**MERLE F. BRUCE, MD, FACS (775) 786-9300 TOLL FREE: (800) 452-6266 FAX: (775) 786-9280**

## PATIENT INFORMATION

**PATIENT NAME:** _____"_____"
LAST, FIRST, MIDDLE INITIAL NICKNAME

**MAILING ADDRESS:**_____ **APT #:**_____

**ZIP CODE:** _____ **CITY**: _____ **STATE**: _____

**HOME PHONE #:** (_____) _____-_____ **WORK PHONE #:** (_____) _____-_____

**CELL PHONE#:** (_____) _____-_____ **EMAIL:**_____

**DATE OF BIRTH:** _____/_____/_____ **AGE:** _____ **SOCIAL SECURITY NUMBER:** _____-_____-_____

**MARITAL STATUS**: SINGLE MARRIED DIVORCED WIDOWED OTHER_____

**PATIENT RELATIONSHIP TO THE INSURED:** (circle one) **SEX:** (circle one) FEMALE MALE
SELF SPOUSE CHILD OTHER

**PRIMARY CARE PHYSICIAN:**_____ **REFERRED BY:** _____

**PATIENT'S EMPLOYER INFORMATION:**

COMPANY: _____ PHONE#: (_____)_____

**DRUG ALLERGIES**_____

**ACCIDENT INFORMATION:** DATE OF ACCIDENT:_____ WORK RELATED?_____ AUTO:_____ OTHER:_____

**EMERGENCY CONTACT**_____ Phone **(_____)**_____

RELATIONSHIP TO PATIENT: _____

## FINANCIALLY RESPONSIBLE PARTY INFORMATION (IF SAME AS ABOVE PLEASE DISREGARD)

**RESP. PARTY NAME:** _____
LAST FIRST MIDDLE

**ADDRESS:** _____

**HOME PHONE #:** (_____) _____-_____ **WORK PHONE #:** (_____) _____-_____

**CELL PHONE#:** (_____) _____-_____ **EMAIL:**_____ **AGE:** _____

**DATE OF BIRTH:** _____/_____/_____ **SEX:** (circle one) FEMALE MALE

**SOCIAL SECURITY NUMBER:** _____ - _____ - _____

**RESPONSIBLE PARTY'S EMPLOYER INFORMATION:**

COMPANY: _____ PHONE# (_____)_____

## INSURED OR EMPLOYEE INFORMATION (IF SAME AS ABOVE PLEASE DISREGARD)

**INSURED OR EMPLOYEE NAME**: _____
LAST, FIRST, MIDDLE INITIAL

**ADDRESS:** _____

**HOME PHONE #:** (_____) _____-_____ **WORK PHONE #:** (_____) _____-_____

**CELL PHONE#:** (_____) _____-_____ **EMAIL:**_____ **AGE:** _____

**DATE OF BIRTH:** _____/_____/_____ **SEX:** (circle one) FEMALE MALE

**SOCIAL SECURITY NUMBER:** _____ - _____ - _____

**RESPONSIBLE PARTY'S EMPLOYER INFORMATION:**

COMPANY: _____ PHONE# (_____)_____

**MEDICAL INFORMATION:**

List any health conditions Dr. Bruce should be aware of:

_____

Medication you are currently taking:

_____

Have you ever had any form of Hepatitis? If yes, which type? A, B, or C? _____

**MEDICAL RELEASE INFORMATION:**

I authorize the release of my medical records to all other providers involved in my care. Additionally, I authorize Dr. Bruce or his office staff to request any medical records from other physicians on my behalf. I also authorize Dr. Bruce or his office staff to communicate health related information to me via voice mail or facsimile.

**FILE DESTRUCTION POLICY:**

We destroy all medical records after seven years, unless otherwise notified.

**BILLING AND COLLECTION POLICY:**

1. CONTRACTED INSURANCE COMPANIES: We bill insurance companies we are contracted with. You are responsible for any co-payments at the time of service. We reserve the right to collect a portion of your deductible and or your co-insurance at the time of your appointment, however most times we will balance bill you for your deductible and or your co-insurance balance after we have billed your health insurance.

2. NON CONTRACTED INSURANCE COMPANIES OR INDEMNITY PLANS: We bill private insurance companies as a courtesy. We will generally collect a small payment at the time of service and send you a bill for any remaining balance.

3. NO INSURANCE OR COSMETIC CONSULTATIONS: Payment is due in full at the time of service.

   How do you wish to pay for your co-pay, co-insurance or deductible, if applicable? Cash __Check __Visa/MC __

Billing insurance companies is a courtesy we provide to our patients, however the patient or guardian is ultimately responsible for any balances in this office. If we do not receive payment from your insurance company within 30 days of submitting the medical claim, it becomes the patient or guardian responsibility to assist with getting claims processed and paid.

I authorize payment of medical benefits to Dr. Bruce. I understand that I am fully responsible for payment of all fees incurred through this office regardless of my insurance coverage and I agree to follow the established payment policy of this office, of which I have been informed. I understand that I may be responsible for an additional co-pay or co-insurance amount over and above my initial co-pay for any office procedures or hearing testing provided and I will advise the doctor if I do not wish to receive these services.

In coordinating patient care, it is the patient or guardians responsibility to notify this office of any referral requirements or preferred facility requirements.

It is the discretion of this office as to whether or not a service charge will be applied to any unpaid balances over 60 days past due. If an account becomes delinquent, a processing charge of 20% of the account balance or a flat fee of $25.00, whichever is greater, will be applied to the account balance and that balance will be forwarded to a collection agency.

I have read and understand the above information and will comply with my financial obligations.

SIGNATURE: _____DATE: _____

**DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY**.

This notice is effective as of April 14, 2003.

## USES AND DISCLOSURE OF HEALTH INFORMATION

### *TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS*

Merle F. Bruce, M.D., F.A.C.S., uses and discloses your protected health information for treatment, payment and health care operations. Some examples of when our office may use or disclose your health care information for these purposes include:

-Sharing test results with other health care providers for confirmation of diagnosis;
-Providing your diagnosis or other information about your health to your insurance provider or our billing service to obtain payment for the health care services we provide;
-Reviewing information as part of our quality improvement program.

### *OTHER USES AND DISCLOSURES*

Merle F. Bruce, M.D., F.A.C.S., may also use or disclose your protected health information, in compliance with guidelines outlined by law, for the following purposes:

-Providing you with information related to your health;
-Contacting you regarding appointments, information about treatment alternatives, or other health related services;
-Incidental uses or disclosure (e.g., listing your name on a sign-in sheet, etc.);
-Compliance with all laws (including reports of suspected abuse, neglect or violence);
-Providing certain specified information to law enforcement or correctional institutions;
-Providing information to a coroner, medical examiner, funeral director, or organ procurement organization;
-Public health activities when requested by a public health authority or the FDA;
-Responding to health oversight agencies;
-Responding to court or administrative tribunal orders, subpoenas, discovery requests or other lawful process;
-Research activities;
-When necessary to avert serious threat to health or safety;
-Military affairs, veterans affairs, national security, intelligence, Department of State, or presidential protective service activities;
-Providing information regarding your location, general condition or death to public or private disaster relief agencies; or
-Informing a family member, other relative, or close personal friend when:
    -Information is relevant to the individual's involvement with your care;
    -Notification of your location, general condition or death;
    -To assist in your health care (e.g., pick-up prescriptions or other documents, note follow-up care instructions, etc.).

### *AUTHORIZATION FOR OTHER USES*

Merle F. Bruce, M.D., F.A.C.S., will make other uses and disclosure of your protected health information only after obtaining your written authorization. If you authorize a use not contained in this notice, you may revoke your authorization at any time by notifying us in writing that you wish to revoke your authorization.

## YOUR RIGHTS REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Subject to limitations outlined by law, you have certain rights related to use and disclosure of your protected health information, including the right to:

-Request restrictions on certain uses and disclosures. However, Merle F. Bruce, M.D., F.A.C.S., is not

obligated to agree to requested restrictions.
-Receive confidential communications of protected health information.
-Inspect and copy your protected health information with some limited exceptions;
-Amend your health information;
-Receive an accounting of disclosures of your health information;
-Obtain a copy of this notice.

## MERLE F. BRUCE, M.D., F.A.C.S., DUTIES REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Subject to limitations outlined by law, Merle F. Bruce, M.D., F.A.C.S., has certain duties related to your protected health information, including:

-Merle F. Bruce, M.D., F.A.C.S., is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.
-Merle F. Bruce, M.D., F.A.C.S., is required to abide by the terms of the privacy notice that is currently in effect.
-Merle F. Bruce, M.D., F.A.C.S., reserves the right to change a privacy practice described in this notice and to make such change effective for all protected health information. Revised notice will be posted in our office and available upon request.

## PATIENT CONCERNS

If you believe your privacy rights have been violated, you may make a complaint by contacting Laura Klearman, Privacy Officer, 236 W. Sixth St., Ste. 107, Reno, NV 89503, (775)786-9300, or the Secretary for the Department of Health and Human Services. No individual will be retaliated against for filing a complaint.

## REQUEST TO RELEASE HEALTH INFORMATION

You hereby authorize this office to discuss and or release your health information to the following individuals:

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

It is your responsibility to notify this office, in writing, if you no longer wish your health information to be released to any of the above individuals.

## ACKNOWLEDGEMENT

I acknowledge that I have reviewed this notice regarding the use and disclosure of my health information. If you wish for a copy of this notification, please inform the receptionist.

_____ _____

Signature Date