Natura Medica

THE CENTER FOR NATURAL MEDICINE

CONTACT INFORAMTION DATE _____

PATIENT NAME: _____ PATIENT DATE OF BIRTH:_____

RESPONSIBLE PARTY / PARENT / GUARDIAN NAME:_____

PERMANENT ADDRESS: _____

MAILING ADDRESS (IF DIFFERENT): _____

PHONE NUMBER: _____

PRIMARY INSURANCE:

SELF-PAY /AETNA / ANTHEM BLUE CROSS /CIGNA / UNITED HEALTHCARE /OTHER _____

ID #_____ GROUP#_____ COPAY $_____

POLICY HOLDER RELATIONSHIP TO PATIENT (**CIRCLE ONE**): SELF PARENT SPOUSE/PARTNER OTHER

IF OTHER THAN SELF COMPLETE THE FOLLOWING:

POLICY HOLDER NAME: _____BIRTH DATE: _____

ADDRESS: _____

SECONDARY INSURANCE:

SELF-PAY /AETNA / ANTHEM BLUE CROSS /CIGNA / UNITED HEALTHCARE /OTHER _____

ID #_____ GROUP#_____ COPAY $_____

POLICY HOLDER RELATIONSHIP TO PATIENT (**CIRCLE ONE**): SELF PARENT SPOUSE/PARTNER OTHER

IF OTHER THAN SELF COMPLETE THE FOLLOWING:

POLICY HOLDER NAME: _____BIRTH DATE: _____

ADDRESS: _____

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NOTICE OF PRIVACY PRACTICE

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our commitment to your privacy, and our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following information:

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.
9. Request by Record Release

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have a right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Natura Medica 12 Roosevelt Ave Mystic CT 06355. *Note: We must respond to this request within 30 days.*

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, you request must be made in writing and submitted to Natura Medica 12 Roosevelt Ave Mystic CT 06355. You must provide us with a reason that supports your request for amendment. *Note: We must respond within 60 days. The Privacy Officer/office manager or the patient's doctor will usually do this. If the doctor believes the information is complete and accurate, the doctor can refuse to make any changes.*

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5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the front desk receptionist/office manager.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Manager at Natura Medica 12 Roosevelt Ave Mystic CT 06355. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

Please indicate choice of communication (if both are provided, please indicate preferred method):

PHONE: _____ Preferred ____

EMAIL*: _____ Preferred ____

(*Note: email is not HIPAA compliant when sent unencrypted; not under the protection of a firewall.)

HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information (described below) to:

NAME: _____ RELATIONSHIP:_____

CONTACT INFORMATION/PHONE #:_____

NAME: _____ RELATIONSHIP:_____

CONTACT INFORMATION/PHONE #:_____

I hereby acknowledge that I have received, or reviewed, a copy of Integrative Wellness Center, LLC dba Natura Medica's Notice of Privacy Practices (HIPAA).

Patient Name: _____ Date: _____

Signature: _____

Name and Relation of Person Signing form if other than Patient:

_____

CIRCLE: Parent Guardian Spouse/Partner Attorney