ERIK J FURMAN, M.D. PA
1910 West Henderson St. Suite 100
Cleburne, TX 76033
817-556-2559

REGISTRATION FORM

(Please print)

PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI: _____

Address: _____
STREET CITY STATE ZIP

Telephone: Home (_____) _____ Cell (_____) _____

Date of Birth: _____/_____/_____ Male___ Female___ Single____ Married____ Widowed____ Divorced_____

Social Security #: _____-_____-_____ Driver's License #: _____

EMERGENCY CONTACT:

Last Name: _____ First Name: _____ Relationship: _____
Telephone Number: _____

EMPLOYER INFORMATION:

Employer Name: _____ Occupation: _____
Business Address: _____ Business Phone: (_____) _____

INSURANCE INFORMATION:

Is this patient covered by insurance? Yes _____ No _____ (*If yes, please provide your insurance card to the receptionist*)

Person Responsible for Account: _____
LAST NAME FIRST NAME M.I

Name of Primary Insurance: _____
Group No: _____ ID No: _____
Subscriber's Name: _____
Social Security #: _____-_____-_____ Birth Date: _____
Patient's Relationship to Subscriber: Self __ Spouse ___ Child ___ Other ____

Name of Secondary Insurance (if applicable): _____
Group No: _____ ID No:_____
Subscriber's Name: _____
Social Security #: _____-_____-_____ Birth Date: _____
Patient's Relationship to Subscriber: Self __ Spouse ___ Child ___ Other ____

AUTHORIZATION

I hereby authorize Erik J. Furman, M.D. to examine, treat (including injections), and/or hospitalize me or my dependent (as named above) and to furnish information to insurance companies and/or other treating physicians, concerning me or my dependent's illness and treatment (including Hepatitis and HIV status). I hereby assign all payments for medical services rendered to me or my dependent to Erik J. Furman, M.D. I understand that my eligibility for coverage by my insurance cannot be guaranteed at this time. I understand that I will be responsible for payment of all services rendered, if it is determined that I am not eligible for coverage.

_____ _____
PATIENT/ GUARDIAN'S SIGNATURE TODAY'S DATE

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PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy rule gives the patient the right to request on uses and disclosure of their protected health information (PHI). The patient is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of individual's home. **Our office will never discuss your medical information with a family member unless you have authorized us to do so.**

I wish to be contacted in the following manner:

By home phone: _____ **or** Cell phone: _____

If we get an answering machine/voice mail, may we leave a message? (circle) Yes No

Leave detailed information (circle) Yes No

Provide call back number only (circle) Yes No

Please indicate the family member (s) authorized to discuss your medical care by providing the name (s) and date of birth where applicable**:**

_____

Name, Last Name and Date of Birth Relationship/Phone Number

_____

Name, Last Name and Date of Birth Relationship/Phone Number

_____

Name, Last Name and Date of Birth Relationship/Phone Number

Therefore, I, _____, give permission to Dr. Erik J. Furman or any member of his office staff designated by him, to discuss my medical condition or treatment plan with the person (s) mentioned above.

This statement is valid unless revoked by me in writing.

_____ _____

PATIENT/GUARDIAN'S SIGNATURE TODAY'S DATE

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OFFICE POLICIES

1. EMERGENCIES
   In the case of medical emergency, please call 911. If you need to contact the on-call physician, please call our office at 817-556-2559 and the answering machine will provide the phone number where the physician on-call can be reached. Please do not call the on-call physician for medication refills as these should be handled during normal business hours.

2. MEDICATION REFILLS
   Call your pharmacy directly for any refills. They will notify the doctor of your request. Refill request received before 3:30 pm will be acted on that day. Refill request received after 3:30 pm will be handled the following business day.

3. TEST RESULTS
   All test results will be reported on Wednesday and Friday afternoons. Emergent results will be reported at the time we receive them. If you have not heard from us within5-10 days, please contact us. **Please do not call the office multiple times a day for the same issue**.

4. PAYMENT
   All payments are due at the time of service. Our office accepts payments in the form of cash, personal checks, debit, and credit. We do not accept post-dated checks.

5. MEDICAL INSURANCE
   The matter of insurance coverage is a personal relationship between the patient and the insurance carrier. The patient is responsible for all co-pays and portion designated by the insurance company upon verification of coverage. Co-pays will be collected prior to seeing the doctor at each visit. Patients with standard indemnity insurance or any insurance not accepted by this office are responsible for payment in full at the time of service. Our office will provide you with a claim form so that you may file with your insurance. **Patients must bring insurance card to all appointments.**

6. MEDICARE/MEDICAID
   MEDICARE is accepted for patients 65 and older. MEDICAID is accepted for patients under the age of 18.
   Our office will file all claims directly to MEDICARE and accept assignment on these claims. If the patient has supplemental insurance, it will be filed also. However, if there is no supplemental insurance, patient is expected to pay the 20% that MEDICARE has approved to be the patient's portion, at the time of service. Patients are expected to present a current copy of their MEDICAID card at each appointment.

7. APPOINTMENTS
   The patient is responsible for scheduling and keeping appointment. Our office will do all that we can to provide you with an appointment time that is convenient to you. We will strive to see you in a timely manner. Should you be unable to keep an appointment, we ask that you call as far in advance as possible to reschedule. Routinely not keeping appointments or coming late affects the schedule of our staff and the ability to care for our patients. We will not see anyone who is more than 15 minutes late for their appointment. Please remember our goal is to serve our patients in an efficient manner.

8. TERMINATION
   There are some occasions when it becomes necessary to terminate the doctor/patient relationship. Reason for this would be continuous NO SHOWS for appointments, noncompliance with medical care, violent patient behavior, and non-payment of bill.

9. OTHER
   We **DO NOT** do chronic pain management in this clinic.

I acknowledge that I have read and understand the office policies as outlined in the form. A signed copy has been provided to me.

_____ _____

PATIENT/GUARDIAN'S SIGNATURE TODAY'S DATE

HIPAA NOTICE OF PRIVACY PRACTICE

ERIK J FURMAN, M.D. PA
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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
Your PHI 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.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you or your PHI 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.

Payment: Your PHI 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 PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your PHI in order to support the business activities of our 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 PHI 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 PHI, as necessary, to contact you to remind you of your appointment.

Other Uses and Disclosure We Can Make Without Your Written Authorization or Opportunity to Agree or Object:
We may use or disclose your PHI 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 your authorization at any time, in writing, except to the extent that your 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.

You have the right to inspect and copy your PHI. 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.
You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI 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. 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 your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend 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 an accounting of certain disclosures we have made, if any, of your PHI.

3. 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 of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

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.

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 protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officers, Kim Bigham, in person or by phone at 817-556-2559.

Signature below is only acknowledgement that you have received this notice of our Privacy Practices:

Print Name _____

Signature _____

Today's Date _____