



**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM**

As Required by the Privacy Regulations Created as a Result of the Health Insurance
Portability and Accountability Act of 1996 (HIPPA)

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. Also, we are required by law to provide you with this notice of our legal duties and privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

Our practice will post a copy of our current notice in our offices in a visible location at all times, and you may request a copy of our most current notice.

Carolina Passport Health's Notice of Privacy Practices has been made available to me.

Printed Name: _____

Signature: _____

Date: _____

(Effective date of this notice: April 14, 2003)

Name _____ Date _____
LAST FIRST MIDDLE INITIAL

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth ____ / ____ / ____ Age ____ Gender: Male Female E-Mail _____

Employer _____ Occupation _____

Emergency Contact _____ Relationship _____ Phone _____

Would you like us to send your healthcare provider a copy of your vaccination record? YES NO

If yes, please provide the name and address: Dr. _____

ALLERGIES Please circle if you have any known allergies to the following substances: **NONE**
chicken eggs feathers yeast gelatin mercury thimerosal sulfa aluminum aluminum hydroxide quinine formaldehyde

Any other known allergies please explain _____

MEDICATIONS: **NONE** List current medications _____

MEDICAL HISTORY

- 1) Are you pregnant or possibly pregnant?.....YES NO Are you planning pregnancy in the next 3 months?..... YES NO
- 2) Have you had an allergic reaction to a vaccination in the past?.....YES NO explain _____
- 3) Do you have any chronic medical or mental illness?.....YES NO explain _____
- 4) Do you have high blood pressure?.....YES NO explain _____
- 5) Are you taking any steroid medications, cortisone or prednisone?...YES NO explain _____
- 6) Are you receiving radiation or any other treatments?.....YES NO explain _____
- 7) Do you have any skin conditions such as dermatitis or eczema?.....YES NO explain _____
- 8) Have you ever had a seizure, convulsion or epilepsy?.....YES NO explain _____
- 9) Are you prone to motion sickness?.....YES NO explain _____
- 10) Are you traveling against the advice of a physician?.....YES NO explain _____
- 11) Any other medical conditions or acute problems?.....YES NO explain _____

IMMUNIZATION HISTORY

Please see reverse side to complete shot record.

TRAVEL INFORMATION

Destination: (Please list individual countries in sequence of visit, also city or region):

Date of Departure _____ Date of return _____ Total length of stay _____

Purpose of visit/planned activities _____ Accommodations _____

The information I have provided is accurate to the best of my knowledge. Passport Health keeps active records on file. Inactive records are kept on file for 3 years. Passport Health is not a Medicare provider. I understand that Passport Health will not file insurance and I am responsible for all fees associated with this visit. Payment is due at the time of service by Cash, Visa, MasterCard, or American Express.

Traveler/Parent/Guardian Signature

Date

Please also complete the other side of this form.

