

SAMUEL R. WILLIAMS, M.D., P.A.

ADULT PATIENT INFORMATION

Last Name First Name
Sex M F Birthdate _____ SS # _____
Home Address _____
Street _____
City State Zip Telephone _____
Telephone _____ Cell Phone _____
Whom may we thank for referring you? _____

Children's Names	Birthdate
_____	_____
_____	_____
_____	_____
_____	_____

Patient is: (circle) Single Married Separated Divorced Widowed

EMPLOYMENT INFORMATION

SPOUSE'S INFORMATION

Employer _____
Address _____
Work Phone _____
Occupation _____

Spouse's Name _____
Address (if different from patient's) _____
Home Phone _____ Work Phone _____
Employer _____
Soc. Sec. # _____ Birthdate _____
Occupation _____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____

INSURANCE INFORMATION

Primary Insurance: _____
Complete Mailing Address: _____
Phone # _____
Policy Holder's Name: _____ Relationship _____
Policy # _____ Group # _____
Secondary Insurance: _____
Complete Mailing Address: _____
Phone # _____
Policy Holder's Name: _____ Relationship _____
Policy # _____ Group # _____

RELEASE AND ASSIGNMENT

Person(s) financially responsible _____

AUTHORIZATION TO Samuel R. Williams, M.D./PA

I hereby authorize payment of any medical insurance benefits for which I am entitled to be made directly to the above provider. I agree to pay the balance of any charges not paid or covered under my insurance plan. I also authorize release of medical information necessary to process any and all claims to Samuel R. Williams, M.D./PA and their billing agent.

Signature of Parent/Guardian Date



SAMUEL R. WILLIAMS, M.D., P.A.

Pediatrics and Young Adult Medicine

5707 Calverton St., Suite 1B

Catonsville, MD 21228

Telephone: (410) 788-2350

Fax: (410) 788-6859

Samuel R. Williams, M.D.
Lisa Williams Petit, M.D.

Website:
www.greatestdocs.com

REQUEST FOR MEDICAL RECORDS

Date _____

To: _____

Address _____

City, State, Zip _____

Telephone Number _____ Fax _____

I hereby authorize and request that you release to the medical office of Samuel R. Williams, M.D., P.A. the following:

- newborn records
- hospitalization records for _____
- emergency room records _____
- office medical records
- consultation reports
- diagnostic studies, lab results _____
- other _____

This information is for the following patient(s)

Name	Date of Birth
_____	_____
_____	_____
_____	_____

Relationship to Patient(s) patient guardian self other _____

Signature _____

Print Name _____

NOTICE OF PRIVACY PRACTICES (MEDICAL)

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

SAMUEL R. WILLIAMS, M.D.
PEDIATRICS AND ADOLESCENT MEDICINE
5707 CALVERTON ST., SUITE 1B
CATONSVILLE, MD 21228
TELEPHONE: (410) 788-2350
FAX: (410) 788-6859

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

SAMUEL R. WILLIAMS, M.D.

PEDIATRICS AND ADOLESCENT MEDICINE

5707 CALVERTON ST., SUITE 1B

CATONSVILLE, MD 21228

TELEPHONE: (410) 788-2350

FAX: (410) 788-6859

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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Samuel R. Williams, M.D.

MEDICAL/FAMILY HISTORY QUESTIONNAIRE

Chart # _____

(PLEASE PRINT CLEARLY)

Patient's Last Name _____ First Name _____ Middle Initial _____

DOB _____ SEX M F

Form Completed by _____ Relationship to patient _____ Date _____

Birth History

Name of Hospital _____ State _____ Birth Wt _____ Adopted? no yes

Infant was Fullterm Premature or Postmature How many weeks old? _____ Was Hepatitis B Vaccine given? no yes not sure

Type of Delivery Vaginal C-Section Feeding Breastfed Formula -which one? _____

Any Problems at birth or during pregnancy? _____

Current Household Members

Name _____ Relationship to Patient _____ Age _____ Health Problems? _____

Does anyone smoke cigarettes in the household? no yes Who? _____

Does anyone other than parent take care of child regularly? no yes Who? _____

Family History

Has anyone in the family (parents, grandparents, aunt/uncles, sisters/brothers) had:

	No	Yes	Who?		No	Yes	Who?
Asthma				Mental Disorders			
HIV/AIDS				High Blood Pressure			
Cancer				Chemical Dependency			
Diabetes				Migraine Headaches			
Heart Disease				Blood Disorder/Sickle/SC			
Learning Problems/Attention				Seizure Disorders			
Kidney Disorder				High Cholesterol			

Additional Info _____

**Turn over to
complete**

Day Care/ School

Patient stays at home private daycare home schools attends school family member provides daycare

Name of School (or Daycare) _____ Grade _____

Does child attend school (or daycare) regularly? no yes

Type of class

regular

special class (describe) _____

Grade Failures? no yes which grade(s) _____

Additional Info:

Patient's Medical History

Any Medical Conditions or Problems none yes (please list)

Current Medications none yes (please list)

Current or Previous Medical Conditions none yes (please list)

Hospitalizations or operations none yes (please list)

Allergies none yes (please list)

SAMUEL R. WILLIAMS, M.D., P.A.

PATIENT INFORMATION

Name of Minor/Child _____
Last Name First Name

Sex M F Birthdate _____ SS # _____

Home Address _____
Street

City State Zip Telephone

Child Lives with Mother Father Both Other

Whom may we thank for referring you? _____

Siblings Names	Birthdate
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PARENT INFORMATION

Father's/Guardian's Name _____	Mother's/Guardian's Name _____
Address (if different from patient's) _____	Address (if different from patient's) _____
Home Phone _____ Work Phone _____	Home Phone _____ Work Phone _____
Cell Phone _____	Cell Phone _____
Employer _____	Employer _____
Soc. Sec. # _____ Birthdate _____	Soc. Sec. # _____ Birthdate _____
Father's Occupation _____	Mother's Occupation _____

Parents are: (circle) Single Married Separated Divorced Widowed

EMERGENCY CONTACT

In the event of an emergency, whom should we contact? (other than parents)

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

INSURANCE INFORMATION

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Complete Mailing Address: _____
Phone # _____

Policy Holder's Name: _____ Relationship _____

Policy # _____ Group # _____

Secondary Insurance: _____

Complete Mailing Address: _____
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Signature of Parent/Guardian

Date