right to request, in writing, an "accounting of disclosures", which a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. You have the right to request restriction, in writing, in our use or disclosure of you PHI for treatment, payment or health care operations. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the informatior necessary to treat you. We reserve the right to revoke any voluntary agreement to restrict the use or disclosure of your PHI that we may enter into.

Signature of Patient or Responsible Party:______________________________ Date:______________
(If patient is under the age of 18 yrs) revised 3-20-07