THE BUNCKE CLINIC

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name? (Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Email:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr. ☐ Insurance Plan ☐ Hospital ☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance ☐ [Insurance] ☐ [Insurance] ☐ [Insurance] ☐ [Insurance] ☐ [Insurance] ☐ [Insurance] ☐ [Insurance] ☐ [Insurance] ☐ Welfare *(Please provide coupon)* ☐ Other

Subscriber's name:	Subscriber's S.S. #.	Birth date: / /	Group #.	Subscriber's I.D #

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize THE BUNCKE CLINIC or insurance company to release any information required to process my claims.			
Patient/Guardian signature		*Date*	

Please Read and sign the following information regarding your responsibilities: (below)

I am aware that I am responsible for payment of my bill. I understand that I need to work in cooperation with the Buncke Clinic to communicate with my insurance company that my healthcare expenses are paid in a timely fashion. I am aware that the Buncke Clinic may not be in network with all insurances companies and that this may affect my responsibility for my own medical care. However I do understand if my care is a medical emergency visit my insurance should be bound care to cover that. I understand that with communication on my part The Buncke Clinic will make every effort to work with me in cooperation on payment of my understanding of outstanding bill. I understand that monthly statements are sent and I am responsible for any deductible and co-insurance that my insurance company claims I am liable for. I understand that a monthly late penalty charge will be applied to my outstanding bill. I have read and accept the above terms. Initial: _____

I request that payment and authorization of Medicare or other insurance benefits made on my behalf be assigned to the Buncke Clinic. I know that if payment for services rendered by The Buncke Clinic be made by an insurer it is my responsibility to promptly deliver that check endorsed by me to

The Buncke Clinic: 45 Castro Street Suite 121, San Francisco, California 94114

If I cash any checks intended as payment for services rendered by The Buncke Clinic or any of its providers I understand that I will be held legally responsible for that portion of the bill for services rendered by the Buncke Clinic. The Buncke Clinic does accept payment for Medicare assigned cases and I will only be charged any deductible or co-pay, co-insurance that Medicare claims as my responsibility or any non-covered services. Initial: _____

I authorize The Buncke Clinic to release medical information about me to appropriate parties when required for my care or as necessary to pay my medical claims. Initials: _____

***I consent to any taking of photographs and/or video if required for diagnostic for treatment purposes for the Buncke Clinic. I authorize the use of any image of medical or surgical condition or treatment and the use of the image by The Buncke Clinic for care and educational use or research.* Initial: _____**

By signing, you agree that you have read and understand the guidelines set forth above.
Patient/Guardian Signature:_____ Date:_____

(FOR MEDICARE PRIMARY HOLDERS ONLY)

Please take a moment to complete this questionnaire. Medicare has requested that this information be verified for all Medicare patients every 90 days:

1. Are receiving Black lung benefits? YES NO

2. Are your services today to be paid by a government Research Program? YES NO

3. Are you entitled to benefits through the Department of Veterans Affairs? YES NO

4. Was the illness/injury due to a work-related accident/condition? YES NO

5. Are you currently employed? YES NO
If applicable, date of retirement: _____

6. Do you have a spouse who is currently employed? YES NO
If applicable, date of retirement: _____

7. Do you have Group Health Plan (GHP) coverage based on your own current or former employment?
YES NO
This employs: 1. 1-19 employees 2. 20-99 employees 3. 100+ employees

8. Do you have Group Health Plan (GHP) coverage through your spouse's current or former employer?
YES NO
This employs: 1. 1-19 employees 2. 20-99 employees 3. 100+ employees

9. Do you have Group Health Plan (GHP) coverage through a family member other than your spouse?
YES NO
This employs: 1. 1-19 employees 2. 20-99 employees 3. 100+ employees

Patient/Guardian Signature:_____ Date: _____

Pain Management Agreement

The Buncke Clinic

Patient Name_____ Date _____

The purpose of this agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This agreement is to help you and your provider to comply with the law regarding controlled pharmaceuticals.

Please list below any and all medications you are currently taking including herbal remedies and over the counter medications and the prescribing physician's name.

Medication/Dose	Physician's
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I understand there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances. I understand that this agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this agreement. I understand that if I break this agreement my provider will stop prescribing these pain control medicines. In this case, my provider will taper off the medicine over a period of several days or more as needed to avoid withdrawal symptoms. Also a drug dependence treatment program or psychotherapy may recommended by my provider and I would be cooperative. (Initials)_____

I will fully communicate with my provider about the character and intensity of my pain, the effect of the pain on my daily life and how well the medication is helping to relieve the pain. I will not use any illegal controlled substances including cocaine etc, nor will I misuse or self-prescribe/medicate legal controlled substances. Use of alcohol will be limited to times when I am not driving or operating machinery and will be infrequent. I will not share mu medications with anyone. I will not attempt to obtain any controlled medications including opioid pain medication, controlled stimulants or anti-anxiety medications from any other provider. I will safeguard my pain medication from loss, their unintentional use from others, especially children. Lost or stolen medication will not be replaced. No refills will available during the evenings or over the weekend. (Initials) _____

I agree to use this pharmacy: _____

Located at: _____

Telephone: _____for filling all of my pain medications.

Furthermore I authorize both my providers and the pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the state Board of Pharmacy in the investigation of any possible misuse, sale or other diversion of my pain medication. I agree to wave any applicable privilege or right to privacy or confidentiality with respect to these authorities. (Initials) _____

I agree to a blood or urine test if requested by my provider to determine my compliance with my program of pain control medication. I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program web site periodically. (Initials) _____

I agree that I will use my medication at a rate no greater than the prescribed rate. I will bring unused pain medication to every office visit. I agree to follow these guidelines that have been fully explained to me.

All of questions have been answered regarding treatment. A copy of this document has been given to. This agreement entered into on _____ in _____.

Patients Signature_____

Patients Name_____

Provider's Signature _____

Provider's Name _____

Witness's Signature_____ Name_____

The Buncke Clinic

Health Questionnaire

Patient's Name _____ Date of Birth ____/____/____

I have scheduled this appointment for the following medical problems:

_____

_____

Height _____ Weight _____ Hand dominance _____ Occupation _____

Medical History

☐ Yes ☐ No Chronic pain	☐ Yes ☐ No Circulation problem	☐ Yes ☐ No Blood transfusion
☐ Yes ☐ No Mental health	☐ Yes ☐ No Heart failure	☐ Yes ☐ No HIV/AIDS
☐ Yes ☐ No Alcohol/drug abuse	☐ Yes ☐ No Atrial fibrillation	☐ Yes ☐ No Viral hepatitis
☐ Yes ☐ No Depression	☐ Yes ☐ No Heart murmur	☐ Yes ☐ No Nerve/muscle disease
☐ Yes ☐ No Anxiety	☐ Yes ☐ No High blood pressure	☐ Yes ☐ No Arthritis/gout
☐ Yes ☐ No Seizure	☐ Yes ☐ No Bowel disease	☐ Yes ☐ No Osteoporosis
☐ Yes ☐ No Stroke	☐ Yes ☐ No Kidney disease	☐ Yes ☐ No Diabetes
☐ Yes ☐ No Pneumonia	☐ Yes ☐ No Cancer	☐ Yes ☐ No Elevated cholesterol
☐ Yes ☐ No COPD/ Emphysema	☐ Yes ☐ No Blood clots	Other:
☐ Yes ☐ No Asthma	☐ Yes ☐ No Miscarriage	_____
☐ Yes ☐ No Heart attack	☐ Yes ☐ No Clotting disorder	_____
☐ Yes ☐ No Angina	☐ Yes ☐ No Anemia	_____
☐ Yes ☐ No Pacemaker		

Do you have an objection to medically needed blood transfusions based on personal or religious preferences ☐ Yes ☐ No If yes, please explain _____

Please list allergies to any medications, latex, or foods including reaction _____

_____

Surgical History Please list your previous surgeries including date

_____

_____

_____

_____

Social History

Do you drink alcohol? ☐ Yes ☐ No If yes, number of drinks per week _____

Tobacco use ☐ Never smoked ☐ Currently smoke: _____ packs per day for _____ years

☐ Former smoker: quit date _____

☐ Smokeless tobacco: type _____

Do you use any street drugs ☐ Yes ☐ No If yes, type of drugs _____

What demands do you have on your hands during work, sports, and hobbies?

_____

_____

Please check one: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed

Family History

Do any family members have any of the following? If yes, please list the relationship.

☐ Problems with anesthesia _____

☐ Blood clot or clotting disorder _____

☐ Heart disease _____

☐ Bleeding disorder _____

☐ Other _____

Review of Systems Do you currently have any of the following?

☐ Yes ☐ No Fever	☐ Yes ☐ No Excessive urination	☐ Yes ☐ No Constipation
☐ Yes ☐ No Chills	☐ Yes ☐ No Extra thirsty	☐ Yes ☐ No Blood in stools
☐ Yes ☐ No Weight loss/gain	☐ Yes ☐ No Nose bleed	☐ Yes ☐ No Leg swelling
☐ Yes ☐ No Fatigue	☐ Yes ☐ No Sore throat	☐ Yes ☐ No Pain with urination
☐ Yes ☐ No Pain	☐ Yes ☐ No Breast lump	☐ Yes ☐ No Frequent urination
☐ Yes ☐ No Changes in appetite	☐ Yes ☐ No Cough	☐ Yes ☐ No Muscle/joint pain
☐ Yes ☐ No Rashes	☐ Yes ☐ No Asthma	☐ Yes ☐ No Neck/back pain
☐ Yes ☐ No Skin problems	☐ Yes ☐ No Wheezing	☐ Yes ☐ No Numbness or tingling
☐ Yes ☐ No Vision change	☐ Yes ☐ No Shortness of breath	☐ Yes ☐ No Bruising
☐ Yes ☐ No Eye pain	☐ Yes ☐ No Palpitations	☐ Yes ☐ No Depressed
☐ Yes ☐ No Double vision	☐ Yes ☐ No Chest pain	Other:
☐ Yes ☐ No Hearing loss	☐ Yes ☐ No Nausea	_____
☐ Yes ☐ No Ear pain	☐ Yes ☐ No Vomiting	
☐ Yes ☐ No Dizziness	☐ Yes ☐ No Diarrhea	
☐ Yes ☐ No Congestion		

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
THE BUNCKE CLINIC

I hereby acknowledge that I have received the copy of this medical practioner's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment:

Signature:_____ Date:_____

Relationship to Patient: ■ Adult Patient ■ Parent ■Guardian ■ Other

Patient Name: _____ DOB: _____

■ I give permission for the following communications to be used by the Buncke Clinic. **(Please check all that apply)**

■ Cell phone ■ Text Messages reminders permitted
■ Home phone ■ Work ■ E-Mail:

■ I am granting permission for the Buncke Clinic to disclose their identity to anyone who may answer my home, work or cell phone.

■ I am granting permission for the Buncke Clinic to leave a message with any person who may answer my phone or on my voicemail of the following numbers.
(Please check all that apply)

■ Home Phone ■ Cell Phone ■Work Phone ■ None- Please just ask for a call back
■ Other (Please Explain)

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

Name:_____ **Phone:** _____

Initials: _____ **Date:** _____

The Buncke Clinic/Plastic Surgery Institute

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, ALSO HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY

NOTICE OF PRIVACY POLICY

Effective, 2011

The following is the privacy policy of "The Buncke Clinic & Plastic Institute" (Covered Entity) as described the Health Insurance Portability &Accountability Act of 1996 and regulations promulgated there under, commonly known as **HIPPA. HIPPA** requires Covered Entity by law to maintain the privacy of your personal health information. To provide you the notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations. The application and enrollment process, and/or healthcare providers, health plans, or through other means, as applicable. Your personal health information (PHI) that is protected by law broadly includes any information orally, written or recorded. That is created and received by certain entities, including healthcare providers, such as physicians and hospitals, as well as healthcare insurance companies or plans. The law specifically protects health information that contains data i.e. your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, and to collect payment for those services. To conduct other related healthcare operations otherwise permitted or required by law. Also we are permitted to disclose your personal health information within and among our workforce in order to accomplish the same purposes. However, even with permission, we are still required to limit such uses to disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Examples of treatment activities include: (A) The provision, coordination, management of healthcare and related services by healthcare providers; (B) Consultation between healthcare providers relating to a patent; (C) The referral of a patient for healthcare from one healthcare provider to another.

Examples of payment activities include: (A) Billing and collection activities, related data processing; (B) Actions by a health plan or insure to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreements. Determination of eligibility or coverage, adjudication or subrogation of health benefit claims; (C) Medical necessity and appropriateness of care reviews utilization review activities; (D) Disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Examples of healthcare operations include: (A) Development of clinical guidelines; (B) Contacting patients with information about treatment alternatives or communications in connection with case management or care coordination (C) Reviewing the qualifications of and training healthcare professionals; (D) Underwriting and premium rating; (E) Medical review, legal services, and auditing functions; (F) General administrative activities such as customer service and data analysis.

We may use or disclose your personal health information to the extent that such use or disclose is required by law use or disclosure complies with and is limited to the relevant requirements of such law.

Examples of insurance in which required to disclose your personal health information include: (A) Public health activities, reporting adverse events to the FDA, medical surveillance of the workplace or to evaluate whether the individual has work related illness or injury; (B) Disclosures regarding victims of abuse or neglect, or domestic violence including, reporting to social services or protective service agencies; (C) Health oversight activities necessary for appropriate oversight of government benefits programs; (D) Judicial administrative proceedings in response to an order of a court warrant, subpoena, discovery request, or other lawful process; (E) Law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, missing person, and reporting a death; (F) Disclosures about decedents for purposes of cadaver donation of organs, eyes etc; (G) As other Federal of State regulatory stipulations.

All other situations with your Specific Authorization

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. We are required to use or disclose your personal health information consistent with the terms of authorization. You may revoke your authorization to use or disclose any health information at any time.

Your Rights with Respects to Your Personal Health Information

Under HIPPA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights, and our duties with respect to enforcing those rights.

Right to Request restrictions on Use or Disclosure

You have the right to ask for restrictions on the way we may use and disclose your personal health information for treatment, payments and healthcare operation purposes. You may request that we limit our disclosures to persons assisting your care of payment for your care. We reserve the right to accept or reject your request, and will notify you of your decision. If we agree to restriction, we are bound to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to a restrict uses or disclosures that are otherwise required by law.

Right to Receive Confidential Communications

You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on your providing us with information as how payments will be handled and specification of an alternative address or method of contact. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to requests by you to receive communications of personal health information from us by alternative means or at alternative locations.

Right to Inspect and Copy Your Personal Health Information

Your designated record set is a group of records we maintain that includes Medical Records and billing records about you, or enrollment, payment, claims adjudication, case or medical management records systems as applicable. You have the right of access in order to inspect and obtain a copy of your personal health information contained in your designated record set. We may require written requests and we may charge a reasonable fee for copying, postage and the costs of preparing an explanation or summary as a agreed upon in advance. We reserve the right to deny you access to a copies of certain personal health information as permitted or required by law. Upon denial of request for access or request for information, we will provide you with written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us.

Right to Amend Your Personal Health Information

You have the right to request we amend your personal health information or a record that you believe is incorrect or incomplete. We have the right to deny your request for amendment, i.e. (A) We determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment; (B) The information is not part of your designated record set maintained by us; (C) the information is prohibited from inspection by law; (D) The information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment, If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, description of how you may file a complaint with us or the Secretary of the U.S Department of Health and Human Services (DHHS). Request for amendment shall be sent to the Buncke Clinic at 45 Castro Street, Suite #121 San Francisco, CA 94114.

Right to Receive an Accounting of Disclosures of Your Personal Health Information

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six year period immediately preceding that date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six years from the date of the request. Such disclosures will include the date of each disclosure, the name and the address of the entity or person who received the information and brief description disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement. A copy of your written authorization or written request for disclosure pertaining to such information. We are not required to provide accounting of disclosure for the treatment, payment, and healthcare operations. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials as required by law. We will provide the first accounting to you in any twelve month period without charge, but will impose a reasonable based fee for responding to each subsequent request for accounting within that same twelve month period. All requests for all accounting shall be sent to The Buncke Clinic.

Complaints

You may file a complaint with us and with The Secretary of DHHS if you believe your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to the Buncke Clinic, 45 Castro Street Suite # 121 San Francisco, CA 94114 (415)565-6136 gbuncke@buncke.org. A complaint must name the entity that is the subject of the compliant and describe the acts or omissions believed to be in violation of the applicable requirements of HIPPA or this Privacy Policy. A complaint must be received by us or filed with The Secretary of DHHS within 180 days of when you knew or should have known that the act or emission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to This Privacy Policy

We reserve the right to revise or amend This Privacy Policy at any time. These revisions or amendments may be made effective for all the personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to This Privacy Policy, or changes in the law affecting This Privacy Policy by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of This Privacy Policy at any time upon your written request sent to The Buncke Clinic, 45 Castro Street Suite # 121 San Francisco, CA 94114 (415)565-6136. For any other requests of got further information regarding the pirvacy of your personal health information, and for information regarding the filing of a complaint with us, please contact the address listed above.