Patient Information and Consent Forms

The information on this form applies to the person(s) financially responsible for the patient's account.

Last Name:	**First:**	Initial:
Age:	Date of Birth:	
Adress:		
City:	State:	Zip:
Primary Phone:	Secondary Phone:	
Email:	Would you like to receive our newsletter?	Yes No
Spouse/Partner Information:		
Last Name:	First:	Initial:
Age:	Date of Birth:	
Address (if different from above):		
Primary Phone:	Secondary Phone:	

Please list Children's Names and Ages:	
How did you hear about us?	
Preferred Pharmacy with Phone #:	
Preferred Hospital:	
Nearest Relative not at your address, with Phone #:	
In case of emergency, who do we contact?	
What is their relationship to you?	

ALL PATIENTS PLEASE READ and SIGN IN 3 PLACES BELOW:

Consent for Homeopathic Care:
I, the undersigned, accepting responsibility for educating myself regarding the major differences between homeopathic and conventional medical care, do hereby acknowledge my desire and consent to homeopathic treatment for myself or my dependent. I understand that by seeking a homeopathic approach to treatment that I will be receiving medical care according to the prevailing standard of the homeopathic medical community, as expressed by the American Institute of Homeopathy, and that this type of care may not always include the medications, screenings, physical exam, X-rays, blood or other laboratory tests that are the prevailing standard of conventional care.

I understand also that I am financially responsible for my account and/or my dependent's account. A copy of this signature os as valid as the original.

Patient Name
(printed):____

Signed:____Date:_______________

Medical Malpractice and Medicare:

Karin Cseak, DO, who is a valid certificate holder of a medical license to practice Osteopathic Medicine in the state of Ohio, is not covered by medical malpractice insurance.

Karin Cseak, DO, has opted out of the Medicare program, effective Oct. 1, 2014 for a period of at least two years, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act. Medicare cannot be billed for any services rendered by Dr. Cseak, and the Patient is responsible for all fees incurred for services by Dr. Cseak and/or her staff.

The undersigned acknowledges the receipt of these notices.

Signed: ____Date:_______________

HIPAA Compliance Patient Consent:

Our Notice of Privacy Practices (below) provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However such a revocation will not be retroactive.

By signing this form, I understand that:

____Protected health information may be disclosed or used for treatment, payment, or healthcare operation

____The practice reserves the right to change the privacy policy as allowed by law

____The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions

____The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease

____The practice may condition receipt of treatment upon execution of this consent

May we phone you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell? YES NO

May we leave a message at your employment? YES NO

May we email to your specified email address personal private health information including but not limited to laboratory reports, treatment, recommendations, relevant scientific articles and medical forms? YES NO

Would you like a copy of our Notice of Privacy Practices (initial one): YES_____NO_____

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

This consent was signed by: ____(PRINT NAME)

Signature:____Date:____________________

Witness:____Date:____________________