The Thousand Mile Journey, LLC

INTAKE INFORMATION

Name: _____Gender: _____ Age: _____ DOB: _____

Name of Parent/Guardian, or Spouse: _____

Address: _____City: _____ ZIP: _____

Phone: Home ( )_____Cell( ) _____ Work( )_____

Other Address: _____ City: _____ ZIP: _____

Phone: Home( )_____Cell( ) _____ Work( )_____

Emergency contact name/number: ________

Relationship Status: Never Married ____ Married ____ Divorced ____ Widowed ___ Partnership/ Other _____

Children/Siblings: Names and Ages _____

Client's, Parent's or Guardian's Employer _____

Custody 50/50 M_____ F_____

INSURANCE INFORMATION

Insurance Company: _____
Phone:_____
Insured Person _____
Insured's Policy/ID#_____
Group Number/Employer_____
Insured's SS#_____
Other Insurance _____

Pharmacy address, including zip code and /phone number:
_____

Signature:_____
Date:_____

The Thousand Mile Journey, LLC

MEDICAL INFORMATION

First and Last Legal Name: _____

Family Medical History: (Please state which of your relatives have/had the following.)

_____ Alcohol/Drug Use	_____ Heart Disease	_____ Trauma or other:
_____ Cancer/Tumors	_____ Mental Illness	
_____ Neurological Disorders	_____ Thyroid Disorder	

Personal Medical History: (Check all that have occurred to you at any time.)

		___ Irritable Bowels
___ Alcohol/Drug Use	___ Depression	___ Neurological Disorder
___ Allergies	___ Diabetes	___ Seizure
___ Anemia	___ Eating Disorder	___ Skin Problems
___ Anxiety	___ Fatigue	___ Sleep Difficulties
___ Arthritis	___ Self harm, Suicide	___ Smoking Tobacco
___ Asthma	___ Frequent Headaches	___ Stomach Problems
___ Back Trouble	___ Heart Problems	___ Thyroid Disorder
___ Cancer	___ High Blood Pressure	___ Vision Problems
___ Chronic Pain	___ Infectious Disease	___ Weight Loss/Gain

ALLERGIES or Reactions to any medications: _____

Significant past or present medical problems not listed above such as medication dependence/misuse, illicit substance use, excessive alcohol use, sexual/psychological, emotional trauma, accidents, worker's injury, legal proceedings, etc.;

_____

Are you now under the care of a primary care doctor other health practitioner? **If, yes:** Name/Address/phone/ fax number:

_____

Problem _____

Date of last visit _____

Date of last physical exam: _____ Results: _____

Have you been hospitalized or been in the emergency room in the past 3 years? Yes ____ No ____
Why? _____

Are you currently taking any prescription or non-prescription medications? Yes _____ No _____
If yes, name & dosage: _____

Have you ever participated in counseling or been seen by a psychiatrist? Yes ___ No ___
If yes, please give name and dates: _____

_____

Are you currently pregnant or planning a pregnancy? _____ Yes _____ No

SELF-ASSESSMENT for INITIAL VISIT

*We ask everyone to fill out this form at the time of their first visit. Please do your best to answer all the questions. If you do not understand a question, our staff can explain it. Everything is **CONFIDENTIAL** and part of your medical record.*

Name:

Date of Birth: **Date of Visit:**

Have you had...			***Have you had...***		
• **CONSTITUTIONAL**	**YES**	**NO**	• **EYES**	**YES**	**NO**
Any recent weight change	☐	☐	Vision change in past 6 months	☐	☐
Persistent fever	☐	☐	Wear glasses/ contact lenses	☐	☐
Fatigue more than 6 months	☐	☐	• **EARS/ NOSE/ THROAT**		
• **RESPIRATORY**			Change in hearing in 6 months	☐	☐
Chronic/ frequent cough	☐	☐	Nose bleeds	☐	☐
Shortness of breath	☐	☐	Recurrent sore throat	☐	☐
Wheezing	☐	☐	Voice change	☐	☐
Snoring	☐	☐	Dental problems	☐	☐
• **CARDIOVASCULAR**			• **GASTROINTESTINAL**		
Chest pain	☐	☐	Loss of appetite	☐	☐
Palpitations/irregular heartbeat	☐	☐	Abdominal pain	☐	☐
Cannot climb 2 flights of stairs	☐	☐	Nausea/vomiting	☐	☐
• **MUSCULOSKELETAL**			Change in bowel habits	☐	☐
Painful/swollen joints	☐	☐	Blood in stool	☐	☐
Back pain	☐	☐	• **GENITOURINARY**		
Difficulty in walking	☐	☐	Burning/pain on urination	☐	☐
• **HEMATOLOGIC/ LYMPH.**			Blood in urine	☐	☐
Easy bleeding/bruising	☐	☐	Difficulty holding urine	☐	☐
Lumps in neck, armpits, groin	☐	☐	Sexual difficulty	☐	☐
• **NEUROLOGICAL**			• **SKIN**		
Chronic/frequent headaches	☐	☐	Hair loss/ excess hair growth	☐	☐
Any fall in past 12 months	☐	☐	Rashes/itching	☐	☐
Convulsions/seizures	☐	☐	Change in skin color	☐	☐
Memory problems	☐	☐	• **ENDOCRINE**		
• ***FOR MEN ONLY***			Any loss in height	☐	☐
Discharge from penis	☐	☐	Excessive thirst/urination	☐	☐
Sore/lump on penis	☐	☐	Bothered by hot/cold weather	☐	☐
Lump on testicles	☐	☐			
• ***FOR WOMEN ONLY***			**ALLERGIES to food/medicine:**	☐ yes	☐ no
Abnormal vaginal bleeding	☐	☐	***Specify allergy:***		
Vaginal discharge/lesions	☐	☐			
Discharge/lump in breast	☐	☐			
Date of your last period					

Any comments:

_____

Client Signature Patient/ Parent/Guardian Signature Dat

CONSENT TO RECEIVE TREATMENT

All clinicians at The Thousand Mile Journey, LLC want you to be aware of your rights as a client and request your consent to receive treatment. Medication therapy, psychotherapy, laboratory, diagnostic procedures, and other appropriate alternative therapies with a clinician for the purposes of determining and resolving issues and concerns. Specific treatment goals will be developed between you and your clinician.

The benefits of treatment may include, but are not limited to, a greater ability to cope with stressful situations, improved skills in communication and fulfilling your emotional needs, more satisfying and intimate relationships, and a better understanding of your personal values, needs, and goals.

Treatment may include the risk of remembering unpleasant events and can arouse intense emotions of sadness, fear, and anger. Anxiety, depression, frustration, loneliness, or helplessness may also be experienced. The success of therapeutic services depends upon many variables, among them your willingness and ability to take part in the process. Your clinician may suggest alternate treatment modalities and will make referrals when appropriate or necessary.

The use of medication may or may not be a part of your treatment. If medication is necessary, and you wish to be seen by the nurse practitioner and other providers for an evaluation, an appointment can be made. Any questions you have pertaining to the use of medication, or its side effects will be discussed with you at that time.

It is your right to refuse therapy or medication at any time. If you forego treatment, it is possible that your problems will not be resolved or may become worse than they were at the time you discontinue therapy. A clinician will discuss with you at any time the possible outcome of withdrawal from treatment.

This informed consent will be in effect until you are discharged from treatment, either by mutual agreement with your provider, through your own decision, or for a period no longer than fifteen months. This consent can be withdrawn at any time with written or verbal notice. You have a right to receive a copy of this consent upon request.

Client's Name (please print)	Signature	Date
Parent or Guardian Signature	Relationship to Client	Date
Witness Signature		Date

RELEASE OF INFORMATION TO INSURANCE COMPANY

I authorize the release of information from The Thousand Mile Journey to my health insurance company as necessary for the purpose of processing my insurance claim. I also authorize payment of medical benefits to The Thousand Mile Journey. Should my insurance refuse to pay for services due to lack of coverage, authorization, or medical necessity, **I am financially responsible for all fees related to professional services provided to me and/or my dependents.**

Assignment of Benefits Initial _____

I understand that this serves as a direct assignment of my medical benefits from Medicare, Medicaid, other government carrier, or any commercial/private insurance carrier, to be paid to the TTMJ, LLC.

If I receive ANY payments directly from MY insurance company, I agree to bring them to TTMJ LLC for payment on my account.

_____

Client / Guardian/Authorized Signature Date

TREATMENT POLICY AND FEE STATEMENT

Providing Services:

It is the policy of The Thousand Mile Journey to provide supportive therapy and medical services to any client requiring treatment or to refer the client to another resource that could provide an appropriate services. All clients will be assessed for appropriateness of treatment and continuation of treatment is contingent upon client cooperation. Lack of motivation including but not limited to**, two or more missed sessions without appropriate notice, may result in termination.** Treatment is contracted with a specific therapist, nurse, or doctor.

Minors

It is the policy of this facility to release all information pertaining to minors to their parents or legal guardians upon their request unless it would seriously affect the therapeutic process. The parent or guardian is responsible for **financial obligations incurred by their minors and paid at the time of session**. A release of information may be obtained so that communication may be shared with the primary care physician, pediatric doctors, teachers, or other health related professionals related to the care of the minor.

Charges

Services are billed at $250.00 for the initial evaluation and $130.00 for medication management thereafter. When sessions run over, charges will be made accordingly.

If a client is late, the same hourly fee will be applied to the time remaining in the session.

Client's Responsibility:

The client is responsible for all charges including but no limited to co pays, deductibles, and any costs that the insurance company does not cover. All clients are responsible for checking with their employer and/or insurance company for exact coverage of services, including any changes that may occur with respect to their coverage for services provided by The Thousand Mile Journey. All fees will be paid at the time of session The Thousand Mile Journey accepts cash, checks, and credit cards.

Cancellation:

The Thousand Mile Journey has a strict cancellation policy, **a notice of at least 24 hours must be given before cancellation of any appointment.** If cancellation is not made in compliance with this policy, or an appointment is missed, you may be billed a fee of $30 during a weekday and $60 on the weekend which are not covered by your insurance company.

Emergencies – The Thousand Mile Journey has a 24-hour emergency crisis phone available to all clients. **The number for emergencies only is 262-442-3912.**

_____

Client / Guardian/Authorized Signature Date

Payment Policy

Thank you for choosing us as your care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure

on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that your account is past due. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you, and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

CLIENT'S RIGHTS

1. Clients have the right to treatment free of discrimination by race, gender, color, origin, age, religion, handicap, or sexual preference.
2. Clients have the right to be treated with dignity and respect.
3. Clients have the right to receive prompt and adequate treatment appropriate for his or her needs.

4. Clients have the right to be involved in his or her planning of treatment.

5. Clients have the right to confidentiality and protection of treatment and their records and have the right of access to those records.
6. Clients have the right to refuse treatment or medication.
7. Clients have the right to be informed of the cost of treatment.
8. Clients have the right to be informed of the clinic's grievance procedure.
9. Clients have the right to file a grievance if they believe their rights have been violated.

Right to Amend. If you feel that information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the medical records department. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

• was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

• is of the medical information kept by or for the TTMJ, LLC where you were treated; is part of the information which you would be permitted to inspect and copy; or
• is accurate and complete.

You also may have the right to ask us to add an addendum to your records, which can be up to 250 words for each item you believe to be incorrect or incomplete. Please submit your request for an addendum to the medical records department of the TTMJ, LLC Facility where you were treated.

Right to an Accounting of Disclosures.

You have the right to request an "Accounting of Disclosures." This is a list of the disclosures we made of medical information about you other than disclosures for certain

purposes, such as for treatment, payment and health care operations purposes, as those functions are described above, or any disclosures that have been specifically authorized by you. To request this list or accounting of disclosures, you must submit your request in writing to the Medical Records Department of the TTMJ , LLC or facility where you were treated. Your request must state a time period, which may not be longer than six (6) years or three (3) years depending on the TTMJ, LLC s implementation date of an electronic health record (EHR). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

In addition, we will notify you as required by law following a breach of your unsecured protected health information.

Right to Request Restrictions.

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations purposes. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request, except to the extent that you request us to restrict disclosure to a health plan or insurer for payment or health care operations purposes if you, or someone else on your behalf (other than the health plan or insurer), has paid for the item or service out of pocket in full. Even if you request this special restriction, we can disclose the information to a health plan or insurer for purposes of treating you. If we agree to another special restriction, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the medical records department of the TTMJ, LLC. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications.

You have the right to request that we communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the medical records department at the TTMJ, LLC Facility where you seek treatment. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

GRIEVANCE PROCEDURE

The TTMJ, LLC grievance procedure is as follows:

1. A complaint may be filed, verbally or in writing, with any staff member or with the Clinic Director. A guardian, relative, or concerned person may file a complaint on behalf of the client. If you are uncertain or unable how to file a grievance, assistance will be provided.
2. Within three business days of receiving notification of a grievance, the Clinic Director will hold an informal hearing and attempt to resolve the situation.
3. The Clinic Director will write a report based on her findings. A copy of the report will go to the client (and/or guardian) and a copy will be filed at the clinic with the client's right specialist.
4. If the client is not satisfied with the informal resolution, he or she may pursue the matter by contacting the client's rights specialist.
5. No sanction will be threatened or imposed upon any person filing a grievance or assisting a client to file a grievance.

POLICY ON THE DENIAL OF CLIENT'S RIGHTS

1. Client's rights may be denied if it becomes known that there is a danger to the life or health of the client, or potential harm to others which will require immediate notification to authorities.
2. The right to confidentiality may be waived if there are indications of child physical sexual abuse or neglect
3. Non-compliance of court ordered treatment must be reported to the court.
4. Upon denial of these rights, a written notice, with clearly stated reason for denial, shall be provided to the client and/or guardian, if applicable, and a copy retained in the client's record.
5. The denial shall only apply to a specific situation and rights will be reinstated when the issue is resolved.
6. If the client is a county department patient a written notice, with specifics, shall be sent to the local county Department of Human Services and client's rights specialist within two days of the denial of rights.
7. At the client's request (or the request of a parent/guardian), an informal hearing will be held regarding the denial of these rights. This hearing will be held within three days after receiving the request.
8. The Clinic Director will conduct the hearing and shall render the final decision.
9. If you disagree with the decision of the Clinic Director you have the right to a hearing with the Client's Rights Specialist.
10. The client may temporarily waive his or her right to confidentiality with verbal consent in cases of emergency. Written consent of disclosure must be obtained within ten days.

_____

Client / Guardian/Authorized Signature **Date**

RELEASE OF INFORMATION AUTHORIZATION

Our staff may need to use your name, address, phone number, email, text and your other clinical records to contact you with appointment reminders, past history of medications, current list of medications, allergies, immunizations and other legal registries for ongoing information about your illness, treatment or insurance information.

If a contact is made by phone and you are not at home, a message will be left on your answering machine. Your signature on the consent for treatment gives us authorization to contact you with these various reminders and methods of obtaining treatment information.

You may restrict the individuals or organizations to which your health care information is released, or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization.

Appointment Reminders.

We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment at a TTMJ, LLC Clinic.

Treatment Alternatives.

We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services.

We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Facility Directory.

We may include certain limited information about you in the facility directory of any hospital e hospital while you are a patient at that hospital. This information may include your name, location in the hospital and your general condition (e.g., fair, good, etc.). Unless there is a specific written request from you to the contrary, this directory information may also be released to people who ask for you by name. This information is released so your family and friends can visit you in the hospital and generally know how you are doing. If you wish to "opt out" of the facility directory, please contact the admitting department at where you are being treated and request that your information not be included in the facility directory. **INTIAL: _____**

Individuals Involved in Your Care or Payment for Your Care; Disaster Relief Efforts. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. Unless there is a written request from you to the contrary, we may also tell your family or friends about your condition. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with special medical needs, so long as the medical information they review does not leave our site. We will almost always ask for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the TTMJ, LLC.

Business Associates. There are some services provided for our organization through contracts with an outside organization, also known as a business associate. Examples include billing services to submit your claim to the insurance company for payment, transcription services to transcribe dictated reports from the health professionals caring for you in the hospital and copy services for making copies of your health record. When these services are performed by a business associate, we may disclose your information to our business associates so they can perform the job we have asked them to do.

As Required by Law. We will disclose medical information about you when required to do so by the Federal, State or local law.

Averting a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public, police or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Marketing and Sales. Most uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of medical information, require your authorization. I am not aware or receive any payments from any third parties for this type of service.

Fundraising Activities. We may use certain information about you (including demographic information and dates you received service) to contact you in the future in an effort to raise money for a TTMJ, LLC. We may also disclose this same information to our TTMJ, LLC philanthropic foundations for the same purpose. The money raised will be used to expand

and improve the services and programs we provide to the community. If you do not wish to be contacted for our fundraising efforts, you must notify the foundation director or at the

TTMJ, LLC where you were treated. Notification may be made in writing, including email, texting, by phone or in person.

Organ and Tissue Donation. We may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military.

Workers' Compensation. We may release medical information about you for the Workers' Compensation or similar programs. These programs provide benefits for the work-related injuries or an illness.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following:

- To report reactions to medications or problems with recommended treatment outcomes
- To notify of all of all treatments you may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report the abuse or neglect of children, elders and dependent adults, regardless of timeline

- to notify emergency response employees regarding possible exposure to possession f guns, nature of mental illness, HIV/AIDS, to the extent necessary to comply with state and federal laws.

Law Enforcement. If permitted by applicable law, we may release medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about death we believe may be the result of criminal conduct;
- about criminal conduct at the hospital; and
- in emergency circumstances to report a crime, the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

Protective Services for the President, National Security and Intelligence Activities.

We may release medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations, or for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement of official, we may release medical information about you to the correctional institution or law enforcement official, if the release is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Multidisciplinary Personnel Teams. We may disclose health information to a multidisciplinary personnel team relevant to the prevention, identification, management or treatment of an abused child and the child's parents, or elder abuse and neglect.

Note on Other Restrictions. Please be aware that certain federal or state laws may have more strict requirements on how we use and disclose your medical information. If there are stricter requirements, even for the purposes listed above, we will not disclose your medical information without your written permission, or as otherwise permitted or required by such laws. For example, we will not disclose your HIV test results without obtaining your written permission, except as permitted by state law. We may also be restricted by law to obtain your written permission to use and disclose your information related to treatment for certain conditions such as mental illness, or alcohol or drug abuse.

INTIAL:_____

In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. Your signature releases information in order to process claims.

You also authorize The Thousand Mile Journey to receive payment of medical benefits on your behalf. **Please be aware that you are financially responsible for all fees related to professional services provided to you or your dependents.**

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

_____

Client / Guardian/Authorized Signature **Date:**

Patient Authorization for Electronic Health Records

To provide better care to our patients, we have chosen to participate in an electronic health records system called "Practice Fusion". Under that system, each patient has a single, secure set of electronic information that can be accessed by participating physicians and other providers from their offices, urgent care facilities, the emergency room, the hospital, and other locations. Among other benefits, that system:

Allows immediate access to results of tests, imaging procedures and other potentially critical information for routine and emergency treatment.

Allows the coordination of prescriptions and care by multiple providers;
Reduces the chances of error; and otherwise improves the quality of care you receive; Helps in the processing of insurance and other claims.

We recognize the importance of keeping your individual information confidential. Accordingly, Practice Fusion has, through contracts and strict rules, limited access to individual information to health care providers and those providing assistance to them, and only for the purposes of providing health care to you and related activities. Your privacy is also protected by state and federal law. By obtaining care from us, you consent to our participation in the Practice Fusion Chart system, and use of that system to provide care to you, to the fullest extent permitted by law. If you do not consent, you must find care elsewhere.

I ACKNOWLEDGE AND CONSENT TO USE ELECTRONIC PRACTICE FUSION

CHART.

_____

Date: Patient or Guardian Signature (circle one)

_____ _____

Date: Printed Name of Patient or Name of Signatory and Relationship (if not patient)

If you have any questions about this notice, please contact the Privacy Officer of our office at 414-543-3333

OUR PRIVACY PLEDGE

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are other several circumstances in which we may have to use or disclose your health care information.

- We may need to disclose your health information to other health care providers, pharmacists, clinicians, therapist, PT/OT, ER or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control, facilitation of treatment or other operational purposes.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Right to Request Restrictions.

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations purposes. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request, except to the extent that you request us to restrict disclosure to a health plan or insurer for payment or health care operations purposes if you, or someone else on your behalf (other than the health plan or insurer), has paid for the item or service out of pocket in full. Even if you request this special restriction, we can disclose the information to a health plan or insurer for purposes of treating you. If we agree to another special restriction, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the medical records department. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications.

You have the right to request that we communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request con denial communications, you must make your request in writing to the medical records department. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future.

Right to a Paper Copy of This Notice.

You have the right to a paper copy of this Notice even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

_____

Client / Guardian/Authorized Signature **Date**

INFORMATION CHECK OFF FORM

I have reviewed the following forms and have had them sufficiently explained to me. I would like obtained mailed copy of forms to:

email address: _____

INTIAL:_____

___x__ Consent to receive treatment.

___x__ Client's rights/grievance procedure.

___x__ Policy on the denial of client's rights.

___x__ Treatment policy and fee statement.

___x__ Release of information and collection of the data statement

__x_Reminder visit notification statement.

_____

Client/Parent/Authorized Signature **Date**

_____

Witness Signature **Date**

STORING PAYMENT INFORMATION

I authorize The Thousand Mile Journey to securely store my credit card information for the purpose of payment of fees. The data can be repealed upon request and will be deleted upon discharge.

Client /Guardian/ Authorized Signature _____ Date: _____

New Client Welcome Letter:

Please know you are not a number to me and I treat you as if you were part of family.

I hope that you will be as honest with me as possible. I can't remember a time when a patient told me something that made my treat them differently.

The following comment from a patient reassure me that my efforts to be non-judgmental are sincere: "Ania made me feel more comfortable than any previous doctor about discussing touchy topics–to where I was completely candid about some things I have kept to myself with other docs".

Wait Time

I value your time and I sincerely strive to minimize the amount of time patients have to wait for me. I never double-book, and I allow 60 minutes for new patient visits. My average wait time is less than 15minutes, and I strive to see patients as soon as they arrive.
Sometimes I will ask you wait more than I am comfortable with. Sometimes 30 minutes is not enough time to discuss a grave illness. I always take as much time as necessary to answer every question, assuage any fears, and construct a plan to deal with illnesses in a collaborative manner. Sometimes that makes me run late, and if I could predict when I need extra time, I would. If I am ever more than 15 minutes behind schedule, I will ask you if you want to reschedule, suggest that we speak on the phone later if the issue is solvable that way, or I will give you my best estimate as to when I will be able to see you.
If you are running late, it would be so gratefully appreciated if you could call the office and let us know. I completely understand that things happen: trains break-down, kids have melt-downs, one can't find his keys.

What to Expect During Your Initial Visit

Most often patients come to me to establish a relationship with clinician and for me to perform a full exam and obtain a complete history. Sometimes a new patient will come with an acute illness. In that case, I will give the patient the option of trying to address the acute issue or doing a complete history and physical. I feel, though, that except for the most minor complaints, doing a thorough work-up is the best way to diagnosis and treat the issue.

Health History

For all my clients I try to obtain a complete history. My position is not to judge, label or ridicule you as a person. Sometimes the questions I ask may seem a bit invasive, but knowing about your sexual preferences, exercise, employment, social support,

alcohol, tobacco, legal problems and illicit drug use is critical to my being able to understand your health risks.

I will also ask about your family medical history, any chronic medical problems you may have, abnormal tests, surgeries you've had performed, medications, herbal supplements you are taking and drug allergies of which you are aware of.
I also like to take this opportunity to ask about your hobbies, educational background and etc.

While these questions are probably not super-medically relevant, it helps me understand you as a person, and to see you as the individual you are.

Warm Welcome,

Ania Person Nurse Practitioner, The Thousand Mile Journey, LLC

10501 West Research Drive, Suite G200 Milwaukee, WI 53266 Tel: 414-543-3333, Fax: 414-302-1040; ttmjclinic@gmail.com