MAIN STREET MEDICAL CLINIC

Name: _____ Sex: ○M ○F Date of Birth: _____ Age: ____ yrs
LAST FIRST MI mm/dd/yyyy

Home Phone: ☐ _____ Cell Phone: ☐ _____ Other Phone: ☐ _____
CHECK BOX IF PREFERRED CONTACT NUMBER CHECK BOX IF PREFERRED CONTACT NUMBER SPOUSE/PARENT CHECK BOX IF PREFERRED CONTACT NUMBER

Mailing Address: _____ City: _____ State: _____ Zip: _____

Social Security: _____ Email: _____

Occupation: _____ Employer: _____ Work Phone: _____
PARENT'S IF PATIENT IS A MINOR

Spouse: _____ Employer: _____ Work Phone: _____
2ND PARENT'S IF PATIENT IS A MINOR

Race / Ethnicity: ○ White ○ African American ○ Hispanic / Latino ○ Native American ○ Asian ○ Other: _____

Language: ☐ English ☐ Spanish ☐ Hindi ☐ Urdu ☐ Tamil ☐ Swahili ☐ Other: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone: _____

MEDICAL RELEASE INFORMATION

- Can we discuss your medical condition or test result(s) with your family member(s)? ○NO ○YES, can be shared with _____
- Can we leave a message on your answering machine at: (a) Home? ○NO ○ YES (b) Cell? ○NO ○ YES (c) Work? ○NO ○ YES
- Fax a copy of your result(s) to another physician if need be: ○ NO ○ YES

INSURANCE INFORMATION

Primary Insured: ☐ Self IF: ○ Spouse or ○ Parent _____

Name of Insurance Co. 1. _____ 2. _____

Policy No. / Group No. 1. _____ / _____ 2. _____ / _____

CONTROLLED SUBSTANCE AGREEMENT

Main Street Medical Clinic doctor(s) and/or any appropriately authorized provider(s) may at any time discontinue the controlled substance prescription(s) at his/her discretion. Patient's progress will be periodically reviewed and, if the controlled substance(s) are not improving patient's health, it may be discontinued. Main Street Medical Clinic may also discontinue prescribing certain medication(s) if they believe they are being abused.

FINANCIAL RESPONSIBILITY

By signing below you agree that you have insurance coverage as above and assign directly to Main Street Medical Clinic or Dr. Abbas Jafri, MD all medical benefits, if any, otherwise payable to you for services rendered. You understand that you are financially responsible for all charges whether or not paid by insurance. You hereby authorize Main Street Medical Clinic to release all information necessary to secure the payment of benefits or process your insurance claims. You also agree to the Medical Release and Controlled Substance agreement mentioned above.

Signature: _____ **Name:** _____ **Date:** _____

Thank you for allowing us to take part in your healthcare. To help manage the cost of your healthcare, we have developed a fair payment policy so that you can receive comprehensive care and minimize the stress associated with the financial burden of good care. If you have a past due balance or incur substantial new charges that make it difficult for payment at the time of service, the office staff has the capacity to allow you to make a payment plan to address those amounts. The payment plan requires as little as $10 at a time, but does require that payment is automated. Be assured all private information is managed by a national 3rd party vendor who follows federal privacy regulations.

If you have insurance, we will bill it for the services we provide, however, please realize, insurance benefits, is a contract between you and/or your employer and your insurance carrier. If there are services within certain standards that we provide, even if the insurance does not pay, they are your responsibility. It is also your responsibility to advise us of any updates or changes to your insurance. Most insurance will not pay if a claim is filed after 60 days and therefore it would be your responsibility.

Co-Pays are due at the time of service. We may send periodic statements with any balances after your insurance company has paid. If you have any questions about charges on your statement, please contact the Billing Department immediately. The balance on your account is due immediately once responsibility has been determined, whether, by the EOB (Explanation of Benefits) from your insurance company or by statement.

Please be courteous and call Main Street Medical Clinic promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to timely care.

* Patients who fail to show for their scheduled appointment or did not notify the office within 24 hours of their scheduled appointment time, shall be subject to a "No Show/ Cancellation" fee of $25.00. In the event of an actual emergency and prior notice could not be given, consideration will be given, and a one-time exception may be granted. If appointment is canceled by the physician office, then the patient is not subject to this charge.
*These fees are not covered by insurance and is therefore the sole responsibility of the patient.

MAIN STREET MEDICAL CLINIC

Welcome to our practice. We are committed to your health. The purpose of this questionnaire is to establish a baseline of factors that are important to your health. It provides information that is critical in your treatment both today and in the future. We will ask you to fill the questionnaire once a year. It serves as a checklist of health issues that you would like to discuss and those that need to be addressed. **Please** do your best at answering all questions. Our practice utilizes physicians and advanced practitioners (PAs and Nurse Practitioners) and you as a patient always have a right to see the practitioner of your choice.

NAME: _____ AGE: _____ SEX: ○M ○F DATE: _____

CONCERNS (& DURATION):

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

MEDICATIONS (DOSE & DIRECTION):

1. _____ 5. _____ 9. _____
2. _____ 6. _____ 10. _____
3. _____ 7. _____ 11. _____
4. _____ 8. _____ 12. _____

Non-Prescription: _____

ALLERGIES (Describe Reaction): _____

HABITS & SAFETY:

Smoking _____ cigarette(s)/day x _____ years Alcohol _____ per week Recreational Drugs? ○Yes ○No Coffee _____ cups/day Wear Seat Belts? ○Yes ○No Helmets if you ride bike? ○Yes ○No Home Smoke Alarm? ○Yes ○No Multiple sexual partners, past or present? ○Yes ○No If yes, do you practice safe sex (utilize protection)? ○Yes ○No Any routine exercise program? ○Yes ○No Do you feel you are overweight? ○Yes ○No What is your height? ____ feet ____ inches

PAST SURGERIES (Year or Age): _____

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

OTHER ILLNESSES (Such as High Blood Pressure, Diabetes, Asthma, Heart Disease, Seasonal Allergies, Cancer, etc.):

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

FEMALES: Last Period: _____ ▫ Menopausal Hysterectomy? ○Yes ○No Last PAP (mo/yr): _____ Last Mammogram: _____
No. of Pregnancies: _____ No. of Children: _____ Miscarriages: _____ Do you perform self Breast exams? ○Yes ○No

OTHER CONCERNS:

- ☐ Abdominal Pain
- ☐ Always Tired
- ☐ Anemia
- ☐ Anxious
- ☐ Asthma
- ☐ Bloating
- ☐ Blood in Stool
- ☐ Blood in Urine
- ☐ Blood Pressure Elevation
- ☐ Blurred Vision
- ☐ Chest Pain on Exertion
- ☐ Chest Pains
- ☐ Chest Pressure/Heaviness
- ☐ Chronic Cough
- ☐ Concentration Problems
- ☐ Constipation Frequently
- ☐ Dark Stools Frequently
- ☐ Decreased Urine Force
- ☐ Depression
- ☐ Diarrhea Frequently
- ☐ Excessive Thirst
- ☐ Eye Pain
- ☐ Fainting
- ☐ Frequent Bronchitis
- ☐ Frequent Night Sweats
- ☐ Frequent Urine Infections
- ☐ Headaches Frequently
- ☐ Hearing Difficulty
- ☐ Heart Murmur
- ☐ Heartburn Frequently
- ☐ High Cholesterol
- ☐ History of Hepatitis
- ☐ History of Ulcers
- ☐ HIV Risks
- ☐ Hypoglycemia
- ☐ Indigestion Frequently
- ☐ Irregular Heart Beats
- ☐ Joint Pains
- ☐ Leg Pains
- ☐ Light Headedness
- ☐ Loss of Energy
- ☐ Loss of Interest
- ☐ Memory Loss
- ☐ Migraines
- ☐ Moodiness
- ☐ Nausea Frequently
- ☐ Nervousness
- ☐ Night Urination Frequently
- ☐ Numbness
- ☐ Numerous Sexual Partners
- ☐ Painful Urination
- ☐ Palpitations
- ☐ Recent Hair Loss
- ☐ Recent Nose Bleeds
- ☐ Recent Vision Change
- ☐ Recurrent Back Pains
- ☐ Recurrent Hives or Rash
- ☐ Seasonal Allergies
- ☐ Sexual Difficulties
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Skin Lesions
- ☐ Skin Rashes
- ☐ Sleeping Difficulty
- ☐ Strain to Urinate
- ☐ Stress Easily
- ☐ Swallowing Problems
- ☐ Swelling of Ankles or Feet
- ☐ Tremor
- ☐ Urination Excessively
- ☐ Urine Leakage/Incontinence
- ☐ Weakness _____
- ☐ Weight Gain Recently
- ☐ Weight Loss Recently
- ☐ Wheezing

FAMILY HISTORY (Check Boxes)	FATHER	MOTHER	BROTHER(S)	SISTER(S)	PATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	MATERNAL GRANDMOTHER	FATHER'S SIDE	MOTHER'S SIDE
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Problem	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Strokes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alzheimer's Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Been around someone with long duration of fever, weight loss, cough, and/or coughing up blood?
○Yes ○No ○Not Sure

Contact with anyone who is an intravenous drug user, has HIV, in prison, or recently moved to US?
○Yes ○No ○Not Sure

Due for Tetanus (if < 10 years)?
Last: _____ ○Yes ○No

Had Pneumonia Immunization (if over 65 yrs)?
○Yes ○No

Would you like us to notify you of annual flu shots?
○Yes ○No

Would you like information on advance directive?
○Yes ○No

MAIN STREET
MEDICAL CLINIC

HIPPA NOTICE OR PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Main Street Medical Clinic uses an electronic medical record system that allows electronic prescribing of medications. Medications are sent to your pharmacy and insurance company through a secure electronic prescription connection which improves the timely and accurate transmission of your medication information. To optimize the use of this electronic capability, and coordinate your care between us and your specialists, this will allow us to access your medication history through the pharmacies and insurance companies' electronic database.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, which may identify you and that relates to your past, present, or future physical or mental health or condition and related health services.

1. Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.
    a. Treatment: We 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 example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

    b. Payment: Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

    c. Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation, research, criminal activity, military activity, and national security, workers' compensation, inmates. Required uses and disclosures: under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. **Other permitted and required uses and disclosures** will be made only with your consent, authorization, or opportunity to object unless required by law. **You may revoke this authorization** at anytime, in writing, except to the extent that you physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2. Your Rights: Following is a statement of your rights with respect to your protected health information.

    a. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

    b. You have the right to request a restriction of you protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices.

    c. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure or your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

    d. You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

    e. You have the right to obtain a paper copy of this notice from us, upon request, if you have agreed to accept this notice alternatively i.e. electronically.

    f. You may have the right to your physician amend your protected health information. If we deny your request for amendment, 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 such rebuttal.

    g. You have the right to receive an accounting of certain disclosures we have made, if any, or your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact or your complaint. We will not retaliate against you for filing a complaint. We are required by law to maintain the privacy or, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name: _____ **Signature:** _____ **Date:** _____