

Registration Instructions

Thank you for registering. There are three (3) forms.

1. A standard HIPPA privacy statement as required by federal law.
2. Patient Information Record: It is self explanatory. Please sign at the bottom if you understand and agree with our privacy practices.
3. Patient Medical History: Note... Skin cancer screening is included with your office visit if you wish. You may continue to wear your undergarments underneath of the provided gown and drape. Please note that there are two columns of past medical history to review. Sign at the bottom.

Please visit our website if you haven't done so already: www.johnbradymd.com. It has information about our office policies as well as useful information.

We request that you arrive 15 minutes before your appointment with the completed forms, and look forward to seeing you!

Dr. Brady and Staff

John W. Brady, Jr., M.D.
8650 Sudley Road, Suite 310
Manassas, VA 20110-4416

September 1, 2008

NOTICE OF PRIVACY 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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, health care operations, and when we are required to do so by federal, state, or local law.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.
- **Disclosures required by law** examples of this include public health risks and court orders.

We may also create and distribute de-identified health information by removing all references to individually identifiable Information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and 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 our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

John W. Brady, Jr. MD
8650 Sudley Road, Suite 310
Manassas VA 20110-4416
703 369 3376
703 369 1118 fax

For more information about HIPAA or to file a Complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
202 619 0257
Toll Free: 1-877-696-6775

Patient Information RecordTODAY'S DATE:

PATIENT'S LEGAL NAME (LAST, FIRST MI)			SEX	DATE OF BIRTH	SSN OR ID#
STREET ADDRESS			HOME PHONE		PRIMARY CARE PHYSICIAN
CITY	STATE	ZIP	CELL PH.		REFERRING PHYSICIAN IF DIFFERENT THAN ABOVE
EMPLOYER			WORK PH.	WORK FAX	OCCUPATION (INDICATE IF STUDENT)

Spouse's Information

NAME (LAST, FIRST MI)	DATE OF BIRTH	SSN OR ID#	WORK PH. CELL
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Person Responsible for Payment if Different From Patient

NAME (LAST, FIRST MI)	DATE OF BIRTH	ADDRESS	CITY	STATE	ZIP	HOME PH. WORK CELL
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Complete the Next Block for Minor Patients or Patients Under Parent's Insurance

MOTHER'S NAME (L,F MI)	DATE OF BIRTH	MOTHER'S SSN OR ID #	STREET ADDRESS			
MOTHER'S EMPLOYER		HOME PH. WORK CELL	CITY	STATE	ZIP	
FATHER'S NAME (L,F MI)	DATE OF BIRTH	FATHER'S SSN OR ID #	STREET ADDRESS			
FATHER'S EMPLOYER		HOME PH. WORK CELL	CITY	STATE	ZIP	

Note any restrictions we may have in contacting the patient or responsible party NONE**Please read the following privacy statement & sign at the bottom****NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I understand that, under the Health Insurance Portability & 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 may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Disclose protected health information required by law.

I have received, read and understand 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 Privacy 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 or Responsible Party: _____

Relationship to Patient: _____

**Signature:** _____**Date:** _____**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

DATE	INITIALS	REASON
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Patient's Medical History

Patient Name: _____ Date of Birth: _____ Age: _____ Today's Date: _____

Reason for today's visit: _____

Skin cancer screening today? (CIRCLE): Complete Above-waist Decline

Are you **allergic** to any medications or had an ill reaction to local (dental) anesthesia? **NO** If **YES**, please list: _____

List all medications you are currently taking (INCLUDE PRESCRIPTION, OVER-THE-COUNTER, VITAMINS, AND HERBALS): NONE

COMPLETE BOTH COLUMNS & CIRCLE APPROPRIATE CHOICES

Medical History and Review of Systems: Do you have now, or previously had conditions of (CIRCLE):

<p>Y N Lungs (CIRCLE) <input type="checkbox"/> <input type="checkbox"/> wheezing, shortness of breath, coughing, bronchitis, Emphysema, Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Cardiovascular (CIRCLE) high blood pressure, heart attack, chest pain, heart murmur, arrhythmia, blood clots, bleed easily, legs swelling, mitral valve prolapse, artificial heart valve</p> <p><input type="checkbox"/> <input type="checkbox"/> PACEMAKER / DEFIBRILLATOR</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer (WHAT KIND? _____)</p> <p><input type="checkbox"/> <input type="checkbox"/> Gastrointestinal (CIRCLE) nausea, vomiting, diarrhea, Crohn's / ulcerative colitis</p> <p><input type="checkbox"/> <input type="checkbox"/> History of STD's (CIRCLE) genital warts / herpes, molluscum, syphilis, gonorrhea (OTHER? _____)</p> <p><input type="checkbox"/> <input type="checkbox"/> HIV, Hepatitis B or Hepatitis C?(CIRCLE)</p>	<p>Y N Constitutional (CIRCLE) <input type="checkbox"/> <input type="checkbox"/> fevers, chills, night sweats, poor appetite, weight loss</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid disease (WHAT KIND? _____)</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney disease (WHAT KIND? _____) Are you on dialysis?</p> <p><input type="checkbox"/> <input type="checkbox"/> Bladder / Prostate incontinence, dark urine, prostate disease(CIRCLE)</p> <p><input type="checkbox"/> <input type="checkbox"/> Musculoskeletal / Rheumatologic (CIRCLE) arthritis, limited motion, artificial joint, Lupus, Rheumatoid Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Neurological / Psychiatric (CIRCLE) headaches, dizziness, seizures, fainting, depression, anxiety</p> <p><input type="checkbox"/> <input type="checkbox"/> Eyes, Ears, Nose, Throat (CIRCLE) Eyes: burning, itching, grittiness, glaucoma, cataracts Nose: nasal polyps, hay fever, Mouth: canker sores, cold sores (OTHER? _____)</p>
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Skin: Have you ever had skin cancer? YES NO
 When exposed to sunlight, do you usually BURN BURN & TAN TAN Do you use sunscreens? Y N
 Do you have a history of a specific skin disease? YES NO if yes, _____

List any other diseases or conditions or clarify any of the above: _____

List any surgical procedures you have had in the last 6 months: _____

Social History:

What is your occupation? _____

Do you drink alcohol?	YES	NO	Do you use recreational drugs?	YES	NO
Do you use tobacco products?	YES	NO	What kind?		

Women: Are you pregnant or trying to conceive? YES NO How many weeks? _____ Due Date: _____
 Are you currently breastfeeding? YES NO

Family History: Please circle or list any relevant family medical history (skin or otherwise):

Allergies	Diabetes	High blood pressure	Psoriasis	Cancer	Tuberculosis
Arthritis	Eczema	Hives	Melanoma	Heart Disease	
Asthma	Hay fever	Lung disease	Skin cancer	Lupus	

PLEASE SIGN AND DATE BELOW WHEN COMPLETE

Completed by: _____ Date: _____ Medical Staff: _____ (INITIALS)
 Patient or Guardian Signature

Reviewed by: _____ Date: _____
 Physician Signature