PATIENT INFORMATION

Patient's Full Name:____

Date of Birth: ______________________________

Home Address:____

(City, State, and Zip Code)

Primary Care Physician: ____

PATIENT BILLING INFORMATION: Payment is expected in full from you on the day services are provided. Any other arrangements must be made with Dr. Epstein prior to the appointment. As a service to you, we will be happy to provide you with an insurance statement that you can file with your insurance carrier, or we will file a claim with your carrier for you. Any reimbursement from the insurance carrier will be made directly to you. **To Divorced and/or Separated Individuals:** We cannot bill another party for services rendered through this office unless that individual has signed an authorization to that effect. In the event of default on this account, we reserve the right to hold either parent or spouse responsible for charges incurred. **Please sign that you have read and understand our billing procedures.**

____

(Signature)

____

(Date)

Who is responsible for payment: ________**Self** _________**Parent**

Full Name of Responsible Party: ____Birthdate:_____________

Home Address:____

(City, State, and Zip Code)

Home Telephone: (_________)____________________**Cell Number: (**_________)__________________________

Employer's Name:____**Work Telephone:** (______)_______________

Employer's Address:____

(City, State, and Zip Code)

Spouse's Full Name:____Birthdate:_____________

Home Address:____

(City, State, and Zip Code)

Home Telephone: (_________)____________________**Cell Number:**(_________)__________________________

Employer's Name: ____**Work Telephone: (**______**)**_______________

Employer's Address:____

(City, State, and Zip Code)

Who referred you to our office:____

DR. LEE EPSTEIN & ASSOCIATES
HEALTH HISTORY FORM

Patient Name____Today's Date:__________________

Birth date:__________________ Age:_________ Date of your last physical____

What is the reason for the visit today?____

If you have or have had in the past year any of these symptoms please mark with an "X"

GENERAL SYMPTOMS
____Chills
____Depression
____Dizziness
____Fainting
____Fever
____Forgetfulness
____Headaches
____Nervousness
____Numbness or Tingling
____Sleeplessness
____Sweats
____Weight Loss
____Poor Appetite

GASTROINTESTIONAL
____Bloating
____Bowel changes
____Constipations
____Diarrhea
____Excessive hunger
____Excessive thirst
____Gas
____Hemorrhoids
_____Indigestion
____Nausea
____Rectal Bleeding
____Stomach Pain
____Vomiting
____Vomiting blood

THROAT, EAR, NOSE, EYE
____Bleeding Gums
___Blurred Vision
____Crossed eyes
____Difficulty swallowing
____Double vision
____Earaches
____Hay fever
____Hoarseness
____Hearing Loss
____Nosebleeds
____Persistent Cough
____Ringing in ears
____Sinus problems
____Vision Flashes or Halos

MUSCULAR
Any pain, weakness, or numbness
____Arms ____Hips
____Back ____Legs
____Feet ____Neck
____Hands ____Shoulders

UNINARY
____Blood in urine
____Frequent urination
____Loss of bladder control
____Painful Urination
____Prostate

CARDIO
____Chest pain
____High blood pressure
____Irregular heart beat
____Low blood pressure
____Poor circulation
____Rapid heartbeat
____Swelling in ankles
____Varicose veins

SKIN
____Bruising easily
____Hives
____Itching
____Change in moles
___Rash
____Scars
____Sores that will not heal

FOR MEN ONLY
____Breast Lump
____Erection difficulties
____Lump in testicles
____Penis discharge
____Sore on penis
____Other

FOR WOMEN ONLY
____Abnormal Pap Smear
____Bleeding between period s
____Breast Lump
____Extreme menstrual pain
____Hot flashes
____Nipple discharge
____Painful intercourse
____Vaginal discharge
____Are you pregnant

If you have or have had any of the following conditions within the past year please mark with an "X"

____AIDS
____Alcoholism
____Anemia
____Anorexia
____Appendicitis
____Arthritis
____Asthma
____Bleeding Disorders
____Bronchitis
____Bulimia
____Cancer
____Cataracts
____Chemical Dependency
____Chicken Pox
____Diabetes
____Emphysema
____Epilepsy
____Glaucoma
____Goiter
____Gonorrhea
____Gout
____Heart Disease
____Hepatitis
____Hernia
____Herpes
____High Cholesterol l
____HIV Positive
____Kidney Disease
____Liver Disease
____Measles
____Migraine Headaches
____Miscarriage
____Mononucleosis
____Multiple Sclerosis
____Mumps
____Pacemaker
____Pneumonia
____Polio
____Prostate Problem
____Psychiatric Care
____Rheumatic Fever
____Scarlet Fever
____Stroke
____Suicide Attempt
____Thyroid Problems
____Tonsillitis
____Tuberculosis
____Typhoid Fever
____Ulcers
____Vaginal Infections
____Venereal Disease

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING CURRENTLY: ____

____

____

DO YOU HAVE ALLERGIES? IF SO, PLEASE DESCRIBE:____

FAMILY HISTORY INFORMATION

Please mark with an "X" if any of your blood relatives have had any of the following and list their relationship to you:

____Arthritis, Gout Relationship____
____Asthma, Hay Fever Relationship____
____Cancer Relationship____
____Chemical Dependency Relationship____
____Diabetes Relationship____
____Heart Disease or Stroke Relationship____
____High Blood Pressure Relationship____
____Kidney Disease Relationship____
____Tuberculosis Relationship____

The following information is needed on your immediate family:

Father: Age_________ Living_______ Deceased__________ Age at Death_______ Cause of death___________________________________

Mother: Age ________ Living_______ Deceased ___________Age at Death _______Cause of death __________________________________

Brother(s) Ages _____________ Living________ Deceased______ Age(s) at Death ____________ Cause of death______________________

Sister(s): Ages______________ Living________ Deceased ______ Age(s) at Death ____________ Cause of death______________________

Have you been hospitalized? If so, please list date(s) and the reason for hospitalization and the outcome: _________________________

____

____

____

Please list all pregnancies: Year of birth_____________ Sex of Birth _____________ Complications if any_____________________________
Year of birth ____________ Sex of Birth _____________ Complications if any ____________________________
Year of birth ____________ Sex of Birth _____________ Complications if any ____________________________
Year of birth ____________ Sex of Birth ______________ Complications if any ____________________________

Have you had a blood transfusion? ____Yes ____No If you answered yes, please give approximate dates and reasons: ______________

____

Have you had any major illnesses or injuries? If yes, please provide dates and outcomes: ____

____

____

Do you use : ___Caffeine - how much__________________

____ Tobacco - how much ________________

____ Street Drugs - how much __________________ what types ____

____ Other - Explain ____

Does your job expose you to: ____Stress ____Heavy Lifting ____Hazardous Materials

The above information is correct and provided to the best of my knowledge. I understand it is my responsibility to inform the doctor if I or my minor child ever have a change in health status.

____ Date __________________________________
Signature of patient, parent, personal representative or guardian

____
Relationship of person providing this information (other than patient)

DR. LEE EPSTEIN & ASSOCIATES
DR. DEBORAH G. BLAIR
3333 BARDSTOWN ROAD
LOUISVILLE, KY 40218
PHONE: 504-459-7433 FAX: 502-459-5650

AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ___________________________________ Date of Birth: _____________________
Social Security #:__________________________________

I hereby authorize and request the use and/or disclosure of my protected health information as described below:

___**RELEASE TO:**
Dr. Lee Epstein & Associates
Dr. Deborah G. Blair
3333 Bardstown Road
Louisville, KY 40218

_____**OBTAIN FROM (**Complete name, address, phone)
____
____
____
____

_____**OBTAIN FROM:**
Dr. Lee Epstein & Associates
Dr. Deborah G. Blair
3333 Bardstown Road
Louisville, KY 40218

_____**RELEASE TO: (**Complete name, address, phone)
____
____
____
____

1. The following information pertaining to the patient named above:
_____Entire Medical Record (including psychotherapy notes, psychological evaluations) OR
_____History & physical examination _____Laboratory tests _____X-ray reports _____Discharge Summary
_____Other (please list) ____
2. I understand that this information may include information related to Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, or mental or behavioral health or psychiatric care.
3. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy regulations, then such information may be re-disclosed and would no longer be protected.
4. I understand that I have a right to evoke this authorization at any time. My revocation must be in writing in a letter to Dr. Lee Epstein & Associations and/or Dr. Deborah G. Blair at the address listed on this authorization form. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.
5. Unless otherwise revoked, I understand that this authorization will expire one hundred eighty days (180) days from the date of this form or on the following date or event: __________________________
6. I understand that I may refuse to sign this authorization and that Dr. Lee Epstein & Associates and/or Dr. Deborah G. Blair may not condition treatment on the completion of this authorization except as indicated in 45 CFR 164.508 (b)(4).

I certify that I have read and received a copy of the authorization. This authorization supersedes any and all previous authorizations.

____ __________________________
Signature of Patient or Patient's Representative **Date**

____ ________________________
Printed Name of Patient's Representative given authority to act for patient **Relationship to Patient**

DR. LEE EPSTEIN & ASSOCIATES
DR. DEBORAH G. BLAIR
3333 BARDSTOWN ROAD
LOUISVILLE, KY 40218
PHONE: 504-459-7433 FAX: 502-459-5650

NO SHOW POLICY:

Patients who miss appointments will be charged for ALL NO SHOW APPOINTMENTS. Patients will not be seen again unless the charges for the no show appointments have been paid. The fee for each no show appointment is $50.00.

CANCELLATION POLICY:

We understand that sometimes circumstances prevent you from keeping appointments and we will work with you to reschedule whenever possible. We ask that whenever you need to cancel or reschedule an appointment you notify us at least 24 hours in advance. **LAST MINUTE CANCELLATIONS ARE SUBJECT TO BE CHARGED A FEE ($50.00).**

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES:

____ __________________________
Patient Signature/Patient's Representative Relationship to Patient

____
Patient Name (Printed)

____
Date

DR. LEE EPSTEIN & ASSOCIATES
DR. DEBORAH G. BLAIR
3333 BARDSTOWN ROAD
LOUISVILLE, KY 40218
PHONE: 504-459-7433 FAX: 502-459-5650

This office will accept patients regardless of race, creed, or ethnic background

PATIENT RIGHTS

All patients will have access to treatment regardless of race, creed, nationality, or source of payment.

All patients have the right to considerate, respectful care at all times and under all circumstances.

All patients have the right to expect reasonable safety in clinical practices and clinical environment.

All patients have the right to know the identity and professional status of individuals providing service to them as well as their relationship to any other health care or educational institution.

All patients have the right to complete and current information concerning their medical treatment.

All patients who do not speak or understand the predominant language of the community will have access to an interpreter.

All patients have the right to reasonably informed participation in and consent for decisions involving their health care. Patients also have the right to be informed of human experimentation or other research/educational projects affecting their care or treatment and the patient has the right to refuse to participate.

All patients have the right to refuse treatment to the extent permitted by law. If such refusal prevents the provision of appropriate care, the relationship with the patient may be terminated upon reasonable notice.

All patients have the right to request and receive an itemized and detailed explanation of their bill.

All patients have the right to know the rules and regulations that apply to their conduct as patients. all patients have the right to file complaints regarding their treatment with the appropriate personnel.

PATIENT RESPONSIBILITIES:

The patient has the responsibility to be considerate and cooperative in dealing with office staff and to respect fellow patients.

The patient has the responsibility to ask questions and to seek clarification as may be necessary to adequately understand his or her illness and/or treatment.

The patient has the responsibility to obtain and carefully consider all information he or she may need or desire in order to give informed consent for a procedure and/or treatment.

The patient has the responsibility to weigh the potential consequences of any refusal to comply with instructions or recommendations of the health care provider.

The patient has the responsibility to schedule appointments and to arrive at the office in time for scheduled visits. The patient also has the responsibility to notify us if he or she must cancel or be late for a scheduled appointment.

The patient has the responsibility to express opinions, concerns or complaints in a constructive manner.

The patient has the responsibility to insure that all information provided for inclusion in his or her record is complete and accurate.

The patient has the responsibility to pay all copay, deductibles, or amounts not covered by their mental health insurance for services provided in this office.

DR. LEE EPSTEIN
DR. DEBORAH BLAIR
NOTICE OF PRVACY PRACTICES

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.

Dr. Epstein and Dr. Blair are required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.

This notice describes how we may use of disclose your "protected health information" for various purposes. It also describes your rights to access and control your protected health information. "Protected health information" is information about you that may identify you and relates to your past, present, or future physical or mental health or condition and related health services.

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 this Notice and to make the new Notice provisions effective for all protected health information that we maintain. Upon your request, we will provide you with any revised Notice of Privacy Practices by your written request to our office.

USE AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Your protected mental health information may be used and disclosed by your psychologist, our office staff and others outside of our office that are involved in your care and treatment for the purposes of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of this practice.

The following are examples of the types of uses and disclosures of your protected health care information that Dr. Epstein and/or Dr. Blair are permitted to make:

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. We may disclose your protected health information to another physician or health care provider (i.e., specialist) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

PAYMENT: We will use your protected health information to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you. These may include making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

HEALTHCARE OPERATIONS: We may use your protected health information to support the business activities of this practice. This may include but is not limited to using a sign in sheet at the registration desk, where you will be asked to sign your name, we may call you by name in the waiting room, or we may use your protected health information to contact you to remind you of your appointment.

USES AND DISCLOSURES THAT MAY BE MADE WITH YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke such an authorization, at any time, in writing, except to the extent that your psychologist or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

USES AND DISCLOSURES THAT MAY BE MADE UNLESS YOU OBJECT

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use of all or part of your projected health information. If you are not present or able to agree to object to the use of disclosure of the protected health information,

then your psychologist may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others involved in your healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such necessary information if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition or death. Finally, we may use of disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individual involved in your health care. In the case of my (and most) psychological practice, protected health information is not disclosed to any non-caregiver unless you are considered to be a danger to yourself or others and unable to cooperate in your care. That is considered a psychiatric emergency.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your acknowledgment of your understanding as soon as reasonably practicable after the delivery of treatment. If we are required by law to treat you and we have attempted to obtain your acknowledgment, but are unable, we may still use or disclose your protected health information for treatment, payment, and health care options.

Communication Barriers: We may use and disclose your protected healthcare information if your psychologist or another professional in the practice attempts to obtain an acknowledgment of our Private Practices from you, but is unable to do so due to substantial communication barriers.

OTHER PERMITTED & REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSTENT, AUTHORIZATION, OR OPPORTUNITY TO OBJECT

We may use or disclose your protected health information in the following situations without your acknowledgement or authorization. These situations include by way of example: legal proceedings, military activity, public health, law enforcement, national security, communicable diseases, coroners requests, funeral worker's health oversight, organ donation, abuse or neglect, inmates, food and drug research, required uses and administration, or criminal activity disclosures.