

WEST KENTUCKY SURGICAL, INC.

PATIENT INFORMATION

(PLEASE PRINT AND COMPLETE IN FULL MAKE CORRECTIONS IF NECESSARY)

Date: _____
Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell: _____ Age: _____ Birthdate: _____

Social Security#: _____ Sex: _____ Status: _____ Single _____ Married

Patient's Employer: _____ Work Phone#: _____

Spouse's Name: _____ Spouse's SS#: _____

Spouse's Birthday: _____ Spouse's Employer: _____ Work phone # _____

Please complete if Patient is a Minor:

Responsible Party: _____

Address: _____

City: _____ State _____ Zip Code: _____

Phone#: _____ Work Phone: _____

Soc Sec#: _____ Employer: _____

IN CASE OF EMERGENCY CONTACT: _____ **PHONE#** _____

Do you have Medical Insurance? _____ YES _____ NO

Primary Insurance _____

Secondary Insurance _____

What is your copayment amount \$ _____ Does your ins. require a referral? Y or N

Referred by: _____ Your Drugstore _____

Who is your primary doctor? _____

Have you ever been a patient at West Kentucky Surgical in the past? YES or NO

If so, was it under a different name? _____

PLEASE PRESENT INSURANCE CARD (s) TO RECEPTIONIST TO BE COPIED

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS:

I hereby assign all medical benefits to include major medical benefits, all private insurances, and other health plans to: West Kentucky Surgical, Inc. This assignment of benefits will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE.

SIGNATURE OF RESPONSIBLE PARTY: _____

DATE: _____

HIPAA NOTICE OF PRIVACY PRACTICES

**West Kentucky Surgical, Inc.
300 South 8th Street, Suite 401E
Murray, KY 42071
(270) 753-2444**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we at West Kentucky Surgical, Inc., may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or a surgical procedure may require that your relevant PHI be disclosed to the insurance company to obtain approval or precertification.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients in our office. In addition, we may call you by name in the waiting room when the physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you or to reschedule your appointment time.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Your physician is not required to agree to a restriction that you may request. You then have the right to use another Healthcare Professional. If the physician believes it is in your best interest to permit use and disclosure of your PHI, then your PHI will not be restricted.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from West Kentucky Surgical, Inc., upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this notice and will inform you of any changes. You have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print
Name: _____ Signature: _____ Date: _____

WEST KENTUCKY SURGICAL, INC.

HEALTH REVIEW

NAME: _____

DOCTOR: _____

Drug Allergies: _____

Are you allergic to tape? Yes No

Are you allergic to iodine or seafood? Yes No

Past Surgeries: _____

Primary Care Provider (MD/ARNP): _____ **Referring Doctor:** _____

Social / Personal History:

Yes	No	Item	How much per day?		For how long?
<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke tobacco?			
<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol?			

FAMILY HISTORY: Has your parent, grandparent, brother or sister ever had? If so, indicate who

Yes	No	Check each item	Yes	No	Check each item	Yes	No	Check each item
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease-who	<input type="checkbox"/>	<input type="checkbox"/>	AAA / Aneurysm-who	<input type="checkbox"/>	<input type="checkbox"/>	Cancer: where/who
<input type="checkbox"/>	<input type="checkbox"/>	CVA / Stroke-who	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes-who	<input type="checkbox"/>	<input type="checkbox"/>	Colon polyps-who

PERSONAL HISTORY: Has a doctor ever told you that you have any of the following?

Yes	No	Check each item	Yes	No	Check each item	Yes	No	Check each item
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid trouble	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Stomach ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis / TB	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Colon polyps	<input type="checkbox"/>	<input type="checkbox"/>	Convulsion/Seizures
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's colitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis / Blood Clot	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer (where)

Have you recently been troubled with any of the following symptoms?

Yes	No	Check each item	Yes	No	Check each item	Yes	No	Check each item
<input type="checkbox"/>	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Eyes Yellow	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Nosebleed	<input type="checkbox"/>	<input type="checkbox"/>	Change bowel habits	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells
<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Tingling in hands or feet
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in neck
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes
<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss
<input type="checkbox"/>	<input type="checkbox"/>	Bloody sputum	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>	Weight gain
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain / pressure	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	Depression / worry
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Cancer (where)
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Leg pain	<input type="checkbox"/>	<input type="checkbox"/>	Sleep apnea
<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Feet swelling	<input type="checkbox"/>	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting Blood	<input type="checkbox"/>	<input type="checkbox"/>	Non-healing wound	<input type="checkbox"/>	<input type="checkbox"/>	

Please list your medications and doses: _____

