Huntington Health Physicians

Patient Name: _____
Date of Birth: _____
Patient #/ MRN: _____

Acknowledgement Form

Notice of Privacy Practices

I hereby acknowledge that I have been provided the 'Notice of Privacy Practices' which describes how medical information about me may be used and disclosed, and how I can get access to this information. Initials _____

Consent for Photographs

I hereby consent for photographs to be taken for medical treatment purposes. Initials _____

Financial Policy

I hereby acknowledge that I have read and understand Huntington Health Physicians' financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time. Initials _____

Confidential Communication Request

As required by the Health Information Portability and Accountability Act of 1996, you have the right to request that communications concerning your personal health information be made through confidential channels. As an organization our mailing practice is to send items to the home address we have on file. I wish to be contacted in the following manner. ❒ **Mail**

Cell: _____
- ❑ Leave a detailed message
- ❑ Leave call back number only

Home: _____
- ❑ Leave a detailed message
- ❑ Leave call back number only

Work: _____
- ❑ Leave a detailed message
- ❑ Leave call back number only

Email Address

Email Address:

By providing email above, I acknowledge that the email I've provided above will be used only by Huntington Health Physicians (HHP) and its licensees to contact me with helpful information on healthcare treatments, services, and health education informational purposes, along with information regarding my participation in health and wellness events and community events hosted by HHP. I understand that HHP will not sell or transfer my name to any third-party for marketing use. HHP respects your personal health information and complies with applicable laws regarding the use of such information. I understand that this consent remains valid for five (5) years. To be removed from the mailing list, please contact customer service at (626) 397-8335.
▭Check if you do not wish to give your email.

Clinical Registries

Clinical registries are databases that systematically collect health-related information on individuals who are:

- treated with a particular surgical procedure, device or drug (e.g. joint replacement);
- immunization tracking (e.g. California Immunization Registry-CAIR);
- diagnosed with a particular illness (e.g. stroke); or
- managed via a specific healthcare resource (e.g. treated in an intensive care unit).

Information in clinical registries is captured on an ongoing basis from a defined population. Clinical registries provide the most suitable and accurate method of providing monitoring and benchmark data and provide the greatest potential to improve healthcare performance across institutions and providers.

(PLEASE TURN PAGE)

Huntington Health Physicians participates in these registries

ePrescribing

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. The U.S. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program. These include:

- **Fill status notification** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up or partially filled.
- **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

Understanding all of the above, I hereby provide informed consent to Huntington Health Physicians to enroll me in the E-Prescribe Program. I had the opportunity to ask questions and all of my questions have been answered to my satisfaction

(Please Select ONLY one)

Initial here **to be enrolled** in the ePrescribing program. Initials _____

Initial here **to not enroll** in the ePrescribing program. Initials _____

Primary Pharmacy

Name:_____ Phone Number: _____

Cross Street: _____ City: _____

Mail Order Pharmacy: _____ Phone number: _____

Advance Directive

I have an advance directive. ❒YES ❒NO
I will bring a copy of my advance directive to my doctor. ❒YES ❒NO
I would like information about advance directives. ❒ YES ❒ NO

Primary Language spoken (Required by the California Department of Health Services)

(Please Circle One) English Spanish Chinese Other (Please List) _____

Additional field required by Federal Regulations

Race: (Please circle one) American Indian or Alaska Native Asian
Hispanic or Latino – Black Native Hawaiian or Pacific Islander White
Hispanic or Latino – White Black or African American

Ethnicity: (Please circle one) Hispanic or Latino Not Hispanic or Latino

By signing below, I acknowledge all the above items have been read and received.

_____ _____
Signature of Patient/Guardian Date

_____
Print Name