OAKLAND ARTHRITIS CENTER, P.C.
Martin M. Pevzner, M.D.
Joseph G. Skender, M.D.
Neil G. Levitt, M.D.
Judith L. Bateman, M.D.
248-646-1965
Fax: 248-594-7158

PATIENT REGISTRATION

Patient Name____

You have an appointment scheduled on ___________at_____________ with:

_______Dr. Pevzner ________Dr. Skender _________Dr. Levitt _________Dr. Bateman

Please plan on arriving at your appointment 15 minutes early! Our location is 32270 Telegraph Road, Suite 120, Bingham Farms, Michigan 48025. We are between 13 and 14 Mile Road, closer to 14 Mile on the east side of Telegraph road.

On your first visit please bring with you:

- Completed patient information forms
- Any medical history, x-ray reports or films relevant to your appointment
- Any letters, requests or referrals from your primary care physician
- List of all medications you are currently taking
- Your driver's license and insurance card(s)

Our staff will ask for your picture identification and insurance card at your first visit. As a service to you, we will be happy to bill your insurance company for your visit if you have appropriate coverage. Please be advised that your copay is expected at the time of service. If you have an HMO that requires a referral, that must also be present at the time of your appointment. If you have any questions, please contact the office.

Without proper identification and insurance card(s), we may have to reschedule your appointment. If you have any questions, please do not hesitate to contact our office at 248-646-1965.

You must contact our office if you are unable to keep your scheduled appointment.

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Patient Information

Last Name:____________________________First:__________________________Middle:__________

Address:__________________________________City:_________________State:__________Zip:____

Phone: Home___________________Work:_________________________Cell:_____________________

Social Security Number:___________________________________

Please indicate the best phone number to contact you.

Email:____________________________ Date of Birth:_________________ Male:_____Female:_____

Marital Status:____________________________Spouse Date of Birth:___________________________

Employment Status: Full Time: _____Part Time:____Retired:______ Unemployed:_____ Student:_____

Primary Care/Referring Physician:____

Address:____

Phone Number:_____________________________ Fax Number:__________________________

If you are <u>not</u> the subscriber of your insurance, please indicate the person who should receive bill (guarantor or responsible party):

Name:______________________________________Relationship to Patient:_______________________

Address:____City:____________State:_________Zip____

Home Phone:_________________Work Phone:_____________________Cell Phone:________________

Email:____Date of Birth_________________________

Please provide us with the name and address (including the city) of the following:

Local Pharmacy:____

Mail Order Pharmacy:____

Specialty Pharmacy:____

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Patient Name:___________________________________

Medication:

Name of Medication	Strength	Directions
______________________________	______________	______________
______________________________	______________	______________
______________________________	______________	______________
______________________________	______________	______________
______________________________	______________	______________
______________________________	______________	______________
______________________________	______________	______________
______________________________	______________	______________
______________________________	______________	______________
______________________________	______________	______________
______________________________	______________	______________

Medication allergies including latex or iodine

Name of Medication	Reaction
______________________________	______________________________
______________________________	______________________________

Social History

Do you smoke:___________ If so, how many packs a day:______ for how many years:_________________No:______________

If not, have you smoked in the past:____How long ago did you quit:_____ Do you drink alcohol?_____If so, how often_____

Do you do any recreational drugs (cocaine, marijuana, heroin and/or intravenous drugs?_____________________If so, please discuss with your physician.

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HIPAA Notice of Privacy Practices

Oakland Arthritis Center, P.C.

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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected health information" is information about you, including demographic information that identifies you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

2. Treatment

We will use and disclose your PHI to provide, coordinate or manage your health care and any released services. This includes the coordination or management of your health care and third party. For example, we would disclose your PHI as necessary to a home health agency that provides care to you. Your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

3. Payment

Your PHI information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to your health plan to obtain approval for the hospital.

4. Healthcare Operations

We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see our patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. 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 PHI, as necessary, to contact you to remind you of your appointment. We may use or disclose PHI in the following situations without your authorization. These situations include as required by law: Public Health issues as required by law, communicable diseases: Health Oversight: Abuse or Neglect: Food or Drug Administration requirements, Legal Proceedings: Law Enforcement: Coroner's, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required uses and disclosures. Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other permitted and Required Uses and Disclosures will be made only with your consent; authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

5. Your Rights

Following is a statement of your rights with respect to your PHI.

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: physcotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding and PHI that is subject to law that prohibits access to PHI.

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Your Rights (continued)

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI 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. Your request must state specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e.; electronically. You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement or disagreement with us and we may prepare a rebuttal to your statement and will provide a copy of such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, or your PHI. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

6. **Complaints**

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 privacy contact with your complaint. We will not retaliate against you for filing a complaint. This notice was published and became effective on or before April 14, 2003.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. 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 telephone number.

Signature below is only acknowledgement that you have received this notice of our privacy practices.

Print Name____

Signature____Date:_____________