Consent To Obtain Medication History

Patient Medication History is a list of prescriptions that Healthcare Providers have prescribed to you. A Variety of Sources, including Pharmacies and Physicians' offices, contribute to collection of this history.

The collected information is stored in the practice's Electronic Medical Record (EMR) system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness' properly and to avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also, over the counter drugs, supplements, or herbal remedies that you take on your own may not be included.

By signing this consent form you are giving our office permission to collect and share your pharmacy and health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV, and Mental Health Issues.

Sign _____ Date _____

Code of Conduct

In an effort to provide a safe and healthy environment for our staff, patients, visitors and their families, our office requests that visitors refrain from unacceptable behaviors that may be disruptive to the office or pose a threat to others.

The following behaviors are prohibited:

-Possession of firearms or any weapon while in the office
-Physical assault, arson or inflicting bodily harm
-Throwing objects
-Children climbing on furniture or chairs (adults are expected to supervise children)
-Making verbal threats to harm another individual or destroy property
-Intentionally damaging equipment or property
-Attempting to intimidate or harass other individuals
-Making harassing, offensive, intimidating statements and/or gestures
-Making threats of violence through phone calls, letters, voicemail, emails
-Racial or Cultural slurs or other derogatory remarks associated with, but not limited to race, language or sexuality
-Theft of property of Dr Jeffrey Monash or his staff

If you are subjected to any of these behaviors or witness inappropriate behavior, please notify any staff member. Violators are subject to removal from the office and discharge from the practice.

Sign_____ Date _____

FMLA/Disability Policy

The following information is regarding our FMLA/Disability policy

Health Care Certification Form: Please hand in your Health Care Certification form from your employer to us as soon as possible. This is to allow enough time for us to provide an assessment and complete the required paperwork.

Please complete all Request Forms so that we may properly identify you. It is important to include your full name, signature, date of birth, daytime phone number and the requested days of leave. Your form will be sent back to you if it is not completed in its entirety, which will delay the process

Typical turnaround time is 2 weeks from when your request is received

Our office will contact you when your paperwork is completed, forms can be mailed or emailed. If you prefer them mailed, we will need to be notified in advance, pre postage paid may be requested

If you do not hear from our office within two weeks, please contact us at 520-319-6000

For each completed FMLA/Disability packet, there is a 25-dollar processing fee. These is payable upon submission of your forms to us for completion

Sign _____ Date _____

HIPPA/Communication Consent Form

I hereby authorize direct payment of my insurance benefits to Jeffrey Monash, MD, FACS, or to the physician individually for services rendered to myself or my dependent by the physician under his supervision. I understand that I am responsible for knowing what my insurance benefits are, and whether the services I am to receive are covered under my policy. I understand and agree that I will be responsible for any copay or balance due that my insurance is unable to collect from my insurance carrier

I certify that I have received and read a copy of Dr Monash's Patient Information Privacy Policy HIPAA. I hereby authorize that Dr Monash's office staff may release any of my or my dependents medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation or the for the processing of my medical claims

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pays, or balance due for these services if they are not reimbursed by my insurance

I certify that I understand the privacy risks of the mail, phone calls and emails. I hereby authorize Dr Monash's office to mail, call or email me with communications regarding my healthcare such as, but not limited to, appointments reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying the office to that effect in writing

Communication Preferences

What is your preferred primary contact phone number? _____

Do we have permission to leave a detailed message on your voicemail if you are unable to answer your phone? _____ Yes ____No

May we send you Medical information in an email? ____ Yes ____No

By Signing this form, I agree to all the statements above

Signature _____ Date_____

HIPPA Notice of Privacy Practices

This notice describes how Medical Information about you may be used and discussed and how you can get access to this information. Please review it carefully.

Jeffrey B Monash MD, FACS understands that your Medical Health Information is personal. Protecting your health information is important. We follow strict Federal and State Laws that require us to maintain the confidentiality of your health information.

When you receive care from our physicians, we may use your protected information (PHI) for treating you, billing services and conducting our normal business known as health care operations.

Examples of how we use your information include:

Treatment: We keep records of the care and services provided to you. Our providers use these records to deliver quality care to meet your needs. For example, the provider may share your health information with a specialist who may assist in your treatment. Some health records including some communications with a mental health professional and some substance abuse records may have additional restrictions and disclosure under state and federal law

Payment: we keep billing records that include payment information and documentation of the services provided to you. Your information may be used to obtain payment from you, your insurance company or other third parties. We may also contact your insurance company to verify coverage for your care or to notify them of upcoming services that may need prior notice or approval. For example, we may disclose information about the services provided to you to obtain payment from your insurance company

Healthcare Operations: we use health information to improve the quality of care, train staff, provide customer service, manage costs, conduct required business duties and make plans to better serve our community. For example, we may use your health information to evaluate the quality of treatment and services provided by our physicians, nurse practitioners and other health care workers

Continued..

Other uses of your Protected Health Information (PHI)

-Recommend Alternative Treatment
-Tell you about health services and products that may benefit you
-Share information with family or friends involved in your care or payment for your care, when appropriate
-Share information with third parties who assist us with treatment, payment and health care operations
-Remind you of an appointment
-Contact you to provide you with office education materials such as newsletters or research participation requests

There are limited situations when we are permitted or required to disclose health information without your signed consent. These situations are:

-To protect victims of abuse, neglect or domestic violence
-For health oversight activities such as investigations, audits and inspections
-For law enforcement purposes
-For lawsuits and similar proceedings
-When otherwise required by law
-When requested by law enforcement as required by law of court order
-To coroners, medical examiners and funeral homes
-For organ and tissue donations
-For research under strict federal guidelines
-To reduce or prevent a serious threat to public health and safety
-For workers' compensation or other similar programs of you are injured at work
-For specialized government functions such as intelligence and nation security

All other uses and disclosures, not described in this notice, require your signed authorization. You may revoke your authorization at any time with a written statement (with limited exceptions as provided by federal regulations)

Your Individual rights, the following statements of your rights with respect to your protected health information:

You have the right to inspect and copy your protected health information (fees may apply) under federal law, however, you may not inspect or copy the following records: Psychotherapy note, information compiled in reasonable anticipation of or used in a civil, criminal, or administrative action or proceeding. PHI restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosures may results in harm or injury to you or another person, or information that was obtained under a promise of confidentiality

Continued...

You have the right to request a restriction of your protected health information. This means you may ask not to use or disclose any part of your protected health information, and by law we must comply when the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your PHI 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. Your request must state the specific restriction request and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request confidential communications, from us by alternative means or at an alternative location. You have the right to request a paper copy of this notice from us. Even if you accept this form electronically.

You have the right to request an amendment to you your PHI, 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 any such rebuttal

You have the right to receive and accounting of certain disclosures, except for disclosures pursuant to an authorization, for purposes of treatment, payment, healthcare operations, required by law, that occurred prior to April 14, 2003, or SIX (6) years prior to the date of the request

You have the right to obtain a paper copy of this notice from us even if you agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes at your following appointment. We will also make available copies of our new notice if you wish to obtain one

Complaints may be made 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 Compliance Officer of your complaint. We will not retaliate against you for filing the complaint

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to PHI, we are also required to abide by terms of the notice currently in effect. If you have questions about this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 520-319-6000

The office of Jeffrey Monash, MD, FACS is required by law to:

-Maintain the privacy of your health information
-Provide this notice that describes the ways we may use and share your health information
-Follow the terms of the notice

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We reserve the right to make changes to this notice at any time and make the new privacy practices effective for all the information we maintain. Current notices will be posted in our office. You may also request a copy of any notice from our office manager

This notice describes the privacy practices of Jeffrey Monash, MD, FACS including employees and volunteers. This notice also describes the privacy practices of affiliated providers while they are performing services on behalf of Dr Monash unless they provide you with notice of their specific privacy practices. Affiliated providers are not employed by Dr Monash but are authorized to provide services to patients. Affiliated providers may have different privacy practices from those described in this notice. For more information about the privacy practices of affiliated providers, please contact them directly.

Contact us

If you would like further information about your privacy rights or are concerned that your privacy rights have been violated, or disagree with a decision that we made about access to your PHI, please contact our office manager at 520-319-6000

Please sign below acknowledging that you read HIPAA Notice of Privacy Practices

Sign: _____ Date _____