# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW CAPE COD MEDICAL CENTER MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Cape Cod Medical Center is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by Cape Cod Medical Center or received by Cape Cod Medical Center from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. Cape Cod Medical Center will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.

Cape Cod Medical Center reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

Uses and Disclosures of Your Protected Health Information not Requiring Your Consent

Cape Cod Medical Center may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;

For example, Cape Cod Medical Center may share or transfer your healthcare information with your referring physician, primary care doctor or other health care provider.

Payment activities may include:

- Activities undertaken by Cape Cod Medical Center to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you.

For example, Cape Cod Medical Center will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare operations may include:

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, Cape Cod Medical Center may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

Cape Cod Medical Center may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when Cape Cod Medical Center is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

- As permitted or required by law. In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime. Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.
- For public health activities. We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure. We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of

an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food and Drug Administration when required by federal law. We may disclose healthcare records, except for HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

- For health oversight activities. We may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.
- Judicial and Administrative Proceedings. Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.
- For activities related to death. We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.
- For research. Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.
- To avoid a serious threat to health or safety. We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.
- For workers' compensation. We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

Cape Cod Medical Center will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that Cape Cod Medical Center has taken action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by Cape Cod Medical Center to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Cape Cod Medical Center may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Cape Cod Medical Center send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Cape Cod Medical Center not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that Cape Cod Medical Center amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by Cape Cod Medical Center for the six years prior to the date of the request, beginning with disclosures made after January 25, 2009. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive a paper copy of this Notice, if you had previously received or agreed to receive the Notice electronically.

*It is the policy of Cape Cod Medical Center that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

Any person or patient may file a complaint with Cape Cod Medical Center and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Cape Cod Medical Center, please contact the Privacy Officer at the following:

Privacy Officer Cape Cod Medical, 65 Route 134, Dennis, MA 02660

Name: _____ Date: _____ Dennis, MA 02660

**Timothy L. Biliouris, M.D.**
**Cape Cod Medical Center**

## PATIENT INFORMATION

PATIENT NAME _____
(last name) (first name) (middle)
STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ SS# _____

HOME PHONE (___) _____ MARITAL STATUS: M ☐ S ☐ D ☐ W ☐ O ☐

## EMPLOYER INFORMATION

**(If patient is a minor, please fill in employer info of parent or guardian)**

EMPLOYER _____
STREET ADDRESS _____
CITY _____ STATE _____ ZIP _____
WORK PHONE # (___) _____ EXT _____

## COLLEGE STUDENT STATUS

SCHOOL NAME _____
STREET ADDRESS _____
CITY _____ STATE _____ ZIP _____
**STUDENT STATUS** FULL TIME ☐ PART TIME ☐

## PERSON RESPONSIBLE FOR BILLS

NAME _____ PHONE#(___) _____
ADDRESS _____
(City) (State) (Zip)

## INSURANCE INFORMATION

PRIMARY INS. CO. NAME _____
ADDRESS (Claims) _____
CITY _____ STATE _____ ZIP _____
PHONE NUMBER (___) _____
**INS. ID#** _____ **GROUP #** _____
**EFFECTIVE DATE OF INS.** _____
**SUBCRIBER'S NAME** _____
**SUBCRIBER'S EMPLOYER** _____
**SUBSCRIBER'S DATE OF BIRTH** _____ **SS#:** _____
**PATIENT'S RELATIONSHIP TO SUBSC.** **Spouse** ☐ **Child** ☐ **Other** ☐

**SECONDARY INSURANCE**
**(if applicable)**

SECONDARY INS. CO. NAME_____
ADDRESS (Claims)_____
CITY_____STATE_____ZIP_____
PHONE NUMBER (____)_____
**INS. ID#**_____**GROUP#**_____
**EFFECTIVE DATE OF INS.**_____
**SUBSCRIBER'S NAME**_____
**SUBSCRIBER'S EMPLOYER**_____
**SUBSCRIBER'S *DATE OF BIRTH***_____**SS#**_____
**PATIENT'S RELATIONSHIP TO SUBSC.** **Spouse** ☐ **Child** ☐ **Other** ☐

## Assignment of Insurance Benefits

I hearby authorize direct payment of surgical/medical benefits to Timothy L. Biliouris, M.D. for services rendered by this group practice. I understand that I am financially responsible for any balanced not covered by insurance.

Signature: _____ Date: _____

## Authorization to Release Information

I hearby authorize Timothy L. Biliouris, M.D. to release any medical or incidental information that may be necessary for medical care, or the processing of applications for financial benefits.

Signature: _____ Date: _____

**AUTHORIZATION TO REALEASE MEDICAL INFORMATION TO FAMILY MEMBERS OR OTHER NAMED PARTIES**

***If you are 18 years of age or older, no medical information will be released to a parent or guardian or significant other without your permission. Do you give permission for information contained in your medical records to be released?***

**YES ( )** **NO ( )**

***Please name the person or persons that you give permission to receive information contained in your medical records:***

**NAME**_____**RELATIONSHIP**_____

**NAME**_____**RELATIONSHIP**_____

PATIENT HISTORY QUESTIONNAIRE

**Timothy L. Biliouris, M.D.,**
**Cape Cod Medical Center**
**65 Route 134 · Dennis, MA 02660**

# Patient History Form

Name:_____ Age:_____ Date:_____
Occupation:_____ Company:_____

1. Do you have or have you ever had any of the following – Please specify how long you've had it or when the problem occurred:
   Diabetes_____ Asthma_____
   High Blood Pressure_____ Ulcers_____
   Heart Attack_____ Anemia_____
   Heart Disease_____ Epilepsy_____
   Tuberculosis_____ Cancer (Where?)_____
   Kidney trouble_____ Thyroid trouble_____
   Other_____
2. Please list medicines that you are allergic to and reaction that occurs:
   _____
   _____
3. Please list foods that bother you in any way and reaction that occurs:
   _____
   _____
4. If you have hayfever, list what you are allergic to and which season(s)is worse:
   _____
5. Please list the dates of **all** your immunizations, if you can remember (especially Important to complete this section if a child):
   Diphtheria, Tetanus, Pertussis_____
   Oral Polio Vaccine_____
   Measles, Mumps, Rubella_____ Meningitis_____
   Tuberculosis Test_____ Adult Tetanus Shot_____
6. Do you smoke?_____ How much per day?_____ How many years? _____
   Are you a former smoker?_____ How much?_____ How many years?_____
   When did you quit?_____
7. How many cups of caffeinated beverages do you drink each day?_____
8. How much alcohol do you drink each day? (Be honest)_____
   If you used alcohol heavily in the past, when did you quit?_____
9. Do you eat a balanced diet?_____
10. Please list any operations you have had, what year it was done and the name of the surgeon:_____
    _____
11. List any other hospitalizations besides surgery, including the year and the physician at the time:_____
    _____
12. Are you: Single_____ Married/# of years_____ Widow(er)_____ Divorced_____
    **(Females only - #'s 13-21):**
13. How many pregnancies have you had (please include any miscarriages or abortions in this number): _____ Out of this number, how many
    Miscarriages?_____ Abortions?_____ Stillbirths?_____
14. Please give total number of living children_____
15. What date did your last period begin?_____
16. How old were you when you had your first period?_____
17. Are your periods regular?_____ If yes, how many days apart are they and how long do they last? _____
18. Do you get severe menstrual cramps?_____ If yes, when do they first start?
    _____
19. When was your last Pap test and who was the doctor that performed it? _____
    _____
20. Have you ever had a Pap test that was abnormal?_____ If yes, please indicate therapy given, if any: _____
21. If you have gone through menopause ("the change of life"), approximately how many years ago? _____

**FAMILY HISTORY**

22. List whether parents are living or deceased. Please give current age or age at time of death and cause of death:
    Mother_____ Father_____
23. List first names and ages of all of your children. Please indicate adopted or step-children is applicable: _____
    _____
24. Please list name, age and cause of death of any deceased children: _____
    _____
25. Please list number of living brothers_____ sisters_____
25. Please list number of deceased brothers_____ sisters_____
27. Please list any family member(s) that has ever had any of the following illnesses. Please be specific as to which side of the family (mother's or father's) and go back as far as your great-grandparents if you can. Remember to include uncles, aunts, cousins, nieces and nephews:
    Diabetes: _____
    High Blood Pressure: _____
    Heart Attack: _____
    Other heart disease: _____
    Ulcers: _____
    Asthma: _____
    Epilepsy: _____
    Cancer: _____
    Thyroid trouble: _____
    Other illnesses: _____

28. List medications that you take, the dosage and how often you take it: _____
    _____
    _____
    _____

**REVIEW OF SYMPTOMS**

29. Please indicate if you have ever or now have any problems with the following. Please try to be specific as to the nature of the problem, when it occurs, and what makes it better and/or worse:
    Eyes, Ears, Nose, Throat: _____
    _____
    Chest pain: _____
    Shortness of breath: _____
    Constipation, Diarrhea: _____
    Stomach trouble: _____
    Do you get a lot of indigestion? _____ If so, which foods seem to bother you the most? _____
    Urinary trouble: _____
    (Men) Problems of the penis or testicles, including difficulty with erections or ejaculation _____
    (Women) Vaginal infections (how often?) _____
    Urinary tract infections (how many times in past and when was the last one?)
    _____
    Joint pains (which joints) _____
    Worse in wet weather? _____ Worse in cold weather?_____
    Do your legs ever swell up? _____ When? _____
    Do you ever wake up from sleep short of breath? _____
    How many pillows do you sleep on at night? _____ If more than one, is it for comfort of do you breathe easier? _____
    Do you ever feel cold or hot when everyone else in the room is comfortable?
    _____
    Any other problems? _____
    _____
    _____
    _____

**Timothy L. Biliouris, M.D., Cape Cod Medical Center**
**65 Route 134 · Dennis, MA 02660**

Our physicians make every effort to utilize local providers, Shields MRI, Quest labs and Tufts Medical Center when needed. This assures that we will get your records and consults as quickly as possible. If you request to be sent to a hospital or doctor off Cape Cod, it is your responsibility to make sure that they are covered by your insurance and also that a copy of all records be sent to us. In these cases, the medical records may not always be available in a timely manner. Thank you.