WELCOME TO OUR OFFICE

PATIENT NAME_____ DATE_____

MALE/FEMALE DATE OF BIRTH_____ AGE_____

ADDRESS_____ CITY_____

STATE_____ZIP CODE_____HOME PHONE_____

CELL PHONE_____EMAIL_____

SOCIAL SECURITY#_____-____-____ SPORTS PLAYED_____

OCCUPATION_____

HEIGHT _____WEIGHT_____SHOE SIZE_____ SHIRT SIZE_____

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE? *(Patient, Doctor,*

Facebook, etc.) _____

WHAT IS YOUR MAIN CONCERN TODAY?

_____

PLEASE LIST YOUR FAMILY DOCTORS NAME_____

ADDRESS_____

FAMILY DR PHONE #_____FAX#_____

MEDICATIONS _____

ALLERGIES _____ TOBACCO USE: YES NO

PAST SURGICAL HISTORY _____

TYPE OF ATHLETE_____

NAME & SCHOOL LOCATION _____

PROFESSIONAL ATHLETE TEAM & LOCATION _____

ATHLETIC TRAINERS NAME _____

RECENT ATHLETIC/ACADEMIC ACCOMPLISHMENTS _____

I hereby give my permission to DR LEE S COHEN ASSOCIATES to administer the proper care necessary in the diagnosis and treatment of my condition. I understand I am financially responsible to DR LEE S COHEN ASSOCIATES for any balance that my insurance carrier does not pay. A copy of this signature is as valid as the original.

PATIENT SIGNATURE X_____DATE _____

THANK YOU FOR FILLING OUT THIS FORM AND CONGRATULATIONS FOR TAKING THE TIME TO INVEST IN YOURSELF!!

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Signature: _____ Date: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Authorization for Use and Disclosure of Protected Health Information

Name of Practice: Dr. Lee S Cohen Associates (the "Practice")

Authorization:

By my signature below, I affirm, as a patient of the Practice named above OR as the parent or legal guardian of a minor child that is a patient of the Practice named above (the **"Patient"**), that I authorize the Practice: (i) to capture photographic or video images of the Patient (the "Images"); (ii) to reproduce, use, and disclose the Images, with or without the Patient's name; (iii) to publicize the fact that medical services were provided to the Patient; (iv) to reproduce and publish any testimonials the Patient provides regarding the Practice (collectively referred to herein as the **"Information"**); and (v) to secure copyright registration for any materials that incorporate the Information, at the election and sole expense of the Practice. The authorization is given to the Practice listed above, for disclosures to any persons, without limitation, who may view the Information in printed or digital form in promotional materials including social media or Internet sites.

Purpose:

The purpose of this authorization is to permit the Information, including Images, to be used for marketing of the Practice, and I explicitly consent to the use of Information for advertising and marketing activities to promote the Practice. I acknowledge and agree that no compensation will be provided for the use of the Information.

Expiration and Revocability:

If Patient is signing on his or her own behalf, this authorization expires when the Patient informs the Practice that he or she is no longer a patient of the Practice. If Patient is signing on behalf of a minor child, this authorization expires when the Patient reaches the age of majority, but the authorization remains valid for protected health information already used or disclosed until revoked by the Patient who has attained majority. However, I understand that protected health information already used or disclosed prior to any revocation may no longer be protected. I understand that I may revoke this authorization at any time by notifying the Practice by Certified Mail, return receipt requested, but that revocation will only affect uses and disclosures initiated after the date notice is received by the Practice. Upon receipt of the notice of revocation, the Practice will make reasonable efforts to remove protected health information from social media platforms over which it has control but cannot guarantee removal from all sites. I understand and explicitly acknowledge that the Internet allows for wide sharing and forwarding of information, and that the Practice cannot control all re-disclosure of information.

No Effect on Treatment:

This authorization is voluntary. I understand that the Practice cannot condition treatment of the Patient on whether I sign this Authorization, and that my decision not to sign will not influence or affect the Patient's treatment in any way.

Name of Patient (printed): _____
(Self or minor child)

Date of Birth of Patient: _____

Signature of Patient OR
Parent/Legal Guardian (if signing for minor): _____

Printed Name of Parent or Guardian:
_____
(if signing on behalf of minor child)

Date of Signature: _____