Neil Baum, M.D.
3525 Prytania Street , Suite 614
New Orleans, LA 70115
Phone (504) 891-8454
Fax (504) 891-8505

PATIENT INFORMATION				
Last Name		**SSN**	**Home Phone**	
First, MI			**Work Phone**	
Address 1			**Cell Phone**	
Address 2			**Sex**	
City			**Date of Birth**	
State		**Zip**	**E-mail**	
Employer			**Marital Status**	
Referring Dr			**Employment**	**Full Part**
Primary Care Dr			**Student**	
Emergency contact (not living with you)				
Emergency Phone #			**Relationship to patient**	
Pharmacy Name			**Pharmacy Phone #**	
Spouse (parent/guardian if minor)			**Spouse's date of birth**	
Spouse's / Parent's employer & address			**Phone #**	
Do you have a living will			**Do you have power of attorney**	**Yes No**
How did you hear about our practice	**____ad ____ doctor ____yellow pages ____family / friend ___other __________________**			
	____website ____hospital ____insurance plan			

Payment Authorization

I hereby authorize my benefits to be paid directly to NEIL BAUM, M.D. and am financially responsible for non-covered services and / or balances not paid by the insurance carrier. I also authorize release of my income information required to process these claims. I authorize you to give me reasonable and proper medical care, including diagnosis, treatment (medical and surgical), by today's standards.

In addition, I agree to pay a $25 fee for any missed appointments ($100 for procedures) not cancelled by 3:00 pm on the business day before my scheduled appointment.

SIGNATURE____ DATE_____________________________

PLEASE PRESENT YOU DRIVER'S LICENSE and INSURANCE CARD at CHECK IN

INSURANCE INFORMATION			
Primary Insurance		Expiration date	
Effective date		Patient's Relationship: ______Self _______Spouse ______Child	
Subscriber Name		Patient's Certificate suffix:	
Member ID No.		Subscriber's Certificate suffix:	
Group Name		Policy Telephone #:	
Group No.			
Subscriber D.O.B.			
Secondary Ins.		Expiration date	
Effective date		Patient's Relationship: ______Self _______Spouse ______Child	
Subscriber		Patient's Certificate suffix:	
Certificate		Subscriber's Certificate suffix:	
Group Name		Policy Telephone #:	
Group No.			

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NOTE: This is a confidential record and will be kept at your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

DATE ___________/___________/____________
LAST NAME____________________________ FIRST NAME_________________________ MIDDLE____________
SOCIAL SECURITY NO.________________________ DATE OF BIRTH________/_______/_______
REF. PHYSICIAN_________________________ PRIMARY PHYSICIAN__________________________

CHIEF COMPLAINT: What is the main reason for your visit today? (Describe your problem in detail.)
____
____
____

For Physician's Use Only (4)

History Of Present Illness

*Location____
*Quality____
*Severity____
*Duration____
*Timing____
*Context____
*Motivating Factors____
*Associated Signs & Symptoms____

Past Medical & Social History

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, cancer, heart disease, etc.)

______________________ ____________________________ ______________________
______________________ ____________________________ ______________________

List any personal past illnesses and/or surgeries and when they occurred.

Illness or Surgery	Date	Illness or Surgery	Date

Are you on any medications? YES OR NO
____
____

Do you: Consume caffeinated food/drinks? YES OR NO
If yes how much?__________________________

Smoke? YES OR NO
If yes how long/packs per day?_______

Consume Alcohol? YES OR NO
If yes how much?__________________________

Have a special diet?________________

Do you have any known drug allergies? YES OR NO (If yes, list all.) _________________
____
____

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Review of Systems

Do you now or have you had any problems related to the following systems? Circle yes or No.

A. Constitutional Systems

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other___________________

B. Eyes

Blurred Vision	Y	N
Double Vision	Y	N

Other___________________

C. Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N

Other__________________

D. Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/Tingling	Y	N

Other__________________

E. Endocrine

Excessive Thirst	Y	N
Too Hot/Cold	Y	N
Tired/Sluggish	Y	N

Other___________________

F. Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N

Other___________________

G. Cardiovascular

Heart Trouble	Y	N
High Blood Pressure	Y	N

Other___________________

H. Integumentary

Skin Rash	Y	N

Other__________________

I. Musculoskeletal

Joint Pain	Y	N
Back Pain	Y	N

Other__________________

J. Ear/Nose/Throat/Mouth

Sinus Problems	Y	N

Other__________________

K. Genitourinary-Male

Urine Retention	Y	N
Erectile Dysfunction	Y	N
Urinary Frequency	Y	N

Other_________________

L. Genitourinary-Female

Loss of Urine	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N

Date Last Menstrual Period:
Other________________

M. Respiratory

Frequent Cough	Y	N
Shortness of Breath	Y	N

Other________________

N. Hematological/Lymphatic

Swollen Glands	Y	N
Blood Clotting Problems	Y	N

Other________________

O. Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N

Other__________________

For Physicians Use Only (Comments/Notes)

Physician:____ Date:______/_______/________

Last Updated: 09/2009

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RELEASE OF PERSONAL MEDICAL INFORMATION

I, _________________________________, allow the office of Neil Baum, M.D. to discuss my medical information with the following individuals:

________________________________	___________________________
Name	Relationship to Patient
________________________________	___________________________
Name	Relationship to Patient
________________________________	___________________________
Name	Relationship to Patient
________________________________	___________________________
Name	Relationship to Patient

________________________________ ______________
Patient Signature Date

Expires one year from date signed.

FOR OFFICE USE ONLY

Date:	Initials of Witness:

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact the Privacy Officer at ***(504) 891-8454***
or by mail at:

Neil Baum, M.D., A.P.M.C.
3525 Prytania Street, Suite 614
New Orleans, LA 70115

A. WHO WILL FOLLOW THIS NOTICE: This Notice describes our Organization's practices and that of:

1. **Neil Baum, M.D., A.P.M.C.** (collectively referred to as the "Organization"): All follow the terms of this Notice. In addition, this Organization and its various departments, sites, units, and locations may share medical information with each other for treatment, payment or health care operation purposes described in this Notice;
2. Any health care professional authorized to enter information into your Organization chart;
3. Any member of a volunteer group we allow to help you while you are treated in the Organization; and
4. All employees, staff and other Organization personnel.

B. WHAT IS THIS NOTICE: This is a Notice of Privacy Practices ("Notice") for the Organization. The Notice describes the Organization's practices with respect to the ways in which we may use and disclose Health Information about you. It also describes your rights and certain obligations the Organization has regarding the use and disclosure of Health Information.

C. UNDERSTANDING YOUR HEALTH INFORMATION:

1. Each time you visit the Organization, physician, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examinations and test results, diagnosis, treatment, a plan for future care or treatment, and the like ("Health Information"). This Health Information, often referred to as your medical record or chart, serves as a:
   a. Basis for planning your care and treatment;
   b. Means of communication among the many health professionals who contribute to your care;
   c. Legal document describing the care you received;
   d. Means by which you or a third-party payer can verify that services were properly billed;
   e. Tool in educating health professionals;
   f. Source of data for medical research;
   g. Source of information for public health officials charged with improving the health of the nation;
   h. Source of data for facility planning, fundraising, and marketing; and
   i. Tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.
2. Understanding what is in your medical record and how your Health Information is used and disclosed helps you to:
   a. Ensure its accuracy;
   b. Better understand who, what, when, where, and why others may access your Health Information; and
   c. Make more informed decisions when authorizing uses and disclosures.

D. OUR PLEDGE REGARDING HEALTH INFORMATION: We consider your Health Information private and confidential and have policies and procedures in place to protect the Health Information against unlawful use and disclosure. We create a record of the care and services received by you through the Organization. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your health care generated by the Organization, whether made by Organization personnel or your doctor. We are required by law to: make sure that Health Information that identifies you is kept private; provide you notice of our legal duties and privacy practices with respect to Health Information about you; and follow the terms of the Notice that is currently in effect.

E. HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The following categories describe different ways that we use and disclose Health Information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose Health Information will fall within one of the categories:

1. **For Treatment**: We may use Health Information about you to provide you with medical treatment or services. We may disclose Health Information about you to doctors, nurses, technicians, medical students, or other Organization personnel who are involved in taking care of you at the Organization. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. The Organization may also disclose Health Information about you to people outside the Organization who may be involved in your medical care after you leave the Organization, such as family members, clergy, or others we use to provide services that are part of your care.
2. **For Payment**: We may use and disclose Health Information about you so that the treatment and services you receive at the Organization may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatments you received at the Organization so that your health plan will pay us or reimburse you for the treatments. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the intended treatment.

3. **For Health Care Operations**: We may use and disclose Health Information about you for Organization operations. These uses and disclosures are necessary to run the Organization and make sure that all of our patients receive quality care. For example, we may use Health Information to review our treatment and service and to evaluate the performance of our staff in caring for you. We may also combine Health Information about any Organization patients to decide what additional services the Organization should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose Health Information to doctors, nurses, technicians, medical students, and other Organization personnel for review and learning purposes. We may also combine the Health Information we have with Health Information from other health care entities to compare how we are doing. However, we may remove information that identifies you from this set of Health Information so others may use it to study health care and health care delivery without learning who are the specific patients.
4. **Appointment Reminders**: We may also use and disclose Health Information to contact you as a reminder that you have an appointment for treatment or medical care at the Organization.
5. **Treatment Alternatives**: We may use and disclose Health Information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
6. **Health-Related Benefits and Services**: We may use and disclose Health Information to tell you about health-related benefits or services that may be of interest to you or the entities participating in a healthcare provider network or health plan network. We may also use or disclose Health Information to you to describe if, and to what extent, a product or service is provided by the Organization or included in a plan of benefits.
7. **Individuals Involved in Your Care or Payment for Your Care**: We may release Health Information about you to a friend or family member who is involved in your medical care. We may also give Health Information to someone who helps pay for your care. We may also tell your family or friends your condition and that you are currently receiving care at the Organization. In addition, we may disclose Health Information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition and location.
8. **Business Associates**: There are some services provided in the Organization through contacts with business associates. Examples include certain laboratory tests, data processing, and a copy service we may use when making copies of your health record. When these services are contracted, we may disclose your Health Information to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your Health Information, however, we require the business associate to appropriately safeguard your Health Information.
9. **Research**: Under certain circumstances, we may use and disclose Health Information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All research projects, however, are subject to a special approval process designed to protect your Health Information from improper use or disclosure. This process evaluates a proposed research project and its use of medical information. It tries to balance the research needs with patients' need for privacy. For example, when people prepare to conduct a research project, they need to review Health Information to look for patients with specific medical needs. To protect your Health Information we require that the information they review does not leave the Organization. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the Organization.
10. **As Required By Law**: We will disclose Health Information about you when required to do so by federal, state or local law.
11. **To Avert a Serious Threat to Health or Safety**: We may use and disclose Health Information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

F. SPECIAL SITUATIONS:

1. **Organ and Tissue Donation**: If you are an organ donor, we may release Health Information to Organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
2. **Military and Veterans**: If you are a member of the armed forces, we may release Health Information about you as required by military command authorities. We may also release Health Information about foreign military personnel to the appropriate foreign military authority.
3. **Workers' Compensation**: The workers' compensation program provides benefits for work-related injuries or illness. We may release Health Information about your work-related injury or occupational sickness to your employer, or as otherwise required by state law.
4. **Public Health Risks**: We may disclose Health Information about you for public health activities. These activities generally include the following:
   a. Preventing or controlling disease, injury or disability;
   b. Reporting births and deaths;
   c. Reporting child abuse or neglect;
   d. Reporting reactions to medications or problems with products;
   e. Notifying people of recalls of products that they may be using;
   f. Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
   g. Notifying the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
5. **Food and Drug Administration**: We may disclose to the FDA Health Information relative to either an FDA-regulated product or activity, or to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacements. These activities are necessary for the government to monitor quality, safety, and effectiveness.

6. **<u>Health Oversight Activities</u>**: We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
7. **<u>Lawsuits and Disputes</u>**: If you are involved in a lawsuit or a dispute, we may disclose Health Information about you in response to a court or administrative order. We may also disclose Health Information about you in response to a subpoena, properly issued discovery request, or other lawful process by someone else involved in the dispute, except to the extent that you have requested or obtained an order protecting the information requested.
8. **<u>Law Enforcement</u>**: We may release Health Information if asked to do so by a law enforcement official:
   a. In response to a court order, subpoena, warrant, summons or similar process;
   b. To identify or locate a suspect, fugitive, material witness, or missing person;
   c. About the victim or a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
   d. About a death we believe may be the result of criminal conduct;
   e. About criminal conduct at the Organization; and
   f. In emergency circumstances to report a crime; the location of the crime or victims; or the identity, descriptions or location of the person who committed the crime.
9. **<u>Coroners, Medical Examiners and Funeral Directors</u>**: We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information about patients of the Organization to funeral directors as necessary for them to carry out their duties.
10. **<u>Protective Services for the President and Others</u>**: We may disclose Health Information about you to authorized federal officials so they may provide protection to the President, other authorized persons, foreign heads of state, or to conduct special investigations.
11. **<u>Inmates</u>**: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information about you to the correctional institution or law enforcement official. This release is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
12. **<u>Alcohol/Drug Patient Records</u>**: The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser unless one of the following conditions is met: (1) the patient consents in writing; (2) the disclosure is allowed by a court order; or (3) the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

G. <u>YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU</u>:

1. **<u>Right to Inspect and Copy</u>**: You have the right to inspect and copy Health Information kept in the Organization's designated record set and used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy your Health Information, you must submit your request in writing to the Privacy Officer, **Neil Baum, M.D., A.P.M.C., 3525 Prytania Street, Suite 614, New Orleans, LA 70115**. If you request a copy of your Health Information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request, as allowed by state law. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to Health Information, you may request in writing that the denial be reviewed. Please submit your written request to the Privacy Officer who will forward the matter to another licensed health care professional chosen by the Organization to review your request and the denial. The person conducting the review will not be the person who denied your initial request. We will comply with the outcome of the review.
2. **<u>Right to Amend</u>**: If you feel that Health Information we have about you is incorrect or incomplete, you may request in writing that it be amended. You have the right to request an amendment for as long as the Health Information is kept by or for the Organization. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend Health Information that:
   a. Was not created by us, unless reasonable proof exists that the person or entity that created the information is no longer available to make the amendment;
   b. Is not part of the Health Information kept by or for the Organization;
   c. Is not part of the Health Information which you would be permitted to inspect and copy; or
   d. Is otherwise accurate and complete.
3. **<u>Right to an Accounting of Non-Routine Disclosures</u>**: You have the right to request an accounting of disclosures. This is a list of "non-routine" disclosures we made of Health Information about you, and may include disclosures for research, pursuant to a subpoena, or to public officials if required by law. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six years and may not include dates before April 13, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
4. **<u>Right to Request Restrictions</u>**: You have the right to request a restriction or limitation on the Health Information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery. However, ***we are not required to agree to your request.*** To be binding, the Organization's consent must be in writing and approved by the Privacy Officer. If we do agree, we will comply with your request unless the Health Information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must tell us (1) what Health Information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

5. **Right to Request Confidential Communications**: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all requests deemed reasonable by the Organization. Your request must specify how or where you wish to be contacted.
6. **Right to a Paper Copy of This Notice**: You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a paper copy, please submit a written request to the Privacy Officer.

H. CHANGES TO THIS NOTICE: We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for Health Information we already have about you as well as any Health Information we receive in the future. We will post a copy of the current Notice on our website and in publicly visible sites throughout the Organization. The Notice will contain on the first page the issue date (i.e. the effective date) and last revised date. In addition, each time you register at or are admitted for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current Notice in effect. You may view and print a current copy of the Notice on our website at any time.

I. COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the Organization or with the Secretary of the Department of Health and Human Services. To file a complaint with the Organization, contact the Privacy Officer. To contact the Office of Public Health write to Office of Public Health, HIPAA Coordinator, PO Box 629, Baton Rouge, LA 70821. To contact the Department of Health and Human Services, write to U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Washington, D.C., 20201. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

J. OTHER USES OF HEALTH INFORMATION: Other uses and disclosures of Health Information not covered by this Notice or the laws that apply to the Organization will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose Health Information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and 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 maybe 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 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 Private 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: ____

Signature of Patient or
Legally Responsible Party: ____

Relationship to Patient: ____

Date: ____

Expires one year from date signed

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: