OSTEOPATHIC HEALTHCARE OF MAINE

Patient Name_____ Legal Guardian(s) if minor _____

DOB_____ Phone (Home)_____(Cell)_____

Mailing address_____Town_____State_____ Zip_____

Email _____Occupation_____

Primary Care Provider_____Who referred you to OHM_____

Emergency Contact_____ Relationship_____ Phone _____

Please circle: Do you have Maine Care? (YES/NO**)**

Are you a QMB or D-SNP participant? (Dually eligible for Medicare and Medicaid) (YES/NO)

Please check if you permit us to communicate your health information:

□ I do not want any information about my healthcare communicated to family members/caregivers.
□ I give permission to verbally communicate to family members/caregivers listed below:

Names: _____

Please check the specific information that may be verbally communicated to the individual(s) listed above:

□ Prescription Request □ Appointments □ Billing questions □ Mental health
□ Substance Abuse □ HIV/AIDS □ Other (specify):

I have the right to revoke this authorization in writing at any time. Revocation will not cover information or material released before that date but will prevent further release of information.

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 **(HIPAA),** I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

-Conduct, plan, and direct my treatment.
-Follow-up among the multiple healthcare providers who may be involved in treatment directly & indirectly.
-Obtain payment from third-party payers.
-Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received Osteopathic Healthcare of Maine's Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information (available in our waiting room). I understand that Osteopathic Healthcare of Maine has the right to change its Notice of Privacy Practices and that I may contact Osteopathic Healthcare of Maine at any time to obtain a current copy of the Notice of Privacy Practices. I may request in writing that Osteopathic Healthcare of Maine restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that Osteopathic Healthcare of Maine is not required to agree to my requested restrictions, but if an agreement is reached, they are bound by such restrictions.

Patient/Legal Guardian Signature _____Date: _____