Wilson Family Practice

899 Aigner Drive

Boonville, IN 47601

Phone (812)641-0262

Fax (812)641-0557

**PATIENT INFORMATION**

**First Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Middle Initial**:\_\_\_\_\_\_\_\_\_\_\_ **Gender: M F**

**Last Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SSN Number**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOB**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Home Phone**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cell Phone**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mailing Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**:\_\_\_\_\_\_\_\_\_ **Zip Code**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-

**Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMERGENGY CONTACT INFORMATION**

**Contacts Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact Phone**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAYMENT RESPONSIBILITY**

**\**THIS SECTION MUST BE FILLED OUT WITH PARENT INFORMATION FOR ALL PATIENTS UNDER 18***

**First Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Last Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

**Insurance Company**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Policy** #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy holder**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship to patient**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy holder’s SSN**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Street Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**State**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip Code**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home phone**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRIMARY CARE PHYSICIAN**

**Name of Family Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list all current medications with dosage and how often it is taken. Be sure to include over-the-counter medication, prescription drugs, and any supplements and vitamins:**

**Medication Name Dosage Frequency**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Pharmacy** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES**

***\*PLEASE INCLUDE ALL FOOD, DRUG AND INVIRONMENTAL ALLERGIES***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SURGICAL HISTORY**

***\*PLEASE LIST ALL PAST SURGERIES***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY**

**Heart Disease yes no Hyperthyroid yes no**

**Heart Attack yes no Kidney stones yes no**

**Heart Arrhythmia yes no Kidney Disease yes no**

**Atrial Fibrillation yes no Stroke yes no**

**Congestive Heart Failure yes no Gallbladder Disease yes no**

**Hypertension yes no Anemia yes no**

**Vascular Disease yes no Chronic Back Pain yes no**

 **Diabetes yes no Lyme Disease yes no**

 **\*Insulin Dependent yes no Psoriasis yes no**

 **\* Non Insulin Dependent yes no Depression yes no**

 **High Cholesterol yes no Osteoporosis yes no**

**Lung Disease yes no Neuropathy yes no**

 **Asthma yes no Hypothyroidism yes no**

**Reflux Diseas (GERD) yes no Fibromyalgia yes no**

**Ulcers yes no Colitis yes no**

 **Cancer (location)\_\_\_\_\_\_\_\_\_\_ yes no Blood Clots (DVT or PE) yes no**

**FAMILY MEDICAL HISTORY**

**\*PLEASE SPECIFY THE RELATION BETWEEN PATIENT AND FAMILY MEMBER**

**MOTHER: FATHER:**

 **Heart Disease:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Heart Disease:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Heart Attack:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Heart Attack:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Heart Arrhythmia:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Heart Arrhythmia:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Atrial Fibrillation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Atrial Fibrillation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Congestive Heart Failure:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Congestive Heart Failure:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Hypertension:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Hypertension**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Vascular Disease:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Vascular Disease:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Diabetes:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Diabetes:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **High Cholesterol:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **High Cholesterol:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Lung Disease:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Lung Disease:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Asthma:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Asthma:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Reflux Disease (GERD):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Reflux Disease (GERD)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Ulcers:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Ulcers:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Cancer (specify):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cancer (specify):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Blood Clots:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Blood Clots:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Neuropathy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Neuropathy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Osteoporosis:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Osteoporosis:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Depression:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Depression:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Psoriasis:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Psoriasis:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Arthritis (specify):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Arthritis (specify):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Chronic Back Pain:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Chronic Back Pain:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Anemia:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Anemia:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Gallbladder Disease:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gallbladder Disease:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Stroke:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Stroke:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Kidney Disease:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Kidney Disease:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Kidney Stones:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Kidney Stones:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Hypothyroid:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Hypothyroid:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Hyperthyroid:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Hyperthyroid:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TOBACCO/ALCOHOL/RECREATIONAL DRUG USE**

**Smoking Status:**

 **Current smoker: yes no**

 ***If yes, how many packs per day:***\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Previous smoker: yes no**

 ***If yes, specify when you quit:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Chewing Tobacco: yes no**

**Alcohol Use: *(circle the answer)***

 **Occassional Daily None**

**Recreational Drug Use: yes no**

 ***If yes, please specify which drugs are used:***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize my insurance benefits to be paid directly to my physician. I understand that I am financially responsible for non-covered services. I also authorize the physician to release any information required for processing my insurance claim.

**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PROTECTED HEALTH INFORMATION**

 I ,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize my personal health information may be release to the following people.

1. **Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Wilson Family Practice may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the facility has obtained your authorization, or the use or disclosure is otherwise permitted but the HIPPA privacy regulations or state law. Disclosure of your protected health information for the purpose described in this privacy notice may be made in writing, orally or by facsimile.

**Treatment**: WILSON FAMILY PRACTICE will 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 for treatment purposes. For example, we may disclose your information to a pharmacy to fill a prescription or t a laboratory to order a blood test. We may also disclose personal health information to an outside treatment provider for purpose of the treatment activities of the other provider.

**Payment**: Your protected health information will be used, as needed, to obtain payment for the serviced WILSON FAMILY PRACTICE provides. This may include certain communications to your health insurance company to get approval for the procedure that has been scheduled. For example, we may need to disclose information to your health insurance company to get prior approval for the procedure. We may also disclose information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health care plan. In order to get payment for the services we provide to you, we may also need to disclose your information to your health 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 care for the other provider’s payment activities. This may include disclosure of demographic information to pathologist for payment.

**Operation**: WILSON FAMILY PRACTICE may use or disclose your protected health information, as necessary, for our own health care operations to facilitate the function of the facility and to provide quality care to all patients. Health car 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.

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

**Other uses and Disclosures**: WILSON FAMILY PRACTICE may also disclose your protected health information for the following purposes: to remind you of your appointment date, to inform you of potential treatment alternatives or options, to contact you after your treatment as part of our follow up practices, inform you of health-related benefits or services that may be of interest to you, or to contact you to raise funds for the facility or an institutional foundation related to the facility.

**Uses and Disclosures Beyond Treatment, Payment and Health Care Operations Permitted without Authorization or Operations**

Federal privacy rules allow WILSON FAMILY PRACTICE to use or disclose your protected health information without your permission or authorization form for a number of reasons including the following:

**When Legally Required:** WILSON FAMILY PRACTICE will disclose your protected health information for the following public activities and purposes

* To prevent, control, or report disease, injury, or disability as permitted by law
* To report vital event such as birth or death as permitted by law
* To conduct public health surveillance, investigation, and interventions as permitted by law
* To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance
* To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease 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 report suspended abuse, neglect, or domestic violence:** WILSON FAMILY PRACTICE will notify government authorities when they believe a patient is a victim of abuse, neglect, or domestic violence. WILSON FAMILY PRACTICE will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

**To conduct health oversight activities:** WILSON FAMILY PRACTICE may disclose your protected health information to a health oversight agency for activities including audits, civil, administrative, or criminal investigations, proceedings, or actions, inspections, license or disciplinary actions, or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information under the authority if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

**In connection with Judicial and Administrative:** WILSON FAMILY PRACTICE may disclose your protected health information in the course of any judicial or administrative proceedings in repose to an order of a court or administrative tribunal as expressively authorized by such order. In certain circumstances, we may disclose your information response to a subpoena to the extent authorized by state law if we receive satisfactory assurance that you have been notified of the request or that an effort was made to secure a protective order.

**For Law Enforcement Purposes:** WILSON FAMILY PRACTICE may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

* As required by law for reporting of certain types of wounds or other physical injuries
* Pursuant to court order, court ordered warrant, subpoena, or similar process
* For the purpose of identifying or locating a suspect fugitive, material witness, or missing persons
* Under the certain limited circumstances, you are a victim of a crime
* To a law enforcement official if the facility has a suspicion that your health condition was the result of criminal conduct
* In an emergency to report a crime

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

**For Research purposes:**  WILSON FAMILY PRACTICE may disclose your protected health information for research when the use of disclosure for research has been approved by an institution review board that has reviewed proposal and research protocol to address the privacy of your information.

**In the Event of a Serious Threat to Healthcare Facility:** WILSON FAMILY PRACTICE may consistent with law and ethical standards of conduct, use or disclose your protected health information 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 the heath and safety of the public.

**For specific Government Function:**  WILSON FAMILY PRACTICE under certain circumstance, federal regulations authorize the facility to use or disclose your protected health information to facilitate specified government functions relating to military and veteran activities, national security and intelligence activities, protective services for the president and others, medical suitability determinations, correctional institutions and law enforcement custodial situations.

**For Worker’s Compensation WILSON FAMILY PRACTICE may release your health information to comply with worker’s compensation law and similar programs**

**Uses and Disclosures Permitted Without Authorization but with Opportunity to Object:** WILSON FAMILY PRACTICE may disclose your information to your family member or close personal friend if it is directly relevant to the person’s involvement in your treatment or payment related to your treatment. We can disclose your information in connection with trying to locate or notify family members 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 judgement, that it is in your best interest for us to make disclosure of information that is directly relevant to the person’s involvement with your care, we may disclose your information as described.

**Use and Disclosure Which You Authorize**

Other than as stated above, WILSON FAMILY PRACTICE will not disclose your health information other than with your written authorization. Your may revoke your authorization in writing at any time except that we have taken action in reliance upon the authorization.

**Your Rights**

Under federal law you may not inspect or copy the following records: psychotherapy notes, information complied in reasonable anticipation of, or for use in a civil, criminal or administrative action or process, and protected health information that is subject to a law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have a decision to deny access review.

We may deny your request to inspect or copy your protected health information, if in our professional judgement, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.

To inspect and copy your medical information, you must submit a written request to the Privacy officer whose contact information is listed on the last page of this notice. If you request a copy of this information, IMA may change you a fee for the costs of copying, mailing, or other costs incurred by us in the complying with your request.

Please contact the Privacy Officer if you have any questions about access to your medical records.

**The right to request a restriction on uses and disclosure of your protected health information:** WILSON FAMILY PRACTICE may disclose certain parts of your information for the purpose of treatment, payment or health care operations. You may also request we do not disclose your protected health information to family members or friends who may be involved in your care or for notification purposes as described in the privacy notice. Your request must state the specific restriction requested to whom you want the restriction to apply.

The facility is not required to agree to a restriction that you may request. We will notify if we deny your request to a restriction. If the facility does agree to the restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

**The Right to Request to receive amendments to your protected health information:** WILSON FAMILY PRACTICE amendment of protected health information about you in designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Requests for amendment must be in writing and must be directed to our privacy officer. In this written request, you must also provide a reason to support the request amendments.

**The Right to Receive an Accounting:** You the patient have the right to request an accounting of certain disclosures of your protected health information made by WILSON FAMILY PRACTICE. This right applies to disclosures for the purposes other than treatment, payment or health care operations as directed in this privacy notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosure for a facility directory, 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 our privacy officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosure that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess for 6 years. We will provide the first accounting you request during any 12 month period without charge. Subsequent accounting requests may be subject to reasonable cost based fee.

WILSON FAMILY PRACTICE is required by law to maintain the privacy of your health information and to provide you with the privacy 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 future protected health information that we maintain. If the facility changes its notice, we will provide a copy of the revised notice upon request by sending a copy of the notice via mail or through in-person contact.

You have the right to express complaints to WILSON FAMILY PRACTICE and to the secretary of the health and human services if you believe that your privacy rights have been violated. You may complain to IMA by contacting the privacy officer verbally or in writing, using the contact information below. 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.

**Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_