MARK E. CHARIKER M.D., FACS 502-568-4800

Chart No. ____________ Age: ____________

Patient's Name: ____
First *Middle* *Last*

Address: ____
Street & Apt. # *City* *State* *Zip*

Home Phone: ____________ Cell Phone: ____________ Other Phone: ____________

Any restrictions for contacting you? ☐ No ☐ Yes Email: ____________

Contact restrictions ____

Birthdate: ____________ SS#: ____________ Gender: ☐ M ☐ F

Marital Status: ☐ Single ☐ Married to: ____________ ☐ Other ____________

Responsible Party: ____________ Relationship to patient: ____________

____
Phone *Street & Apt. #* *City* *State* *Zip*

Employer: ____________ Work Phone: ____________ Ext. ______

How did you hear about Dr. Chariker? ***(Mark all that apply)***

☐ Website ☐ Magazine ☐ TV News ☐ Phone Book ☐ Radio ☐ Salon ☐ Other ____________

☐ Friend/Relative: ____________ ☐ **Doctor:** ____________

Refferring Doctor Address: ____
Address *Phone*

Emergency Contact: ____
(Not in your household) *Relationship to Patient*

Home Phone: ____________ Work Phone: ____________ Other Phone: ____________

Primary Health Insurance Company: ____

ID #: ____________ Group #: ____________ Ins. Phone: ____________

Referral Required? ☐ No ☐ Yes Copay? ☐ No ☐ Yes $ ____________

Insured: Name ________________ D.O.B. __________ Employer: ______________

Secondary Health Insurance Co. ____

Policy #: ________________ Group #: ________________ Ins. Phone: ____________

Referral Required? ☐ No ☐ Yes Copay? ☐ No ☐ Yes $ ____________

Insured: Name ________________ D.O.B. __________ Employer: ______________

I UNDERSTAND THAT OFFICE VISIT CHARGES ARE PAYABLE ON THE DAY SERVICE IS RENDERED. I AUTHORIZE DR. MARK E. CHARIKER TO BILL MY INSURANCE COMPANY FOR MEDICALLY NECESSARY SERVICES. REGARDLESS OF INSURANCE COVERAGE, I AM RESPONSIBLE FOR ALL BILLS BEING PAID IN A TIMELY MANNER. I UNDERSTAND THAT MY CONTRACT IS BETWEEN DR. MARK E. CHARIKER AND MYSELF.

SIGNATURE: ________________________________ **DATE:** ____________________

Notice of Health Information Practices

At Dr. Chariker's office, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Each time you visit Dr. Chariker's, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosures to other.

Although your health record is the physical property of Dr. Chariker's, the information belongs to you. You have the right to request a copy of your chart, with a release to do so. This copy may be for you or to be sent to another health official (doctor).
Dr. Chariker's office is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

If you believe your privacy rights have been violated, you can file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures:

- Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the member of your health care team. Member of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

- We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

- A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

- Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

- There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill your or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

- We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, you location, and general condition. Or health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. As well funeral directors in consent with the law and to their duties.

Mark E. Chariker M.D., FACS

222 S. First Street, Suite 100
Louisville, KY 40202
Phone: (502) 568-4800
Fax: (502) 589-6882

PROTECTED HEALTH INFORMATION

I hereby consent Mark E. Chariker, M.D. to use my protected health information (PHI) for the purpose of providing treatment, obtaining payment for health care services, or for the purpose of carrying out health care operations. I also consent Mark E. Chariker, M.D. to use or disclose my protected health information for treatment services provided by another health care provider or entity.

I further acknowledge that I have received a copy of the Notice of Privacy Practices, which provides me with a detailed description of the uses and disclosures allowed by this consent, as well as other rights I may have regarding my protected health information.

Signature: ______________________________ **Date:** ______________________________

Mark E. Chariker M.D., FACS
222 S. First Street, Suite 100
Louisville, KY 40202
Phone: (502) 568-4800
Fax: (502) 589-6882

MEDICAL PHOTOGRAPHY RELEASE

Medical photographs are used for the documentation of diseases, as well as following their progression or regression. These photographs are also used to document results before and after surgery. These photographs are essential in surgical planning. In addition, Dr. Chariker is often called upon to instruct other physicians and the photographs are likewise necessary for this purpose. These photographs may also be used in medical publications in medical journals. Dr. Chariker may use your photographs for other patients to see results with the same of similar procedure or diagnosis as you have been treated for. As per the Notice of Privacy Practices for Protected Health Information, **your name or any other associated identification will not be attached to your photographs.**

Please sign the appropriate statement below, as it pertains to the information given above.
I, ______________________, agree to let Mark E. Chariker, M.D. use my photographs for the above mentioned reasons. I understand that Mark E. Chariker, M.D. will not use my name of any other identification information that may reveal my identity. I understand that by signing this agreement to release Mark E. Chariker, M.D. to use my photographic images, I am assigning a specific portion (photographic images) of my protected health information to be released.

Signature: ______________________ **Date:** ______________________

I, ______________________, do NOT agree to let Mark E. Chariker, M.D. use my photographs for the above mentioned reasons.

Signature: ______________________ **Date:** ______________________