CENTER FOR ELDER CARE

3007 South Memorial Parkway, SUITE B • HUNTSVILLE, AL 35801 • 256-799-2500

Patient Information

Last Name: ____________________________ ☐ Mr. ☐Mrs. ☐ Miss ☐ Other: __________ Sex: Male _____ Female _____

First Name: ____________________________ Date of Birth: ____/____/_____ Age: _____ SSN: _______-_____-________

Middle Name: __________________________ Preferred Name: _______________________

Address: _____________________________________City: ______________County:________ State: ____ Zip: ______________

Email Address: ____

Home Phone: ( ) _________________ Cell Phone: ( ) _________________ Work Phone: ( ) __________________

May we leave a message about appointments and/or normal test results on the phone numbers you provided? Yes ___ No ___

Marital Status: ☐Married ☐Single ☐Separated ☐Divorced ☐Widowed

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Other: ________________________

Primary Language: ☐English ☐Spanish ☐Other: _____________________________

Race: ☐ Caucasian ☐ African American ☐Asian ☐Other: __________________

Employment Status: ☐Retired ☐Part ☐N/A Vocation: ____

Pharmacy name: ________________________ Address: _________________________ Phone: ( ) __________________ ___

Emergency Contact: Name: _________________________ Relationship: ______________ Phone: ( ) _________________ ___

Alternate Contact: If you want this Practice to contact you at an alternate address or telephone number, please complete:

Alt. Address: ___________________________ City: _____________ State:____ Zip: ________ Phone: ( ) _______________

Referred by: ____________________________________ Primary Care Physician: _______________________________________

Guarantor/Financially Responsible Person (if different from patient)

Last Name: _____________________________ ☐ Mr. ☐Mrs. ☐ Miss ☐ Other: ________ Sex: Male ______Female ________

First Name: _____________________________ Date of Birth: ____/____/____ Age: ____ SSN: _______-_____-_________

Middle: ________________________________ Relationship to Patient: ____

Address: ____ City: _________________________ State: ________ Zip: __________

Home Phone: ( ) _________________ Cell Phone: ( ) _________________ Work Phone: ( ) __________________

Guarantor/Financially Responsible Person's Email Address:____

Primary Insurance

Insurance Company: ________________________________

Policyholder Name: _________________________________

Member or Policyholder ID#: _________________________

Policyholder Date of Birth: ___________________________

Insurance Co. Phone #: ______________________________

Group#: ____

Relationship to Patient: ______________________________

Secondary Insurance

Insurance Company: ________________________________

Policyholder Name: _________________________________

Member or Policyholder ID#: _________________________

Policyholder Date of Birth: ___________________________

Insurance Co. Phone #: ______________________________

Group#: ____

Relationship to Patient: ______________________________

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Medical History Fact Sheet- Page 1

Patient Name: ____ Date of Birth:___________________________

Past Medical History (Please check if you have had any of the following)

High Blood Pressure ☐
High Cholesterol ☐
Atrial Fibrillation ☐
Heart Disease ☐
Congestive Heart Failure ☐
COPD/Emphysema ☐
Diabetes ☐
Peripheral Neuropathy ☐
Hypothyroidism ☐
Cancer _________________ ☐

Stroke/TIA ☐
Parkinson's Disease ☐
Seizures ☐
Dementia ☐
Osteoarthritis ☐
Osteoporosis ☐
Rheumatoid Arthritis ☐
Urinary Tract Infections ☐

Irritable Bowel ☐
Diverticulitis ☐
GERD (reflux) ☐
Macular degeneration ☐
Glaucoma ☐
Anxiety ☐
Depression ☐

Preventive Care

Bone Density ☐ Est Year of Test____________
Colonoscopy ☐ Est Year of Test____________
Heart Stress Test ☐ Est Year of Test____________
Heart Catheterization ☐ Est Year of Test____________
PSA Test (men only) ☐ Est Year of Test____________
Mammogram (women only) ☐ Est Year of Test____________
Eye Exam ☐ Est. Year of Test____________

Flu shot ☐
Pneumonia shot ☐
Prevnar 13 ☐
Shingles shot ☐

Past Surgical History

Gall Bladder Surgery ☐
Appendectomy ☐
Hysterectomy ☐
Cataracts removed L / R ☐
Prostate Surgery ☐
Back Surgery ☐
Shoulder Surgery L / R ☐
Hip Replacement L / R ☐
Knee Replacement L / R ☐

Colon Surgery ☐
Heart Bypass ☐
Heart Valve Surgery ☐
Other_______________
Other_______________

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Medical History Fact Sheet -Page 2

Patient Name: ________________________________

Family History (Check in the appropriate boxes to identify all illnesses/conditions in your blood relatives)

Relative	Heart Attack	High BP	Stroke	Colon Cancer	Breast Cancer	Colon Polyps	Prostate Cancer	Other Illness or Condition	Age if living	Age of death
Father	☐	☐	☐	☐	☐	☐	☐	☐	______	______
Mother	☐	☐	☐	☐	☐	☐	☐	☐	______	_____
Brother	☐	☐	☐	☐	☐	☐	☐	☐		
Sister	☐	☐	☐	☐	☐	☐	☐	☐		

How many children do you have? ___________ Do they live locally or out of town? ☐ Local ☐Out of town

What is your current living situation? ☐With spouse ☐Alone ☐ With adult child ☐Assisted Living

Do you have a living will? ☐Yes ☐No Do you have a Health Care Proxy? ☐Yes ☐No

If so, who is your Healthcare Proxy? ______________________________

Social History

Marital Status Single☐ Married ☐Divorced☐ Widowed ☐

Occupation: Working ☐ Retired ☐Job:________________

Have you had a fall in the past year?____________________

	Current Use	Past Use	How often per week	How much per day
Smoking	☐	☐		
Caffeine	☐	☐		
Alcohol	☐	☐		
Drug Use	☐	☐		

Specialists

Cardiologist________________________________ Endocrinologist____________________________

Pulmonologist______________________________ Gynecologist ______________________________

Neurologist ________________________________ Dermatologist ______________________________

Gastroenterologist ___________________________ Ophthalmologist ____________________________

Hematologist/Oncologist ____________________ Urologist ___________________________________

Orthopedic _________________________________ ENT _______________________________________

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Current Medications

Patient Name: ________________________________ Date: ____________________

Local Pharmacy: ______________________________ Mail order pharmacy: ________________________

Medication Allergies:____

Medication *(Ex: Your Medicine name)*	**Dosage** *(Ex: 81mg)*	**Times per day** *(Ex: once a day)*

Center for Elder Care

Patient Signature Sheet

Please initial each section below to indicate you have read and understand the information:

______**ASSIGNMENT OF INSURANCE AND FINANCIAL RESPONSIBILITY:** I hereby authorize The Center for Elder Care to release to my insurers and to other physicians full information, including copies of records and operative notes relative to any illness for which I receive services. This authorization will continue in full effect unless cancelled by my request.

______**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize payment directly to my insurance company for the benefits payable under terms of my policy. I understand that I am financially responsible for the charges not covered by this authorization.

______**PRIVACY POLICY NOTICE:** I understand that I have received a copy of CFEC's Notice of Privacy Practices and that I can at any time request a copy. This form details how my information may be used and disclosed as permitted under federal and state law.

______**UNPAID COPAY:** I understand that if there is a copay required from my insurance company, payment will be required at check-in. If I am unable to pay my copay listed in my insurance policy at the time of the visit, I will be billed for my copay **and an additional $10**. I also understand that chronic non-payment will constitute a hold on my account until payment is made and before my next office visit can be scheduled.

_____**MISSED APPOINTMENTS**: If it is necessary to reschedule your office appointment, we require that you give **at least 24 hours notice**. Failure to do so will result in a **$50.00 cancellation fee** on your account. This will not be billed to insurance and you will be responsible for paying the fee. **If you miss your appointment without notifying the office within 24 hours, you will be considered a "No Show" and will be charged a $50.00 fee.** We strive to remind everyone of their appointments. However, it is ultimately your responsibility to write down your appointments and remember them. If you have three "no-shows" in three months, there may be a temporary suspension of services.

_____**PATIENT PORTAL**: I have received the Patient Portal Consent and User Agreement and acknowledge that I have read and agree to comply with this secure form of communication.

Turn page over

_____**ePRESCRIBING CONSENT:** ePrescribing is a federally mandated initiative that requires all physicians to prescribe in this manner. ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, utilizing secure technology to protect the privacy of your personal information. I understand and consent for my prescriptions to be sent to my pharmacy in this manner.

______**CHRONIC CARE MANAGEMENT**: Due to the complexity of the geriatric patient, Medicare and other insurance companies have started a CCM program. This involves quality management of chronic conditions including communication with other providers, smooth transitions from hospital/rehab to home, 24/7 access to your provider, and 24 hour accessibility to your medical record via patient portal. If you have 2 or more chronic conditions and **more than 20 minutes per month are spent on planning and coordinating care outside the face-to-face visit,** we may bill Medicare for the service. Some examples of prolonged time spent in CCM include: making referrals to specialists, coordinating care with assisted living/skilled nursing facilities, and providing prolonged or multiple telephone calls (over 20 minutes). The fee for this service allowed by Medicare is $----, of which **your portion will be a maximum of $---** for each time that this service is billed. You will be responsible for this fee unless your secondary insurance pays the remaining $---. **This is not a monthly fee** and will **only be billed** if 20 minutes or more per month are spent coordinating your care. **If you choose to opt-out of the CCM program, you will be asked to sign a CCM stop form and you will be required to make a face-to-face office visit for the above mentioned services** (referrals, nursing home forms, issues that require prolonged telephone calls/coordination).

I, the undersigned, have read and understand the policies of the Center for Elder Care and agree to comply with all policies and procedures. I understand that I can ask questions at any time regarding the above mentioned policies.

Patient/guardian/POA____Date:________________

Center for Elder Care

Authorization for Disclosure of Health Information

(Medical Records Request)

Patient Name: ___________________________________**Date of Birth**: _________________

I hereby authorize the release of the following information to The Center for Elder Care:

________Complete Medical Record

________ Progress Notes/Consultations (past year)

________Laboratory reports (past year)

________X-ray and imaging: Specific ____________________________

________Immunization records

________Other ________________________________

Purpose of request:

________Information needed to treat patient who is in office now

________Information needed for patient appointment on ______________

________Information needed for billing purposes

________Information requested by Dr. Zaheer Khan to assist with medical care of patient

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that revocation will not apply to information that has already been released in response to this authorization.

I understand that authorizing the disclosure of my health information is voluntary. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signature of Patient or POA: __________________________________Date: _______________

Center for Elder Care

Patient Authorization for Disclosure of Protected Health Information (PHI) to an Individual

This form allows you to indicate which individuals you authorize to have access to your protected health information. Please review it carefully.

Patient Name :____

Social Security Number: ________________________Date of Birth: ____________________

I authorize the Center for Elder Care to disclose or provide protected health information about me to the individual(s) listed below (list each family member, friend, or other individual to receive PHI):

Name:_____________________________________Relationship:_______________________

Name:_____________________________________Relationship:_______________________

Name:_____________________________________Relationship:_______________________

Name:_____________________________________Relationship:_______________________

Purpose of disclosure: Patient request

I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above (check only those items of your record to be disclosed):

- o Entire patient record **OR**
- o Appointment times
- o Office notes
- o Lab results and X-rays
- o Hospital, nursing home, home health, hospice, and other physician records
- o Record of mental health or substance abuse treatment
- o Financial history report (previous 3 years only)

As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Office Manager. You may revoke your authorization at any time. If you would like to change this authorization, please let the front office staff know and they will give you a new form.

We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Patient / Guardian / POA: ___________________________________Date:_______________________

CENTER FOR ELDER CARE

Practice Information Sheet

PROVIDERS: Our providers consist of Dr. Khan and 2 full time nurse practitioners, Julie McCormick, CRNP and Elena Kruse, CRNP.

OFFICE HOURS: Monday through Friday, 8:00am-5:00pm. Phone number is **256-799-2500.**

AFTER HOURS: If you have a medical emergency, call 911 or proceed directly to an Emergency Room. If you have an urgent medical issue that cannot wait until regular office hours, you may call our answering service at **256-799-2500**. The on-call provider will contact you within 30 minutes or less.

APPOINTMENT SCHEDULING: The Center for Elder Care is committed to providing quality health care to all patients with the focus on the needs of the patient. Our patient population has multiple medical problems and our goal is to be able to see you as soon as possible to prevent illnesses from getting worse and to avoid hospitalizations.

Every effort will be made to schedule you with your preferred Nurse Practitioner whenever possible. Appointments for regular checkups should be scheduled well in advance. Each provider's schedule has reserved time for routine, urgent, and same day appointments. We do accept walk-ins but always prefer that you call before you come so that we can more efficiently see you. **Appointments are available Monday through Friday from as early as 8:00 to the last appointment at 3:45.**

If you are unable to keep an appointment, please call at least 24 hours in advance in order to avoid a **$50 cancellation fee** or **$50 no show fee** and to allow your appointment time to be given to another patient.

SCOPE OF SERVICES AND REFERRALS TO SPECIALISTS: As your patient centered medical home, our care teams offer accessible care that is personal, coordinated, and comprehensive. We are able to meet most of your health care needs here in our office, including behavioral health.

Dr. Khan is certified in Internal Medicine and specializes in Geriatric medicine. Our Nurse Practitioners are certified through national credentialing organizations ANCC and AANP and have been trained by Dr. Khan in Geriatric medicine.

All of our providers can diagnose and treat the full range of problems that are common in the elderly and base all their care upon evidence-based guidelines. They will provide support, information and handouts to you as necessary to assist you to help you to understand and self-manage your own health. They will coordinate your care across multiple settings as needed

including specialists, hospitals, assisted and skilled nursing facilities, DME companies, and home health and hospices.

EVIDENCE-BASED GUIDELINES: We base all of your medical care upon evidence-based guidelines. These are guidelines that have been studied and researched and found to be the standard for medical practice. Each individual is different, but these are the standards on which we base our care. Some of the guidelines we use are the following:

CARE COORDINATION: The Center for Elder Care is a part of the Medicare Care Coordination Program. This is a program started by Medicare to encourage primary care practices to better coordinate care between providers. Many of our elderly patients have multiple medical problems that require coordinating care with multiple specialists, nursing homes and assisted livings, DME companies, and others

TRANSFER OF RECORDS: If we feel that your old records are necessary to improve your care, we will request a transfer of records from your previous provider after you sign a release of medical records.

In order to be more efficient with your care, we need accurate and up to date records from the specialist that you may see. If you are currently seeing specialists, **it is your responsibility to request that they send updated notes, scans, and reports to our office as soon as possible after your visit with them**. We will then scan these reports into your medical record.

If you have any questions about transferring records, please contact our front office staff.

PATIENT PORTAL: Each patient will be given a username and password to access our secure patient portal. On the portal, you will be able to access your labs, medication lists, dates of service, and be able to send secure messages to your preferred provider.

FINANCIAL RESPONSIBILITIES: We do accept all Medicare patients and multiple other commercial insurances. Since insurance policies vary greatly in their coverage, it is **YOUR** responsibility to:

- Verify that the provider you are scheduled with is actively participating with your insurance carrier.
- Know your benefits, what services are covered and non-covered.
- Know your financial responsibility in terms of co-pay, percentage of co-insurance, and deductibles.
- Ensure that all pre-approval requirements are met to avoid denials or out-of-network benefits.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITY TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.
State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on March 26, 2013 and will remain in effect until it is amended or replaced by us.
We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made. You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer

We will keep your health information confidential, using it only for the following purposes:
Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

P**ayment**: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013, immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $ _1.00__for each page and the staff time charged will be $ _20.00 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.
Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.
Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make
reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.
Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.
National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.
Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.
Marketing Health-Related Services: We WILL NOT use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.
Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.
Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."
Appointment Reminders: We may use your health records to remind you of your recommended services, treatment or scheduled appointments.
Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form/format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $ _____ for each page and the staff time charged will be $ _____ per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.
Amendment: You have the right to amend your healthcare information if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances your request may be denied.
Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US:

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Huntsville, AL 35801,
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