

Jeffrey H. Chester, DO
1063 Lower Main St, Ste C212
Wailuku, Maui, Hawaii 96793

NOTICE OF PRIVACY POLICIES

It is the policy of my practice and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that my practice and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to my practice and staff for purposes of treatment, payment and healthcare operations (TPO). To that end, my practice and staff will--

- ☞ Adhere to the standards set forth in the Notice of Privacy Practices.
- ☞ Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. My practice and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- ☞ Use and disclose PHI to remind patients of their appointments unless they instruct us not to.
- ☞ Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. My practice and staff will
 - Implement reasonable measures to protect the integrity of all PHI maintained about patients.
- ☞ Recognize that patients have a right to privacy. My practice and staff respect the patient's individual dignity at all times. My practice and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- ☞ Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, My practice and staff will:
 - Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
 - Not disclose PHI data unless the patient (or his or her authorized representative) has properly authorized the release or law otherwise authorizes the release. Recognize that, although my practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. My practice and staff will--
 - Permit patients access to their medical records when their written requests are approved by my practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.
 - Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- ☞ My practice and staff will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon request, so long as their requests are in writing.
- ☞ My practice and staff will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.
- ☞ My practice and staff must adhere to this policy. My practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.
- ☞ My practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

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RECEIPT OF NOTICE OF PRIVACY POLICIES
WRITTEN ACKNOWLEDGEMENT FORM.

I, _____, have read and understand
Print Patient Name

Jeffrey H. Chester, DO's "Notice of Privacy Policies."



Signature of Patient

Date

Do you have, or have you had any of the following? Please check all that apply.

- | | | |
|---|---|--|
| <input type="checkbox"/> surgery: _____ | <input type="checkbox"/> foot problems | <input type="checkbox"/> miscarriage |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> head injury | <input type="checkbox"/> sexually transmitted diseases |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> eye problems | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> high/low blood pressure | <input type="checkbox"/> skin problems | <input type="checkbox"/> back pain |
| <input type="checkbox"/> high cholesterol | <input type="checkbox"/> exposure to chemicals/sun/asbestos | <input type="checkbox"/> nerve/spinal cord problem |
| <input type="checkbox"/> anemia/low blood count | <input type="checkbox"/> ulcer | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> bleeding problems | <input type="checkbox"/> stomach/intestine problems | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> lung disease/TB | <input type="checkbox"/> liver problems/jaundice | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> cancer: _____ | <input type="checkbox"/> kidney stones | <input type="checkbox"/> seizures |
| <input type="checkbox"/> bone disease | <input type="checkbox"/> kidney disease | <input type="checkbox"/> stroke |
| <input type="checkbox"/> fractures: _____ | <input type="checkbox"/> bladder/urine problem | <input type="checkbox"/> aneurysm |
| <input type="checkbox"/> joint dislocation: _____ | <input type="checkbox"/> prostate problem | <input type="checkbox"/> childhood diseases |
| <input type="checkbox"/> arthritis: _____ | <input type="checkbox"/> testicular disease/removal | <input type="checkbox"/> depression/anxiety disorder |
| <input type="checkbox"/> thyroid problem | <input type="checkbox"/> ovarian disease/removal | <input type="checkbox"/> other mental illness |
| <input type="checkbox"/> hormone problem | <input type="checkbox"/> uterine disease/removal | <input type="checkbox"/> other injury/trauma |
| <input type="checkbox"/> poor circulation | <input type="checkbox"/> breast disease/removal | <input type="checkbox"/> other: _____ |

What are your current medicines and dosages (include prescription, over-the-counter, supplements, oral contraceptives, and hormone replacement)?

- I am not currently taking any medications, supplements, oral contraceptives and/or hormone replacement pills.
- Yes, I am taking _____

Do you have any allergies? Please include medicines, food, seasonal, other.

- No Yes _____

Approx. Height _____ ft _____ in Approx. Weight _____ lbs

To the best of your knowledge, could you be **pregnant**? No Yes (if "yes," please inform Dr. Chester when you see him.)

Do you chew or smoke **tobacco**? No Yes (if you answered "yes," how much?) _____

Do you drink **alcohol** (beer, wine, liquor)? No Yes (if you answered "yes," how much?) _____

Do you use intravenous/illicit **drugs**? No Yes (if you answered "yes," how much?) _____

Marital Status: Single Married Divorced Widowed

With whom do you live? _____

Are you **working**? No Yes - your occupation: _____
 Full-time Part-time Regular Duties? No Yes

Do any of the following diseases run **in your family** (parents, brothers, sisters, children)? Please check all that apply.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> heart disease | <input type="checkbox"/> kidney disease | <input type="checkbox"/> bone disease | <input type="checkbox"/> ovarian disease/removal |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> cancer: _____ | <input type="checkbox"/> stomach/intestinal disease | <input type="checkbox"/> uterine disease/removal |
| <input type="checkbox"/> lung disease | <input type="checkbox"/> thyroid problems | <input type="checkbox"/> liver disease | <input type="checkbox"/> breast disease/removal |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> hormone problems | <input type="checkbox"/> skin disease | <input type="checkbox"/> testicular disease/removal |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> stroke | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> other: _____ |

*** END OF FORM ***

DR. CHESTER WILL REVIEW THIS SURVEY WITH YOU

WORKER'S COMPENSATION / NO FAULT / THIRD PARTY INFORMATION FORM

Is this a work-related injury?

No (if you answered "no," skip to the next section)

Yes, Date of injury _____ Time of injury _____ am/pm

Did this injury happen on Maui? Yes No Date supervisor was notified of injury _____

Date you last worked _____ Supervisor's name: _____

Describe how injury occurred: _____

Any previous work-related injuries? No Yes: _____

Is this a motor vehicle accident-related injury?

No (if you answered "no," skip to the next section)

Yes, Date of accident _____ Time of accident _____ am/pm

Did this accident happen on Maui? Yes No: _____

Describe how accident occurred: _____

Were you the driver? passenger?

Were you wearing your seatbelt? No Yes

Was the air bag deployed? No Yes

Was the car damaged? No Yes: _____

Did you hit your head? No Yes

Did you brace yourself? No Yes

Did you go to the Emergency room? No Yes

If "yes," were x-rays taken? No Yes

If "yes," were blood tests taken? No Yes

If "yes," were you given medication? No Yes

Do you have nightmares about the accident? No Yes

Are you nervous about driving? No Yes

Any previous motor vehicle accidents? No Yes: _____

Other injuries: _____

Is this an injury which occurred in a public place (e.g, supermarket, sidewalk, parking lot, restaurant)?

No (if you answered "no," please just sign and date the bottom of this form)

Yes, Date of injury _____ Time of injury _____ am/pm

Did this accident happen on Maui? Yes No: _____

Describe how injury occurred: _____

What is the status of your claim? Open Closed Funds Exhausted Pending Denied

Do you have an attorney for this claim? No Yes, their name is: _____

To all patients with injury claims: Dr. Chester does not accept liens. If you do not file the required paperwork by your insurance, your claim is denied, and/or the funds exhaust or run out, any amount unpaid by insurance is your financial responsibility. If you have private insurance, please provide us with that information. Otherwise, your balance must be paid within 30 days or it will accrue interest at the rate of 1.5% every 30 days. If your balance is 90 days old, your account will be forwarded to a collections agency and an additional \$30 (thirty dollar) service fee will be added. By signing below, you acknowledge your understanding of the above.

 _____
Patient's Signature Patient's Name Printed Today's Date

Please fax or mail back pages 2 – 6 only. All information is kept confidential.

Once your paperwork has been reviewed, you will receive a phone call from our office. This is normally done within 3 business days.

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