REGISTRATION

Trócaire Medical, LLC

Personal information

Name: _____ Date of birth: _____

Address: Street _____ Phone: _____
Apt _____ Alternate phone: _____
City/State/Zip _____ E-mail: _____

Employer: _____ Job title: _____
Work Phone: _____ SSN: _____

Marital status:
- o Single
- o Married
- o Other _____

Medicare patient?
- o Yes
- o No

Insurance information

Provider: _____
Primary cardholder: _____ Date of birth: _____
Address: _____
Phone: _____
Primary cardholder's employer: _____
Relationship to primary cardholder:
- o Self
- o Spouse
- o Child
- o Other - _____

Privacy Practices

I hereby acknowledge that I have been provided with ample opportunity to review the Notice of Privacy Practices of Trócaire Medical, LLC.

I understand that if payment for medical services rendered is to be made by a third party, such as a health insurance provider, medical history and diagnoses as well as details of treatment will be released to that third party, in accordance with laws governing protected health information.

Payment

I will pay my co-pay at the time of service. I understand that I am responsible for all deductibles and any other charges not covered by a health insurance provider or other third party once the billed charges have been adjudicated. I expressly permit secure retention of my credit card information for the purpose of paying charges deemed patient responsibility as per an explanation of benefits provided by my health insurance provider. If my account becomes more than 90 days overdue, it will be turned over to a third party for collection and a service charge of 8% will be applied. Upon request, Trócaire Medical, LLC will provide me a detailed accounting of all charges.

Sign: _____ Date: _____

MEDICAL HISTORY

Trócaire Medical, LLC

Name: _____
DOB: _____

Pharmacy: _____

Tobacco Y/N: Type/Amount: _____
Past use of tobacco: _____
Alcohol Y/N: Amount: _____
Marijuana Y/N medical/recreational: _____
"Street" drugs Y/N type: _____

Medications, including herbal and over-the-counter meds
(name and dose):

_____
_____
_____
_____
_____
_____

Previous surgery (Please list type and date):

_____
_____
_____
_____

Serious injuries/fractures (Please list type and date):

_____
_____
_____
_____

Other medical problems or hospital admissions:

_____
_____
_____
_____
_____
_____

Family medical problems (immediate family only):

_____
_____
_____
_____

Drug allergies (include drug and type of reaction):

_____
_____
_____

Which of the following immunizations have you had:

- Hepatitis A *(date)* _____
- Hepatitis B *(date)* _____
- Tetanus toxoid *(date)* _____

Females: Could you be pregnant? Yes / No

Any **personal** history of the following:

- Infectious illness:
  - Chickenpox
  - Cold sores
  - Genital Herpes
  - Genital warts
  - Gonorrhea
  - HIV/AIDS
  - Hepatitis A / B / C
  - HPV (Human Papilloma Virus)
  - Malaria
  - Measles
  - Meningitis
  - Rubella
  - Scarlet Fever
  - Syphilis
  - Tuberculosis
  - Other _____
- Alcohol, drug addiction, or I. V. drug use
- Anemia ("low blood" or "low iron")
- Angina ("chest pains")
- Arthritis
- Asthma
- Bleeding disorder
- Blood clots or phlebitis
- Bronchitis or Emphysema
- Cancer or tumor
- Depression or other mood disorder
- Diabetes (on Insulin: ○yes ○no)
- Dizziness or vertigo
- Fainting
- Gout
- Head injury (○with ○without loss of consciousness)
- Heart attack
- Hernia
- High blood pressure
- Kidney problems, kidney failure, or dialysis
- Leukemia
- Liver disease
- Loss of a limb or part of a limb
- Low back pain or injury
- Migraines or other severe headaches
- Peptic ulcers (stomach or duodenal)
- Psoriasis
- Psychiatric diagnosis or treatment
- Seizures or tremors
- Sleep apnea
- Stroke
- Swelling or edema
- Sudden loss of strength or sensation
- Thyroid disease or dysfunction
- None of the above

The above information is complete and accurate to the best of my knowledge and recollection:

Sign: _____ Date: _____

Trócaire Medical

NOTICE OF PRIVACY PRACTICES

A federal regulation, known as the "HIPAA Privacy Rule" requires that we provide detailed notice in writing of our privacy practices. This regulation became effective April 14, 2003, and remains in effect until amended, replaced, or repealed.

I. OUR COMMITMENT TO PROTECTING HEALTH INFORMATION ABOUT YOU:

In this notice, we describe the ways that we may use and disclose health information about you. This information is called "Protected Health Information" (PHI). This notice describes your rights and our obligations regarding the use and disclosure of PHI. We are required by law to: maintain the privacy of PHI about you; give you this notice of our legal duties and privacy practices with respect to PHI; and comply with the terms of our notice of privacy practices currently in effect.

II. HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU:

A. USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS:

Treatment: PHI may be provided to a physician or other personnel as required to administer medical treatment and for purposes of scheduling.

Payment: PHI may be disclosed in order to obtain payment due for services provided to you.

Health Care Operations: PHI may be disclosed in connection with health care operations. This may include training, reviewing the competence and qualifications of health care professionals, evaluating practitioner performance, accreditation, certification, and licensing.

B. OTHER USES AND DISCLOSURES WE CAN MAKE WITHOUT YOUR WRITTEN AUTHORIZATION:

Uses and Disclosures for Which You Have the Opportunity to Agree or Object: We may use and disclose PHI about you in situations where you have the opportunity to agree or object to certain uses and disclosures of PHI about you.

Individuals Involved in Your Care or Payment for Your Care: We may disclose PHI about you to your family member, close friend, or any other person identified by you if that information is directly relevant to the person's involvement in your care or payment for your care.

C. OTHER USES AND DISCLOSURES WE CAN MAKE WITHOUT YOUR AUTHORIZATION:

Required By Law: We may use and disclose PHI as required by federal, state or local law. Any disclosure must comply with the law and is limited to the requirements of the law. This includes compliance with law enforcement officials, court orders and subpoenas.

Public Health Activities: We may use or disclose PHI to public health authorities in accordance with regulations.

Abuse, Neglect, or Domestic Violence: We may disclose PHI in certain cases to proper government authorities if we reasonably believe that a patient has been a victim of domestic violence, abuse, or neglect.

Health Oversight Activities: We may disclose PHI to a health oversight agency for oversight activities in compliance with applicable laws.

Coroners, Medical Examiners, Funeral Directors: We may disclose PHI to a coroner or medical examiner to identify a deceased person and determine the cause of death. In addition, we may disclose PHI to funeral directors, as authorized by law.

Organ and Tissue Donation: If you are an organ donor, we may use or disclose PHI in order to facilitate an organ or tissue donation.

_____
initials

Research: We may use and disclose PHI about you for research purposes under certain limited circumstances. We must obtain a written authorization to use and disclose PHI about you for research purposes except in situations where a research project meets specific, detailed criteria established by the HIPAA Privacy Rule to ensure the privacy of PHI.
Military and Veterans: If you are a member of the Armed Services, we may release PHI as required by military command authorities.
Specialized Government Functions: Under certain circumstances, we may disclose PHI: for national security and intelligence activities; to help provide protective services for the president and others; for the health or safety of inmates and others at correctional institutions or other law enforcement custodial situations for the general safety and health related to the facility.
Disclosures Required by HIPAA Privacy Rule: We are required to disclose PHI to the Secretary of the United States Department of Health and Human Services when requested by the Secretary to review our compliance with the HIPAA Privacy Rule.
Workers' Compensation: We may disclose PHI as authorized by workers' compensation laws or other similar programs that provide benefits for work-related injuries or illness.
D. OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRE YOUR AUTHORIZATION:
All other uses and disclosures of PHI about you will be made only with your written authorization. If you have authorized us to use or disclose PHI about you, you may revoke your authorization at any time, except to the extent we have previously taken action based on the authorization.

III. YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU:
Right to Request Restrictions: You have the right to request additional restrictions on the PHI that we may use for treatment, payment, and health care operations. You may also request additional restrictions on our disclosure of PHI to certain individuals involved in your care or benefit coverage that otherwise are permitted by the Privacy Rule.
Right to Receive Confidential Communications: You have the right to request that you receive communications regarding PHI in a certain manner or at a assured location.
Right to Inspect and Copy: You have the right to request the opportunity to inspect and receive a copy of PHI about you in certain records that we maintain.
Right to Amend: You have the right to request that we amend PHI generated and kept by us.
Right to Receive an Accounting of Disclosures: You have the right to request an accounting of certain disclosures that we made of PHI about you.
Right to a Paper Copy of this Notice: You have a right to receive a paper copy of the current version of this notice at any time.
Request in Writing: All requests for exercising of your rights under this regulation must be made in writing.

I have reviewed and understand the above information and a copy has been offered to me for my records.

_____ _____

Signature *Date*

_____

Print name