BluMine Health

INFORMED CONSENT RELEASE

I, _____, voluntarily consent to medical treatment and lab tests as
(Print patient full name)
recommended by BluMine Health. The care provided does not come with any guarantees and I may change providers or chose to seek treatment elsewhere whenever I deem it in my best interests. I acknowledge and have been informed of risks and benefits of various means of receiving medical treatment. I am fully capable of making medical decisions for myself or may delegate a family member to do so if I am unable.

X_____ **Date:** _____
Patient/Parent/Legal Guardian Signature

If Patient is a Minor (under 18):

Print Name Parent/Guardian: _____

Relationship to Minor: _____

BluMine Health

HEALTH HISTORY

Patient Name: _____ **Date of Birth**: _____ **Age**: _____
(Please Print: First, Middle Initial, Last Name of patient)

Social Security Number: _____ Name of Emergency Contact: _____

Emergency Contact Telephone Number: _____ Relationship to Emergency Contact: _____

Do you have Health Insurance? Yes _____ No _____ Insurance Policy Holder Name: _____

Primary Care Physician Name: _____ Pharmacy Name and Phone: _____

Sex: Male / Female / Transgender **Status:** Single / Married / Other

Ethnicity: Hispanic or Latin _____ Not Hispanic or Latin _____ Decline to Answer _____

Race:
American Indian or Alaska Native: _____
Asian: _____
Black or African American: _____
Hispanic: _____
Native Hawaiian or Other Pacific Islander: _____
White: _____
Other: _____
Decline to Answer: _____

Language Preference: English: _____ Spanish: _____ Other: _____

Are you allergic to latex? Yes _____ No _____ Other Allergies: _____

MEDICATION ALLERGIES:	**REACTION TO MEDICATION:**

MEDICATION LIST: Please List any PRESCRIPTION, OVER THE COUNTER MEDICATION OR VITAMINS

MEDICATION	DOSE	HOW OFTEN	WHY ARE YOU TAKING?

(If you need additional space, please use the back of this form to add any other medications.)

Patient Name: _____ **Date of Birth:** _____ **Age:** _____
(Please Print: First, Middle Initial, Last Name)

Please check all that apply, about you personally, that you are experiencing now or have in the past, to the best of your knowledge so that we know how to best treat you. If you need additional help filling out this form, our staff will be happy to assist you.

General:	Now	Past	**Throat/Mouth:**	Now	Past	Change in appetite	Now	Past	High cholesterol/Lipids	Now	Past
Weight loss/gain			Bleeding			Change in bowel habits			High/Low Blood Pressure		
Fatigue			Dentures			Rectal Bleeding			**Neurologic:**		
Fever/Chills			Sore tongue			Constipation			Dizziness/Fainting		
Weakness			Dry Mouth			Diarrhea			Seizures		
Trouble sleeping			Sore throat			Last Colonoscopy?			Weakness		
Skin:			Hoarseness			Abdominal Pain			Numbness/Tingling		
Rashes			Thrush			**Urinary:**			Tremors		
Dryness			Non healing sores			Frequent urination			**Hematologic:**		
New Mole/Color changes			Lumps			Burning/painful urination			Bruise easily		
Hair or nail changes			Swollen Glands			Blood in urine			Clot easily		
Head:			Neck Pain			Incontinence			Hepatitis		
Headache/Migraines			Stiffness			Other			**Endocrine:**		
Head injury			**Breasts:**			**Vascular:**			Heat or cold intolerance		
Neck pain			Lumps			Calf pain w/walking			Sweating		
Ears:			Pain			Leg cramping			Frequent Urination		
Hearing loss			Discharge			Vein changes			Thirst		
Ringing in ears			Self-exams			**Musculoskeletal:**			Diabetes		
Ear pain			Date of Last Mammogram?			Muscle or joint pain			**Nose:**		
Drainage			**Respiratory:**			Osteoporosis			Discharge		
Eyes:			Asthma			Broken bones			Nosebleeds		
Vision change/loss			Coughing up blood			**Cardiovascular:**			Pressure		
Redness			Wheezing			Chest pain/ discomfort			Itching		
Blurry/double vision			Painful breathing			Tightness in chest			**List Other Symptoms:**		
Flashing lights			Other			Palpitations/ murmurs					
Date of last Eye exam?			**Gastrointestinal**			Shortness of breath w/ activity					
Itching			Difficulty Swallowing			Swelling in ankles					

SURGERIES AND HOSPITALIZATIONS: **DATE:**

(If you need additional space, please use the back of this form to add any other surgeries or hospitalizations.)

Patient Name: _____ **Date of Birth:** _____ **Age:** _____
(Please Print: First, Middle Initial, Last Name)

SOCIAL HISTORY:

Alcohol Use:
Do you drink alcohol? Yes ____ No _____ If Yes, number of drinks per week: _____
Alcohol problems in the past? Yes _____ No _____

Cigarette/Tobacco Use:
Do you smoke cigarettes? Yes _____ No _____ Never _____
If Yes, how long have you smoked? _____
If Yes, how many packs a day do you smoke? _____
Do you smoke/use: Pipe _____ Cigar _____ Snuff _____ Chewing Tobacco _____

Drug Use:
Do you use any recreational or illegal drugs? Yes _____ No _____
Have you ever used needles to inject drugs? Yes _____ No _____

Physical Activity:
Do you engage in any form of regular physical activity/exercise (at least 3 days per week)?
Yes _____ No _____

FAMILY HISTORY:
Please check all family history health conditions, both currently and in the past, to the best of your knowledge so that we know how to best treat you.

CONDITION	Mother	Father	Brother/Sister	Grandparents
Cancer				
High Blood Pressure				
Stroke				
Heart Disease				
Diabetes				

Please LIST any other medical conditions that run in your extended family. _____
_____

X Signature: _____ **Date:** _____
Patient/Parent/Legal Guardian Signature

If Patient is a Minor (under 18):

Print Name Parent/Guardian: _____ Relationship to Minor: _____

BluMine Health

I. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You May Refuse to Sign this Section: Receipt of Notice of Privacy Practices)

I have received a copy of this office's Notice of Privacy Practices.

Patient Name: _____ **Date of Birth:** _____ **Age:** _____
(First, Middle Initial, Last Name)

X **Signature:** _____ **Date:** _____
Patient/Parent/Legal Guardian

_____ **Relationship to Minor:** _____
If Patient is a Minor, print name of Parent/Guardian

II. CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

(Refusal to sign this Consent for Use and Disclosure will result in non-treatment)

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health Information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, by contacting our office.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to this office. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE OF CONSENT I HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THE CONTENTS OF THIS Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

X Signature: _____ Date: _____ Relationship to Patient: _____

III. AUTHORIZATION TO RELEASE PATIENT RECORD INFORMATION

(Refusal to sign this Authorization to Release Patient Record will result in non-treatment)

To whom may we talk to about your medical treatment?

In addition to the authorization for release of my personal PHI described in Section I and II of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment, and prognosis to the following individual(s):

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

If any of the above information changes, it is the patient/parent/legal guardian's responsibility to contact our office.

Patient Name: _____ **Date of Birth**: _____ **Age**: _____

Consent to e-mail or text usage for appointment reminders and other healthcare communications:

Patients in our practice may be contacted via e-mail and/or text messaging to remind you of an appointment, labs, RX, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time you provide an e-mail or text address at which you may be contacted, you consent to receiving appointment reminders and other healthcare communications/information at that e-mail or text address from our practice.

I authorize my provider and his/her staff to leave detailed messages regarding the above medical information on the following answering machine/voice mail or e-mail:

- ☐ Home Phone _____
- ☐ Work Phone _____
- ☐ Cell/Mobile Phone _____
- ☐ E-mail: _____

If any of the above information changes, it is the patient/parent/legal guardian's responsibility to contact our office.

X Signature: _____ Date: _____ Relationship to Patient: _____
Patient/Parent/Legal Guardian

IV. MISCELLANEOUS

If the patient is a minor child (under 18), please list any individuals who may bring your child to their appointment in your absence:

Print Name: _____ Relationship to Patient: _____
Print Name: _____ Relationship to Patient: _____
Print Name: _____ Relationship to Patient: _____

Loss of Personal Articles:

I understand that BluMine Health is not liable for the loss of or damage to money, jewelry, glasses, dentures, documents, clothing or other items of personal property.

Smoke-Free Environment:

BluMine Health maintains a smoke-free environment. Smoking is prohibited by health care personnel, patients, and visitors except in designated areas outside the building.

X Signature: _____ Date: _____ Relationship to Patient: _____
Patient/Parent/Legal Guardian

YOU ARE ENTITLED TO A COPY OF THIS DOCUMENT AFTER YOU SIGN IT

FOR BluMine OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

_____ Individual refused to sign _____ Emergency situation prevented us from obtaining acknowledgement
_____ Communication barriers prohibited obtaining acknowledgement _____ Other (Please Specify) _____

BluMine Health

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you will be used and disclosed and how you can get access to this information. Please review it carefully.

BluMine Health ("BMH") is required by law to maintain the privacy of Protected Health Information ("PHI") and to provide you with notice of our legal duties and privacy practices with respect to PHI. PHI is information that may identify you and that relates to your past, present, or future health care services. This Notice of Privacy Practices ("Notice") describes how we may use and disclose PHI to carry out treatment, payment or health care operations required by law. The Notice also describes your rights with respect to PHI. We are required to provide this Notice to you by the Health Insurance Portability and Accountability Act ("HIPAA").
BMH is required to follow the terms of this Notice. We will not use or disclose your PHI without your written authorization, except as described or otherwise permitted by this Notice. We reserve the right to change our practices and this Notice and to make the new Notice effective for all PHI we maintain. Upon request, we will provide any revised Notice to you.

Examples of how we use and disclose protected health information about you

The following categories describe different ways that we use and disclose your protected health information.

- Treatment: We may use your health information to provide and coordinate the treatment, medications and service you receive.
- Payment: We may use your health information for various payment related functions.
- Health Care Operations: We may use your health information for certain operational, administrative and quality assurance activities. We may disclose health information to business associates if they need to receive this information to provide a service to us and will agree to abide by specific HIPAA rules relating to the protection of health information.

We are permitted to use or disclose your PHI for the following purposes. However, BMH may never have reason to make some of these disclosures.

- To communicate with individuals involved in your care or payment for your care: We may disclose to a family member, other relative, close personal friend, or any other person you identify PHI directly relevant to that person's involvement in your care or payment related to your care.
- Food and Drug Administration (FDA): We may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs or replacements.
- Worker's Compensation: We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.
- Public Health: As required by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury or disability.
- Law Enforcement: We may disclose your PHI for law enforcement purposes as required by law or in response to a subpoena or court order.
- As required by law: We will disclose your PHI when required to do so by federal, state or local law.
- Health Oversight Activities: We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.
- Judicial and Administrative Proceedings: If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process, instituted by someone else involved in the dispute; but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.
- Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

- Coroners, Medical Examiners, and Funeral Directors: We may release your PHI to a coroner or medical examiner.
- Notification: We m ay use or disclose your PHI to notify or assist in notifying a family member, personal representative or another person responsible for your care, regarding your location and general condition.
- To Avert a Serious Threat to Health or Safety: We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety or the public or another person.
- Military and Veterans: If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.
- National Security, Intelligence Activities, and Protective Services for the President and Others: We may release PHI about you to federal officials for intelligence, counterintelligence, protection to the President, and other national security activities authorized by law.
- Victims of Abuse or Neglect: We may disclose PHI about you to a government authority if we reasonably believe you are the victim of abuse or neglect. We will only disclose this type of information to the extent required by law, if you agree to the disclosure or if the disclosure is allowed by law and we believe it is necessary to prevent serious harm to you or someone else.
- Other Uses and Disclosures of PHI: We will obtain your written authorization before using or disclosing your PHI for purposes other than those provided for above (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.
- Your Employer or Organization Sponsoring Your Health Plan: We may disclose the protected health information and the protected health information of others enrolled in your group insurance plan to the employer or other organization that sponsors your group insurance plan to permit the plan administrator to perform plan administration functions. We may also disclose summary information about the enrollees in your group insurance plan to the administrator to use to obtain premium bids for health insurance coverage offered through your group insurance plan or to decide whether to modify, amend or terminate your group insurance plan. The summary information we may disclose will summarize claims history, claims expenses, or types of claims experienced by the enrollees in your group insurance plan. The summary information will be stripped of demographic information about the enrollees in the group insurance plan, but the plan administrator may still be able to identify you or other participants in your group health plan from the summary information. We may also disclose enrollment and disenrollment information to either the plan administrator or plan sponsor of your group insurance plan.

Your Health Information Rights

You may:

- Obtain a paper copy of the Notice upon request. You may request a copy of our current Notice at any time. Even if you have agreed to receive the Notice electronically, you are still entitled to a paper copy. You may obtain a paper copy from BMH site (care), mail service location or the Privacy Office.
- Inspect and obtain a copy of PHI. In most cases, you have the right to access and copy the PHI that we maintain about you. To inspect or copy your PHI, you must send a written request to the Privacy Office. We may charge you a fee for the costs of copying, mailing, and supplies that are necessary to fulfill your request. We may deny your request to inspect and copy in certain limited circumstances.
- Request an amendment of PHI. If you feel the PHI we maintain about you is incomplete or incorrect, you may request that we amend it. To request an amendment, you must send a written request to the Privacy Office. You must include a reason that supports your request. In certain cases, we may deny your request for amendment.
- Receive an accounting of disclosures of your PHI. You have the right to receive an accounting of the disclosures we have made of your PHI after April 14, 2003, for most purposes other than treatment, payment, or health care operations. The right to receive an accounting is subject to certain exceptions, restrictions and limitations. To request an accounting, you must submit a request in writing to the Privacy Office.
- Incidental Disclosures. BMH will make reasonable efforts to avoid incidental disclosures of protected health information.

For more information or to report a problem please contact:
BluMine Health, LLC.
2843 Brownsboro Road, Suite 201
Louisville, KY 40206.
Phone: (502) 384-1917
Website: www.BluMineHealth.com
This notice is effective as of August 30, 2015.
Ver: 04122019