Jeffrey I. Mechanick, M.D.

Elise M. Brett, [redacted].

PATIENT INFORMATION

Name: JEFFREY E. EPSTEIN Social Security # [redacted]

Street: 9 EAST 71ST ST. Date of Birth: JAN. 20, 1953

City: NY State: NY Zip: 10021 Sex: (M) F

Marital Status: (S) M D W Partnered Spouse's Name: —

Home Phone: [redacted] Cell Phone: [redacted]

Occupation: BANKER Employer: FINANCIAL TRUST

Business Phone [redacted] Fax: [redacted]

Pharmacy: Phone:

Address:

Primary Care Physician: Phone:

Emergency Contact: [redacted] Relationship: FRIEND

Home Phone: [redacted] Business Phone: —

Referred by: DR. EVA ANDERSSEN Phone:

PRIMARY INSURANCE

HEALTH PLAN [redacted]
MEMBER ID#

Policy #: [redacted] Group # [redacted] Insured JEFFREY E. EPSTEIN

Insurance Co: UNITED HEALTHCARE Relationship to Patient: SELF

Address: PO BOX 740800 Date of Birth: JAN. 20, 1953

City: ATLANTA State: GA Zip: 30374-0800 SS# [redacted]

SECONDARY INSURANCE

Policy: Group # Insured

Insurance Co: Relationship to Patient

Address: Date of Birth

City: State Zip: SS#:

I hereby authorize Jeffrey I. Mechanick, M.D. and Elise M. Brett, M.D. to furnish information concerning my illness and treatment to my insurance carriers. I authorize payment of medical benefits to Jeffrey I. Mechanick, M.D. and Elise M. Brett, M.D. I understand that I am responsible for any part of the charges that are not covered by medical coverage.

Signed: Date:

(Parent or Guardian if patient is a minor)

SAMPLE HIPAA PRIVACY NOTICE

IS 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.

INTRODUCTION

[Insert the name of the Practice] understands that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information." "Protected health information" includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a written copy of our most current privacy notice from the Practice's Privacy Officer or you can access it on our website at _____. **[Note: The reference to the website should be included only if the Practice has a site.]**

MITTED USES AND DISCLOSURES

We can use or disclose your protected health information for purposes of *treatment, payment and health care operations*. For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular use or disclosure in every category will be listed.

Treatment means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating for a broken leg may need to know if you have diabetes bec diabetes may slow the healing process. In addition, the doctor may to contact a physical therapist to create the exercise regimen approp to your care.

Payment means the activities we undertake to obtain reimbursemer the health care provided to you, including billing, collections, cl management, determinations of eligibility and coverage and utiliz review activities. For example, prior to providing health care serv we may need to provide information to your Third Party Payor a your medical condition to determine whether the proposed cour treatment will be covered. When we subsequently bill the Third Payor for the services rendered to you, we can provide the Third Payor with information regarding your care if necessary to o payment. Federal or State law may require us to obtain a written re from you prior to disclosing certain specially protected h information for payment purposes, and we will ask you to sign a re when necessary under applicable law.

Health care operations means the support functions of our pr related to *treatment* and *payment*, such as quality assurance acti case management, receiving and responding to patient comment complaints, physician reviews, compliance programs, audits, bu planning, development, management and administrative activitie example, we may use your protected health information to evalu performance of our staff when caring for you. We may also co health information about many patients to decide what add services we should offer, what services are not needed, and w certain new treatments are effective. In addition, we may r information that identifies you from your patient information s others can use the de-identified information to study health ca health care delivery without learning who you are.

OTHER USES AND DISCLOSURES OF PROTECTED HE INFORMATION

In addition to using and disclosing your information for trea payment and health care operations, we may use your protected health infor in the following ways:

SAMPLE ACKNOWLEDGMENT

I, _____, acknowledge that I have been provided with a copy of **[Insert nar Practice]**'s privacy notice.

Date: _____, 200___ _____

[Note: As discussed in the Step 7 of the Privacy Guide, the privacy regulations require health care provid with direct treatment relationships to make a good faith effort to obtain an individual's written acknowledgement of his/her receipt of the Practice's privacy notice at the time of the first service delivery ept in emergencies). This sample acknowledgment is included for the Practice's use for this purpose.]

279853 2

Date_____

HEALTH HISTORY – please check symptoms you currently have or have had since your last visit here.

General
___ Unexplained weight loss / gain
___ Unexplained fatigue / weakness
___ Fall asleep during day when sitting
___ Fever, chills
___ No problems

Skin
___ New or change in mole
___ Rash / itching
___ No problems

Breast
___ Breast lump / pain / nipple discharge
___ No problems

Ears/Nose/Throat
___ Nosebleeds, trouble swallowing
___ Frequent sore throat, hoarseness
___ Hearing loss / ringing in ears
___ No problems

Eyes
___ Change in vision / eye pain / redness
___ No problems

Cardiovascular
___ Chest pain / discomfort
___ Palpitations (fast or irregular heartbeat)
___ No problems

Respiratory
___ Cough / wheeze
___ Loud snoring / altered breathing during sleep
___ Short of breath with exertion
___ No problems

Gastrointestinal
___ Heartburn / reflux / indigestion
___ Blood or change in bowel movement
___ Constipation
___ No problems

Genitourinary
___ Leaking urine
___ Blood in urine
___ Nighttime urination or increased frequency
___ Discharge: penis or vagina
___ Concern with sexual function
___ No problems

Musculoskeletal
___ Neck pain
___ Back pain
___ Muscle / joint pain
___ No problems

Endocrine
___ Heat or cold sensitivity
___ No problems

Hematologic/Lymphatic
___ Swollen glands
___ Easy bruising
___ No problems

Neurological
___ Headache
___ Memory loss
___ Fainting
___ Dizziness
___ Numbness / tingling
___ Unsteady gait
___ Frequent falls
___ No problems

Allergic/Immune
___ Hay fever / allergies
___ Frequent infections
___ No problems

Psychiatric
___ Anxiety / stress / irritability
___ Sleep problem
___ Lack of concentration
___ No problems

Women only
___ Pre-menstrual symptoms (bloating cramps, irritability)
___ Problem with menstrual periods
___ Hot flashes / night sweats
___ No problems

Men only
___ Erection problems
___ Lump in testicle
___ Prostate cancer
___ Enlarged Prostate
___ No Problems

To the best of my knowledge, the above information is complete and correct. I understand that is my responsibility to inform my doctor if I, or my minor child ever have a change in health. I assign directly to Dr. Elise M. Brett and Dr. Jeffrey I. Mechanick at 1192 Park Avenue, all insurances rendered. I understand I am financially responsible for all charges. I also authorize the disclosure of medical records to other providers for the management of my care in the extent permitted by law. I request payment to be made directly to Dr. Elise M. Brett and Dr. Jeffrey I. Mechanick at 1192 Park Avenue on my behalf.

Signature _____

Print _____ **DOB**_____