Patient History Form

Patient Name: _____ **Date:** _____
Date of Birth: ____/____/____
Primary Care Physician: _____
Pharmacy: _____

What is the reason for your Visit today?

_____

Have you ever been to this Office/Surgeon? Y / N

Do you have cardiac stents? Y / N

Do you have a bleeding or blood clot disorder? Y / N

Do you have a pacemaker or defibrillator? Y / N

Who is your cardiologist? _____

Do you have or have history of:

Wears glasses	Yes ___	No ___
Dentures	Yes ___	No ___
Unexpected Weight Change	Yes ___	No ___
Difficulty Swallowing	Yes ___	No ___
Asthma	Yes ___	No ___
Bronchitis	Yes ___	No ___
Pneumonia	Yes ___	No ___
Chest Pain	Yes ___	No ___
Shortness of Breath	Yes ___	No ___
Atrial Fibrillation	Yes ___	No ___
COPD	Yes ___	No ___
Congestive Heart Failure	Yes ___	No ___
Heart Attack	Yes ___	No ___
High Blood Pressure	Yes ___	No ___
High Cholesterol	Yes ___	No ___
Hernia	Yes ___	No ___
Constipation	Yes ___	No ___
Diarrhea	Yes ___	No ___
Irritable Bowel Syndrome	Yes ___	No ___
Hemorrhoids	Yes ___	No ___
Nausea/Vomiting	Yes ___	No ___
Dizziness	Yes ___	No ___
Headaches	Yes ___	No ___
Nervousness/Anxiety	Yes ___	No ___
Depression	Yes ___	No ___
Sleep Apnea	Yes ___	No ___
Bipolar Disorder	Yes ___	No ___
ADD/ADHD	Yes ___	No ___
Fibromyalgia	Yes ___	No ___
Seizures	Yes ___	No ___
Thyroid Problem (High or Low)	Yes ___	No ___
Hepatitis	Yes ___	No ___
Arthritis	Yes ___	No ___
Diabetes	Yes ___	No ___
HIV/AIDS	Yes ___	No ___
Cancer	Yes ___	No ___

If yes, what kind? _____

Other Diagnoses:

_____

_____

Allergies to Medications:

_____

_____

Latex Allergy: Y / N

Current Medications:

_____

_____

_____

_____

Past Surgeries:

Procedure	Location/Doctor	Date

Past Hospitalizations:

Hospital	Reason	Date

Social History:

Do you smoke? Y / N or Quit
How much? _____ Pack Per Day
How Long? _____ Years
If you quit, how long ago? _____

Do you drink? Y / N or Quit
How much? _____ Drinks/Beers per Week
Did you drink in the past? Y / N
If so, when did you quit? _____

Family History:

Do any of your family members have or have had:
(Please Specify: Mother, Father, Sister, Brother, Aunts, Uncles, and Grandparents, maternal or paternal)

Disease	Which Family Member
Diabetes	
Hypertension	
Bleeding Disorder	
Heart Disease	
Cancer (specify what kind)	

For Women Only:

Date of last menstrual period? _____
Age at first menstrual period? _____
Age at first child? _____How many children? _____
Were children breast fed? Yes _____ No _____
Date of last mammogram? _____
Postmenopausal? Yes _____ No _____
Hysterectomy? Yes _____ No _____
Birth control or hormone therapy? Yes _____ No ___
Any previous breast biopsies? Yes ____ No _____

TOLEDO
Surgical Associates, Inc

Constance P. Cashen, D.O., FACS, FACOS
Rodolfo J. Canos, D.O., MPH, FACS, FACOS
Bettina I. Nazemi, D.O., MPH, FACS, FACOS

Patient Information:

NAME: _____ DATE OF BIRTH: ____/____/_____
ADDRESS: _____LOT/APT. # _____ CITY:_____ STATE: ____
ZIP:_____ S.S.# _____-_____-_____
PHONE NUMBER: (_____) _____-_____ SECONDARY PHONE: (_____) _____-_____
SEX: MALE / FEMALE MARITAL STATUS: MARRIED / SINGLE / DIVORCED / OTHER:_____
OCCUPATION:_____ EMPLOYER:_____
JOB STATUS: FULL TIME / PART TIME / RETIRED / DISABLED / OTHER: _____

Emergency Information:

CONTACT NAME:_____ PHONE NUMBER (_____) _____-_____
RELATIONSHIP TO PATIENT: PARENT / SIBLING / CHILD / FRIEND / SPOUSE/ OTHER: _____

Insurance Information:

PRIMARY INSURANCE
INSURANCE NAME:_____
POLICY I.D. NUMBER_____
POLICY HOLDER NAME:_____
BIRTHDAY_____ SS#:_____-_____-_____

SECONDARY INSURANCE
INSURANCE NAME: _____
POLICY I.D. NUMBER:_____
POLICY HOLDER NAME: _____
BIRTHDAY____/____/_____ SS#:_____-_____-_____

Guarantor (Insured Party) Information (if different from above):

NAME: _____ DATE OF BIRTH: ____/____/_____
ADDRESS: _____CITY:_____ STATE: ____ ZIP:_____
PHONE NUMBER: (_____) _____-_____ SECONDARY PHONE: (_____) _____-_____
SEX: MALE / FEMALE MARITAL STATUS: MARRIED / SINGLE / DIVORCED / OTHER:_____
OCCUPATION:_____ EMPLOYER:_____
JOB STATUS: FULL TIME / PART TIME / RETIRED / DISABLED / OTHER: _____

Physician Information:

Have you EVER been to our office prior to Today? YES / NO when? _____
Who is your Primary Doctor or Family Doctor? Dr._____
Who has referred you to our office today? Dr._____
What pharmacy and location do you prefer? _____

Assignment of Benefits:

I hereby assign all medical and surgical benefits including Medicare, Private Insurance or any other healthcare plan to Toledo Surgical Associates, INC. I authorize all payments to be directed to Toledo Surgical Associates, INC. This assignment will remain in effect until revoked by me in writing. A photo copy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for ALL charges whether insurance paid it or not. I understand that all co-pays are due at the time of service, all balances for the office are due in full within 30 days following the receipt of the insurance payment. I further understand that my payment in full is due within 90 days following payment/response by the insurance company for all surgery/procedure fees. I hereby authorize said assignee to release all information necessary to secure the payment. Also, I am authorizing treatment at this facility.

Signature: _____ Date: _____/_____/_____

TOLEDO
Surgical Associates, Inc

FINANCIAL POLICY

It is our office policy to bill your insurance carrier(s) as a courtesy to you. In order to do this, we will need all of your current and correct insurance and demographic information at the time of service. All copays must be paid at the time of service. Services will be billed per the terms of our agreement with each insurance carrier. You will be responsible for any deductible or balance due following payment or response by your insurance carrier. If your insurance company deems a service to be "non-covered", you are responsible for payment. Medicare will only pay for services that are deemed "reasonable and medically necessary". Therefore, you may be asked to sign a waiver if we determine that your services would likely be denied, and you will be responsible for those charges. If you have an insurance policy that requires a referral for a specialist office visit, please have your referring physician fax it to our office prior to your appointment. It is ultimately your responsibility to ensure that the referral has arrived. If it is not received by the time of your appointment, you may be asked to reschedule or be responsible for the cost of your visit. Since we are not, in most cases, a party to the agreement with your insurance carrier, it is not our policy to contact carriers to establish why they have not paid or why they paid less than originally indicated. Any payment made by your insurance carrier in excess of the balance due on your account will be promptly refunded.

We do not bill for accidents involving litigation. You will be responsible for payment at the time of service. All Workers' Compensation information is required prior to service. If Workers' Compensation information is not available at the time of your appointment, your visit may be rescheduled.

Self-pay patients will be informed of the payment policy upon making an appointment. A fee range, when possible, will be given along with any anticipated additional charges. The full cost of the office visit will be due at the time of service. Payment for any fees for surgical procedures will be coordinated with the Business Office prior to surgery date.

All balances are due and payable within 90 days of the service date or your account may be sent to a collection agency. This allows sufficient time for insurance to process and for you to respond to billing statements.

Please be aware that services you receive in the office or hospital may involve other medical parties. Therefore, you may have additional charges such as laboratory services, pathology services or anesthesia services billed separately by those parties.

You may contact our Business Office at 419-724-4777 with any questions regarding this financial policy.

Office fees will be assessed to patients based on the following:

Office visit cancellation without 24-hour notice	$25.00
No call/No show for appointment	$50.00
Surgical procedure cancellation	$100.00
Collection processing fees	$50.00
Returned check fee	$30.00

Signature of Patient or Legal Guardian: _____

Date: _____

TOLEDO
Surgical Associates, Inc

HIPAA CONTACT FORM

In general, HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I, _____ wish to be contacted in the following manner:

Oral Communication:

- OK to contact you at **home telephone**? _____ Yes _____ No (_____) _____ - _____
  ( ) OK to leave a **detailed message** at this number? _____ Yes _____ No
  ( ) OK to leave a **call-back number only**? _____ Yes _____No

- OK to contact you at your work telephone? _____ Yes _____ No (_____) _____- _____
  ( ) OK to leave a **detailed message** at this number? _____ Yes _____ No
  ( ) OK to leave a **call-back number only**? _____ Yes _____No

Written Communication:

- Ok to mail to your **home address**? _____ Yes _____ No
- Ok to mail to your **work/office address**? _____ Yes _____ No
- OK to **fax** to (_____) _____- _____
- **OTHER** _____

I permit Toledo Surgical Associates, Inc. to discuss and disclose my PHI to the following:

- **Spouse**
  First Name: _____ Last Name: _____
- **Adult Child(ren)**
  First Name: _____ Last Name: _____
  First Name: _____ Last Name: _____
- **Personal Representative**
  First Name: _____ Last Name: _____
- **Other**
  First Name: _____ Last Name: _____

Restrictions:

- List any restrictions that apply: _____

_____ _____
Patient's Signature Date

TOLEDO
Surgical Associates, Inc

NOTICE OF PRIVACY PRACTICES
THIS NOTICE, WHICH IS EFFECTIVE AS OF APRIL 14, 2003, DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The doctors and staff at Toledo Surgical Associates, Inc. ("TSA") believe your medical information should remain confidential. The law requires us to establish office policies that are designed to safeguard your health information. The information contained in this notice constitutes our promise to you that we acknowledge our legal obligation to protect your health information, and it describes your rights concerning our use of your health information.

We will use and disclose your health information for purpose of treatment, payment and/or health care operations.

1. **Treatment** means the provision, coordination or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relation to a patient; or the referral of a patient for health care from one health care provider to another. *For example, a consultation follow up letter from a specialist to your primary care physician would be medical information maintained for treatment purposes.*
2. **Payment** means activities undertaken by a covered health care provider or health plan to obtain our provide reimbursement for the provision of health care. *For example, the medical information furnished to your insurance company so that we may be paid for our services is considered information maintained for payment purposes.*
3. **Health Care Operations** include certain activities of the practice, as well as activities of an organized health care arrangement in which we participate, including, quality assessment and improvement activities, reviews of the competence or qualifications of health care professionals, activities related to underwriting or premium rating of insurance contracts, activities related to legal or accounting services provided to the practice, and business management and planning. *For example, from time to time hospitals and insurance companies will review physician's clinical skills in order to assure that quality care is being provided. When such reviews are conducted, it is often necessary for the reviewer to randomly select and examine patient's medical records.*

We are permitted or required to disclose limited health information about you, without your authorization, in the following circumstances:

1. **As required by law** as long as it is limited to the relevant requirements of such law.
2. **For public health activities**; including prevention and control of disease, vital statistics and public health investigations.
3. For purpose of making required reports about **victims of abuse, neglect or domestic violence.**
4. **Health oversight activities**, including audits, civil, criminal or administrative investigations, proceedings or actions, inspections, licensure or disciplinary actions.
5. **Judicial and administrative proceedings** in response to court orders.
6. **Law enforcement purposes** (i.e. reports of gunshot wounds, grand jury subpoenas and information regarding victims of crime.)
7. **To coroners, medical examiners and funeral directors** for purposes of identifying deceased persons or determining cause of death.
8. **For organ and tissue donation** consistent with applicable laws.
9. **Research**, provided that federal regulations governing research activities that insure the privacy of your health information are met.
10. **To avert serious threats to health or safety.**
11. **Specialized government functions** regarding military personnel and military veterans, certain national security purposed and inmates.
12. **Workers' Compensation** to the extent necessary to comply with applicable laws.

13. **Marketing**, for purposes of appointment reminders, treatment alternatives or other related benefits and services that may be of interest to you.

Any use of disclosure other than those noted above require us to obtain your written authorization, which you may revoke at any time. Any such revocation must be in writing.

You have the following rights with respect to your health information:

1. The right to request restrictions on certain uses of your health information, however, we are not required to agree to your request.
2. The right to request, in writing, the manner or method by which we contact you to furnish confidential communications about your health information (i.e. fax, email, voicemail, etc.). You are obligated to notify us, in writing, of any changes to your request.
3. The right to inspect your health information. (You are entitles to receive a copy of your health information, except for psychotherapy notes and information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding.)
4. In limited circumstances, the right to ask us to amend your health information, however we reserve the right to deny your request. If your request to amend is denied, we will provide you with information about the basis of our denial and your rights to submit a written statement disagreeing with our denial.
5. The right to receive an accounting of disclosures of your health information, except those disclosures related to treatment, payment or health operations, disclosures that are made to you, disclosures made for national security purposes or to correctional institutions or law enforcement officials, or disclosures that we made prior to the compliance date.
6. The right to receive a copy of this notice in writing.

We have the following obligations:

1. We are required by law to maintain the privacy of your health information, and we are required to provide you with a notice of our legal duties and privacy practices.
2. We are required to abide by the terms of this notice.
3. We are required to advise you of any changes we make in the terms of our notice of privacy practices. If any changes are made to notice of privacy practices, we will post the revised notice and make a copy of it available upon request.

Complaints

If you believe we have violated your privacy rights, you may file a written complaint to our Privacy Officer and/or to the Secretary of Health and Human Services. There will be no retaliation for filing a complaint. If you want more information or you believe your rights have been violated, you can contact our Privacy Officer at the following address: Toledo Surgical Associates, Inc., 4646 Nantuckett Drive, Suite B, Toledo, Ohio 43623, Attention: Practice Manager. Or you can call our office at (419) 724-4777. Alternatively, you may wish to contact the federal agency in charge of enforcing patient's privacy rights. That address is: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHS Building, Washington D.C., 20201.

Acknowledgement

I have read the foregoing Notice of Privacy Practices provided to me by TSA and I have been given the opportunity to discuss TSA's privacy practices. I understand that TSA may, at its discretion, change the terms and conditions of the notice. Any questions I may have had have been answered to my satisfaction. I understand the content of the Notice of Privacy Practices and I have been provided with a copy of same.

Printed Name	Signature	Date	Staff Initials
_____	_____	____/____/____	_____

Authorized Information Release To:

Name and Relation	Name and Relation
_____	_____