Rex G. Carr, M.D.
Rehabilitation Medicine
(603)643-5254 Fax (603)-643-5264

45 Lyme Road
Suite 102
Hanover, NH 03755-1220

REGISTRATION FORM

PLEASE INFORM THE OFFICE IF THIS IS A WORKER'S COMPENSATION CLAIM!

Patient's Name:____ Age:___
FIRST LAST INITIAL
Home address:____ email:____
____
City: ________________________State: _____Zip:______
Cell Phone: (____)______-_________ Current Employer:____________________________
Home Phone: (____)______-_________ Address:____________________________
Work Phone: (____)______-_________ ____________________________
Sex: M / F Birth Date:___/___/___ City: _______________State:____ Zip:________
Married or Single ? ____________

Primary Insurance
Billing to: Company:____
Address:____
____
City:_______________________ State: _____Zip:____________
Policy or Group #:_______________________
ID or Certificate or Subscriber #:_____________________
Policyholder's Name:____________________________________ RELATIONSHIP TO
First Last Initial POLICYHOLDER:______
Policyholder's Address:____
____
City:______________________ State:_____ Zip:__________

Secondary Insurance
Billing To: Company:____
Address:____
____
City:___________________ State:______ Zip:______________
Policy or Group #:_____________________
ID or Certificate or Subscriber #:__________________________
Policyholder's Name:_____________________________________ RELATIONSHIP TO
First Last Initial POLICYHOLDER:______
Policyholder's Address:______________________________________
____
City:________________ State:______ Zip:______________

Which are you seeing Dr. Carr for, an Illness or an Injury? ___________
When did you first notice the symptoms Dr. Carr will evaluate? ___/___/___.
Are these symptoms from an automobile accident? Yes / No. If yes, when? ___/___/___.
If these symptoms are from an automobile accident, in which State? __________
Have you ever had similar symptoms before? Yes / No. If yes, when? ___/___/___.
What clinician referred you for consultation?_______________ City/State______________

PLEASE COMPLETE THE SECOND PAGE ALSO

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AUTHORIZATION(S) FOR RELEASE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, OPERATIONS, AND ASSIGNMENT OF MEDICAL BENEFITS

Please fill in the appropriate spaces and sign your name, thank you.

I, ________________________________, give my consent to REX G. CARR, M.D., to release
PATIENT, PARENT/ GUARDIAN OF PATIENT

information from ____________________________'s medical record to ALL LISTED BELOW:
PATIENT'S NAME
and assign directly to Dr. Rex G. Carr all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

I also understand that this will authorize the release of any medical or other information. I further understand that this authorization specifically includes drug and alcohol abuse, mental health, psychiatric, psychotherapic information or HIV (AIDS virus) status. I understand that I may revoke this (these) authorization(s) at any time (except retroactively). These authorizations will stay in effect as long as is needed for the above purposes or until revoked in writing, whichever comes first.

Potential for Re-disclosure
Information that is disclosed, under this authorization, may be disclosed again by the person or organization to which the information is sent. The privacy of this information may not be protected under federal privacy regulations. Treatment is not conditioned upon any authorization (s).

PRIMARY INSURANCE :
Name: __________________________________ Street: ______________________________
City: ________________________ State: _______ Zip: _____________ AND

SECONDARY INSURANCE :
Name: __________________________________ Street: ______________________________
City: ________________________ State: _______ Zip: _____________

SIGNATURE: ___________________________ **WITNESS**:_______________________
PATIENT, PARENT/GUARDIAN

DATE SIGNED:_________________

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Rex G. Carr, M.D. for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon charge determination of the Medicare carrier.

____ Date: _____/_____/_____
Beneficiary (Patient) Signature

Your Rights:

The following is a statement of your rights with respect to your protected health information, under HIPAA.
You have the right to inspect and copy your protected health information. Under federal law, however, you might not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. **You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.
You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice. The notice that is in effect will be displayed in the reception area. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying Dr. Rex G. Carr, M.D. of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

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We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with Dr. Rex G. Carr, M.D. in person or by phone at (603)-643-5254.

We are required by HIPAA to make a reasonable effort to show you this notice. Your signature below is only acknowledgement that you have received this Notice of Privacy Practices:

Print Name:________________________________ Signature: __________________________Date:______________

HIPAA Notice of Privacy Practices

Rex G. Carr, M.D.
Rehabilitation Medicine
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Fax (603)-643-5264

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU IS PERMITTED BY HIPAA TO BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how HIPAA may allow us to use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. Please keep in mind that the same state regulations are still in place and are more protective of confidentiality, and we will continue to follow strict confidentiality rules for TPO and PHI. We must follow rules by HIPAA and by the state of New Hampshire. Below is a summary of HIPAA rules.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We can use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information can be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a medication, device, or treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval.

Healthcare Operations: We can use or disclose, as needed, your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, and licensing. For example, we may disclose your protected health information to medical school students that may from time to time see patients at our office. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.