Lake County Family Practice

9500 Mentor Ave. Suite 100 Mentor Ohio 44060 (440) 352-4880
www.lcfp.net

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. *PLEASE REVIEW IT CAREFULLY.*

Lake County Family Practice (LCFP) is requíred by law to maintain the privacy of patients' personal health information and to provide patients with notice of LCFP legal duties and privacy practices with respect to your personal health information. LCFP is required to abide by the terms of the Notice of Privacy Practices as necessary and make the new Notice effective for all personal health information maintained by LCFP. You may receive a copy of any revised notices by mailing a request to Privacy Officer, Lake County Family Practice, 9500 Mentor Ave., Mentor, Ohio 44060.

USES AND DISCLOSURES OF PERSONAL HEALTH INFORMATION

Your Authorization. Except as outlined below, LCFP will not use or disclose your personal health information for any purpose unless you have signed a form authorizing the disclosure. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Uses and Disclosures for Treatment. LCFP will make uses and disclosures for your personal health information as necessary for your treatment. For instance, doctors, nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to plan a course of treatment for you that may include procedures, medications, tests, ect. LCFP may also release your personal health information to another health care facility or professional who is or will be providing treatment to you. For instance, if you are going to receive home care or are being referred to a specialist for treatment, LCFP may release your personal health information to that facility so that a plan of treatment can be prepared for you.

Uses and Disclosure for Payment. LCFP will make uses and disclosures of your personal health information as necessary for payment purposes of those health professionals and facilities that have treated you or provided services to you. For instance, LCFP may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you, or LCFP may use your information to prepare a bill to send to you or the person responsible for your payment.

Family and Friends Involved in your Care. LCFP may, from time to time, disclose your personal health information to family, friends and others who are involved in your care or in payment of your care. If you are unavailable, incapacitated, or facing an emergency medical situation and it is determined that a limited disclosure may be in your best interest, limited personal health information may be shared with such individuals without your approval.

Appointments and Services. LCFP may contact you to provide appointment reminders or test results. You have the right to request, and LCFP will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, you may wish appointment reminders not to be left on voice mail or sent to a particular address. You may request such confidential communication in writing. Request forms may be obtained from registration at our office.

Health Products and Services. LCFP may from time to time use your personal health information to communicate with you about health products and services necessary for your treatment, to advise you of new products and services offered by LCFP and to provide general health and wellness information.

Other Uses and Disclosures. Federal laws and regulations do not protect any information about suspected child or elder abuse or neglect from being reported under State law to appropriate State or local authorities. LCFP is permitted or required by law to make certain other uses and disclosure of your personal health information without your consent or authorization:

- For any purpose required by law; for public health activities, such as required reporting of disease, injury, birth, death, and for required public health investigations.
- For suspected child/elder abuse or neglect; or if there is suspicion that you may be a victim of abuse, neglect or domestic violence.
- To the FDA to report adverse events, product defects, or to participate in product recalls.
- To your employer when LCFP has provided health care to you at the request of your employer to determine workplace-related illness or injury.
- To coroners and/or funeral directors consistent with the law.
- If necessary to arrange an organ or tissue donation from you or a transplant for you.
- If you are a member of the military as required by armed forces services; or if necessary for national security or intelligence activities.

LCFP may release your personal health information in accordance with any state laws that are more restrictive or limiting than federal privacy regulations. (Ohio law requires that we obtain a consent form from you before disclosing the Performance or results of an HIV test or diagnosis of AIDS or an AIDS-related condition.)

RIGHTS THAT YOU HAVE

Access to Your Personal Health Information. You have the right to inspect and/or copy much of the personal health information that LCFP retains on your behalf.

Amendments to Your Personal Health Information. You have the right to request in writing that personal health information maintained by LCFP be amended or corrected. LCFP is not obligated to make all requested amendments but will give each request careful consideration.

Accounting for Disclosures of your Personal Health Information. You have the right to receive an accounting of certain disclosures made by LCFP of your personal health information after April 14, 2003. The first accounting is free; you will then be charged a fee of $5.00 for each subsequent accounting.

Restrictions on Use and Disclosure of Your Personal Health Information. You have the right to request restrictions on certain of LCFP uses and disclosures of personal health information for treatment, payment, or health care operations. LCFP is not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate .

All requests for Access, Amendments, Accounting for Disclosures, and Restrictions on Use and Disclosure must be in writing and signed by you or your representative. Forms can be obtained from an LCFP receptionist.

RECORDS

Charts that have been inactive for 10 years are destroyed except for the charts of children which are kept until the child is 18 years old.

COMPLAINTS

If you believe your privacy rights have been violated, you can file a complaint with the LCFP Privacy Officer by mail or by telephone. Please direct correspondence to Joyce Taylor, Administration Building, 7590 Auburn Road, Concord Township, Ohio 44077. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights.

LAKE COUNTY FAMILY PRACTICE

FINANCIAL POLICY

In order to provide your health care at the most affordable cost, our medical staff requires payment at the time of service.

IF YOU HAVE INSURANCE:

We will file most insurance, but you are responsible for any balances. If you have health insurance, you will not be held liable for "insurance charges" until 30 days after the date of service. If, after 30 days, your insurance has not paid in full, the entire balance becomes your responsibility. Insurance co-payments and deductibles are due at the time of service.

SELF PAY:

If you are without health insurance, our staff will require payment for the office call at the time of service. Additional services will be billed to you. If full payment cannot be made within 30 days, our staff will be happy to arrange a repayment agreement.

OUR COLLECTIONS POLICY:

If, after 30 days from the date of service, your account is not paid in full, all charges are your responsibility. If, after 60 days from date of service, a balance still remains - we have the option of forwarding your account to our collections department.

If, after 90 days from the date of service, any balance remains on your account, we will consider an outside collection agency or other means to pursue your account., To avoid this, please call our business office to make special arrangements regarding a payment agreement.

DELINQUENT ACCOUNTS:

After 120 days, if a balance remains without a payment agreement, we will no longer continue as your family's provider of health care. We suggest that you place yourself under the care of another physician without delay. Once paid in full, we will be happy to consider reinstating the patient/doctor relationship. However, future services may be based upon a "cash only" agreement, as determined by Lake County Family Practice.

My signature below indicates that I have read and understand the terms of this financial policy.

PATIENT _____ **RESPONSIBLE PARTY**_____

(PRINT NAME) (SIGN NAME)

DATE_____ **WITNESS**_____

White-Office Copy Yellow-Patient Copy

GENERAL HEALTH HISTORY QUESTIONNAIRE (age 13 years or older)

Name: _____ _____ _____ Date:_____
(LAST) (FIRST) (MI)

Date of Birth_____ Male / Female_____ Race_____

SIGNIFICANT ILLNESSES

Do you or have you had: (please circle)

Diabetes	YES	NO
Cancer	YES	NO
Gout	YES	NO
High Blood Pressure	YES	NO
Heart Disease	YES	NO
Kidney Disease	YES	NO
Mental Illness	YES	NO
Abnormal Pap	YES	NO
Asthma	YES	NO
High Cholesterol	YES	NO

Other Illness not listed:_____

HOSPITALIZATIONS/SURGERIES

List all reasons you were hospitalized	Year
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

FAMILY MEDICAL HISTORY

Has any blood relative, including children, had any of the following:

			Relationship
Anemia	Y	N	_____
Bleeding Tendency	Y	N	_____
Cancer	Y	N	_____
Diabetes	Y	N	_____
Epilepsy	Y	N	_____
Heart Disease	Y	N	_____
High Cholesterol	Y	N	_____
Stroke	Y	N	_____
Tuberculosis	Y	N	_____
Colon Polyps	Y	N	_____
High Blood Pressure	Y	N	_____

HEALTH SCREENING

Have you had			Date of Last
Physical	Y	N	_____
Pap	Y	N	_____
Chest X-ray	Y	N	_____
Tetanus Shot	Y	N	_____
MMR shot	Y	N	_____
TB test	Y	N	_____
Mammogram	Y	N	_____
EKG	Y	N	_____
Colonoscopy	Y	N	_____
Hepatitis Vaccine	Y	N	_____
Pneumonia Shot	Y	N	_____
Bone Density	Y	N	_____
Shingles Vaccine	Y	N	_____

SOCIAL HISTORY

Tobacco Use

Current Y N # yrs _____ #per day _____
Former Y N # yrs _____ yr quit _____

Alcohol Y N Drinks per week _____
Caffeine Y N Cups/cans per week_____
Recreational Drugs Y N Times per week _____
Exercise Y N Times per week _____
Occupation _____

ALL ALLERGIES (MEDICA TIONS/FOODS/ETC) REACTION

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

SPECIALISTS SEEN

(List all specialists from whom you are currently receiving care)

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

MEDICATIONS WITH DOSAGE & INSTRUCTIONS

(List all medication you take on a regular basis including over the counter medications)

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

Your Pharmacy _____ Location _____
(example - CVS) (example -Bacon Rd)

Please answer the following:

Over the past 2 weeks, how often have You been bothered by any of the Following problems?	Not At all	Several Days	More than Half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Do you have any specific communication needs due to visual impairment, hearing impairment, or language spoken? YES _____ NO _____ If yes, please describe _____
_____

Do you have any specific concerns today? YES _____ NO _____ If yes, please describe
_____
_____

Lake County Family Practice
9500 Mentor Ave • Suite 100 • Mentor, OH 44060
Telephone: 440-352-4880 • Fax: 440-352-3629

Patient Label

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Part A:

☐ **Tripoint Medical Center** ☐ **Perry Walk-in** ☐ **Mentor Medical Campus** ☐ **Lake Health Physician Group**
☐ **West Medical Center** ☐ **Lake Health Diagnostic Centers** ☐ **Lake Health Sleep Center** ☐ **Mentor Physical Therapy**
Urgent Care Centers: ☐ **Willowick** ☐ **Tyler** ☐ **Madison** ☐ **Chardon** ☐ **Painesville**

Name of Patient:_____
Last First Maiden / AKA

Address:_____

Date of Birth:_____ Home Phone:_____ MR #:_____

Email Address:_____

INFORMATION TO BE:

☐ Released to:_____ ☐ Obtained from:_____

I hereby authorize Lake Health / Lake Health Physician Group to release to/or obtain from the following facility, the information as specified below:

Facility/Name:_____
Phone #: _____ Fax #:_____
Address:_____
Date(s) of Treatment:_____
Reason for Treatment:_____

INFORMATION TO BE RELEASED/OBTAINED: ☐ Pertinent Summary (Includes all * items):

☐ Demographic / Facesheet	☐ Pathology Report *	☐ Radiology Report *	☐ Drug / Alcohol Info
☐ History & Physical *	☐ Consultation Report *	☐ Radiology Films	☐ EKG Report *
☐ ER Report *	☐ Entire Record	☐ Lab Reports *	☐ Cardiac Cath Report *
☐ Discharge Summary *	☐ Physical Therapy	☐ Psychiatric Info	☐ HIV / AIDS Info
☐ Operative Note *	☐ Other:_____		

PURPOSE OF DISCLOSURE: ☐ Continued Treatment ☐ Personal Use ☐ Legal ☐ Other Specific Use_____

To be completed by the Organization if this authorization is for marketing, fundraising, research, or sale of Protected Health Information:
The organization will receive compensation in exchange for using or disclosing the health information as described above: ☐ YES ☐ NO

Upon admission as an inpatient or to an LHPG office practice, you were asked to sign a Consent for Treatment in which you designated that Lake Health could utilize your health information for the purpose of treatment, payment, and other health care operations as defined by law. The above information you have requested to be disclosed requires you to sign an authorization because it is being released to a third party entity outside of Lake Health.

The consent to disclose information may be revoked by you in writing at any time - except those disclosures, made in good faith that have already occurred. This consent expires one year (1) from the date of signature and applies to all services provided and protected health information created by Lake Health prior to the date of this signature.

I certify that this Authorization has been made freely, voluntarily, and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I understand that redisclosure of my medical records by those receiving the above-authorized information may be accomplished without further written authorization and may no longer be protected. I attest that if such redisclosure is made, I will not hold Lake Health responsible.

X _____
Signature of Patient/Parent/Patient Representative/Physician/Other as Allowable by Law

_____ _____ _____
Relationship to Patient ☐ Patient Unable to Sign Date

If signature is other than patient's signature, a copy of all legal documents verifying the patient's personal representative MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care.) For a deceased patient: A death certificate coupled with executor of administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.

Part B:

LH USE ONLY

Pulled and Verified by:_____ Date:_____
Verify Photo ID by:_____ Date:_____
Method of Disbursement: ☐ Mail ☐ In-person ☐ Faxed ☐ Electronic Disclosure ☐ Other:_____
Forms of Records: ☐ Paper _____ # of pages copied _____ Cost ☐ Electronic # Pages _____ , Cost _____ (Retrieval/Media Fee)
Films returned and verified by:_____ Date:_____
☐ No disclosure made (see Part C).

EX4846

Copies of Medical Records are <u>NOT</u> to be emailed directly to patients. Contact HIM DEPT: Healthport Copy Service to process this request for electronic disclosure.

Part C:
Reasons for Denial

To the Requestor:
Lake Health was unable to process your request for the reason(s) identified below. Should you have any questions or receive additional information, please do not hesitate to contact Lake Health at_____ .

_____ Unable to identify the patient. Please provide additional information and resubmit the request to us. For example: (Date of Birth, Dates of Service, SSN, and/or verify spelling of name)

_____ Unable to release records that are dated after the date of patient's signature. Please provide updated authorization.

_____ This patient was not seen at Lake Health_____ .

_____ Authorization was not enclosed with this request.

_____ Authorization is older than one year. Please resubmit your request with updated authorization.

_____ No records at Lake Health _____ for the dates requested.

_____ Signature of patient or legally authorized representative is missing.

*_____ Information requested is psychotherapy notes.

_____ Information requested is not found in the medical record.

*_____ Information compiled in anticipation of, or for use in a civil, criminal or administrative legal action or proceeding.

*_____ Health information related to the Clinical Laboratory Improvement Amendments of 1988 "CLIA", to the extent that CLIA would prohibit individual access, or other information that is exempt from CLIA.

*_____ The health information was obtained from another person (other than a health care provider) under a promise of confidentiality and granting access would likely reveal the source's identity.

_____ The medical record is not complete because the physician has 30 days to complete the medical record after the day of discharge.

_____ Access is reasonably likely to endanger the life or safety of the patient or another person.

_____ Access is reasonably likely to cause substantial harm to another person.

_____ Access is sought by the patient's legal representative and access is reasonably likely to cause substantial harm to the patient or another person.

_____ Other:_____

*no right to review of a denial

Except where indicated, you have the right to have a denial reviewed. If you would like a denial to be reviewed, please submit a written statement to the Director of Medical Records at 7590 Auburn Road, Concord Township, Ohio 44077. If you have any complaints regarding Lake Health's HIPAA policies and procedures, please contact the Privacy Officer at (440) 375-8731.

EX4846

LCFP
Lake County Family Practice
Lake Ambulatory Care Center
9500 Mentor Avenue, Suite 100
Mentor, Ohio 44060

Referred by _____

Date:		Primary Care Physician:	
PATIENT			
First Name	Middle Initial	Last Name	
SSN	□Single □Married □Divorced □Separated □Widowed		Sex □ male □ female
Date of Birth	Employer	□ Full-time □ Part-time	Employer Telephone
Patient Mailing Address			
City		State	Zip
Home Telephone	Cell Phone	E-Mail Address	
RESPONSIBLE PARTY □ Check if PATIENT is same as Responsible party and go to Emergency Contact			
First Name	Middle Initial	Last Name	
SSN	Title		Sex □ male □ female
Date of Birth	Employer	□ Full-time □ Part-time	Employer Telephone
Responsible Party Mailing Address			
City		State	Zip
Home Telephone	Work Telephone	Relationship To Patient	
NAME OF RELATIVE/FRIEND IN CASE OF EMERGENCY			
Name		Relationship To Patient	
Home Telephone	Alternate Phone Number		

PRIMARY INSURANCE			
Insurance Card Holder First Nome	Last Name	Date of Birth	Relationship to Patient
Insurance Company Name	Insurance ID Number	Employer Phone Number	
SECONDARY INSURANCE			
Insurance Card Holder First Name	Last Name	Date of Birth	Relationship to Patient
Insurance Company Name	Insurance ID Number	Employer Phone Number	

CHILDREN/FAMILY

NAME	Date of Birth	NAME	Date of Birth
1) _____	___/___/_____	4) _____	___/___/_____
2) _____	___/___/_____	5) _____	___/___/_____
3) _____	___/___/_____	6) _____	___/___/_____

If necessary, how may we contact you? Preferred for confirming appointments HOME WORK CELL

Home (_____) - _____ - _____ Work (_____) - _____ - _____

Cell (_____) - _____ - _____

May we leave a message? Yes ☐ No ☐ Answering Machine: ☐ Yes ☐ No

REQUEST FOR GENERAL TREATMENT

I request and authorize Lake Health Inc., its employees, my physician, and allied health professionals as are necessary to provide care. Further, I authorize my physician to permit the presence of observers in my treatment as deemed necessary.

I, _____, understand and acknowledge that from time to time, medical students, nursing students or students of other healthcare disciplines may be undergoing clinical education in Lake Health. I hereby authorize and permit such students of any such health profession to participate in my care in so far as they are properly supervised at all times by a licensed and credentialed healthcare practitioner in that field of expertise. I acknowledge that I have a right to ask questions of any physician or nurse regarding the use of students in my care at any time.

X _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION (Insurance/Medicare Beneficiaries)

I authorize Lake Health Inc. to release any medical records or medical information necessary to file an insurance claim, to perform quality and utilization assessments, and to release any medical information which may be requested by my insurance carrier or agencies on their behalf. I authorize release of medical information to a quality assurance of peer review committee or organization, and compliance audits.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge. I am responsible only for the deductible, coinsurance, and non covered services.

I HAVE REVIEWED AND CONSENT TO ALL APPLICABLE CLAUSES BY SIGNING BELOW. I UNDERSTAND THE NATURE OF THIS CONSENT AND IT IS REVOCABLE AT ANY TIME.

Signature X_____ Relationship to Patient_____

Witness to above signature:_____ Date:_____ /_____ / _____

Medicare Received:_____ Date: _____ /_____ / _____
Signature

Privacy Notice Received: _____ Date: _____ /_____ / _____
Signature

CONSENT FOR COMMUNICATION

This consent must be signed in order for Lake County Family Practice – Lake Health Physician Group to discuss protected health information about the patient with a family member, guardian, or friend. This includes information related to the care or changes to the care a patient has received.

_____gives authorization to Lake County Family

(patient Name/Legal Guardian/Healthcare Power of Attorney)

Practice to discuss/release healthcare information about his/her care to the following people. This authorization will remain in effect, until revoked by (Patient/Legal Guardian of Minor/Healthcare Power of Attorney) through written communication

Name: _____ Relationship:_____

Phone:_____

Name: _____ Relationship: _____

Phone:_____

Name: _____ Relationship: _____

Phone:_____

Additional Comments _____

_____

Signature: _____ Date:_____

Patient/Guardian/Power of Attorney

Name (Print):_____

Patient Name Date of Birth

Do you have any of the following Advance Directives?

Living Will	Yes _____ No_____
If you answered no, are you interested in receiving information on this topic?	Yes _____ No_____
Do Not Resuscitate (DNR) order?	Yes _____ No_____
If you answered no, are you interested in receiving information on this topic?	Yes _____ No_____
Medical Power of Attorney or Durable Power of Attorney	Yes _____ No_____

Signature _____ Date _____

Patient ID # _____ Patient Name:_____

Lake County Family Practice

Committed to Excellence in Family Health Care

It is the goal of Lake County Family Practice to make sure that all our patients receive the highest quality of care possible regardless of race, creed or ethnicity.

In an effort to comply with new federal regulations for 2011 , we have been asked to obtain the following information from each of our patients. If you feel strongly against providing this data, please be assured that you may refuse to disclose the information.

The only persons who see this information are registration staff, administrators, and those persons involved in quality improvement and oversight. Please know that the confidentiality of what you provide here is protected by law.

Please indicate your answers by circling the most accurate indicator:

Race: White Native Hawaiian Other Pacific Islander

Hispanic Black or African American Other

Refuse to Disclose

Ethnicity: Hispanic Non-Hispanic Refuse to Disclose

Primary Language Spoken:

English Spanish Sign Language Other

Refuse to Disclose

Thank you for your cooperation,
The Providers of Lake County Family Practice

The Role of the Patient Centered Medical Home

Welcome to the Lake County Family Practice Patient Centered Medical Home!!

In the Lake Health System we are embracing and transitioning to a new health care delivery system that seeks to provide care for you and your family that is comprehensive, coordinated and of the highest quality.

Your personally chosen Primary Care Provider and their team will coordinate your care or any treatment that you may need. Treatment may include outpatient care in our office during regular hours* as well as access to a designated on call physician after hours and on weekends. Both your Primary Care Providers and their delegates will have access to a wide and comprehensive array of specialists for you as well as Urgent Care Centers and Emergency Room and Hospital Care settings when necessary.

Your care will also include regular contact from our talented team of Medical Assistants at Lake County Family Practice as well as future involvement when needed with a Care Manager who is a Registered Nurse. As your medical home, we will include in our records information supplied by you the patient including but not limited to medications, visits to specialists, medical history, self-care information, dates of and reasons for hospitalizations, specialty care and/or ER and Urgent Care visits. We will help you receive and understand any of your results from our office in a timely manner and we will help you to implement your evidence based plan of care and support for your self-management to keep you in good health.

We also promise to secure your care when needed, with an array of professionals including Health Coaches, Mental Health teams, teams of Home Care nurses and coaches, Skilled Nursing Care and Hospice and Palliative Care facilities should they be necessary. Our goal, of course, is to PREVENT illness conditions for you and your family and to reduce unnecessary and costly Emergency Room and Hospital admissions.

In summary, we hope you will enjoy this transition to total care coordination for you by our Lake Health-Lake County Family Practice Patient Centered Medical Home team. Our responsibility is to continue to provide for your total care and to make your experience as pleasant and successful as possible.

Web Links:
http ://www.pcpcc.net/ - Patient Centered Primary Care Collaborative
http ://www.emmisolutions.com/medicalhome/pcpcc/ - Introductory PCMH Video

We offer same day sick appointments by calling our office at 440-352-4880

*Office hours Monday-Thursday 8:00am to 5:00pm Friday 8:00am to 5:00pm (3:00pm on Friday's Memorial Day to Labor Day)
Saturday's 9:00am -11:30 am for same day sick appointments