International Travel Health Consultants

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NY, NY 10019
212-262-2049

243 North Road Suite 202
Poughkeepsie, NY 12601
845-454-7367

www.globaltraveler.com

Last Name:____________________________First Name__________________________DOB:_________

Gender:_______Phone Number:____________________Email:________________________________

Address:____

Occupation/JobTitle________________Employer Address:___________________________________

Emergency Contact:______________________________Phone Number:________________________

Referred By: ___Self-Referral
____Health Department ___________
_____Travel Agent________________
_____Physician__________________
_____Internet___________________
_____Other_____________________

Pharmacy:___________________
Address:____________________
____
Phone______________________
Allergies:___________________

Form of Payment: (Amex) ( )Cash ( )Visa ( ) Mastercard ( ) Other:_______________

I understand that International Travel Health Consultants does not participate with insurance reimbursement for travel medicine visits and vaccinations. I also understand that I am responsible for the total amount of charges for these at the time of my visit.

Signature____Todays Date:____________________

Travel Information

Date of Departure:______________ **Return Date:**__________________

Destination(City/Country)	Where will you stay?	Length of stay.

Who Will You be traveling with?____

Please circle all that apply to your travel plans:

Major Resorts Hotels	Cruise Ships	Camping	Rural Travels
Staying with family	Small Hotel	Safari	Outdoor Activities
Rented foreign House	Youth Hostel		

What is the purpose of your travels?

Business	Student	Vacation	Mission Work
Teacher	Volunteer Agency	Field Work	Climbing>8000FT
Diving	Visit Family/Friends	Medical Tourism	

Do you travel internationally once a year or more? Yes/No

Previous International Travel

Location	Date	Location	Date

Please circle Vaccines you have had in the past:

Typhoid Oral/Injection	Hepatitis A	Hepatitis B	Flu Vaccine
Meningitis	Jap. Enc.	Polio	Immune Globulin
MMR	Varicella	Rabies	PPD
Tetanus Diphtheria	Pneumonia	Yellow Fever	

Covid Vaccine Type	Date	Covid Vaccine Type	Date

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as it is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

Patient Name ____

I, ____________________________________ **date** __________ **I do hereby consent and acknowledge to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**

Signature of Patient / If patient is under 18 years old parent/guardian signature required

Signature ____ Printed Name ____________________________________

Interpreter Name ____________________________________ Interpreter Signature ______________________________