

Patient Name _____

PATIENT HISTORY

ALLERGIES TO DRUG – Write “None” if no Allergies

Drug	Reaction? (breathing problems, rash, stomach upset)
_____	_____
_____	_____
_____	_____

Have you ever been told you are allergic to latex? Yes ____ No ____

CURRENT MEDICATIONS

Medication	Dose (mg)	How many times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle if taking: Aspirin Plavix Coumadin

ILLNESS/SURGERY HISTORY

Do you now or have you had: (circle)

- | | | | |
|-------------------|------------------------|------------|-----------|
| Heart disease | High blood pressure | Diabetes | Stroke |
| Stomach ulcers | Acid reflux | Asthma | Arthritis |
| Bleeding problems | History of blood clots | Depression | Emphysema |
| Hypothyroidism | High Cholesterol | Hepatitis | |

Other Illnesses:

Operations:

Date:

PERSONAL HABITS:

Have you ever smoked? Yes _____ No _____ Quit? When _____
If you have smoked, how many packs a day? _____ For how many years _____

Do you drink alcohol? Yes _____ No _____
How many beers in a week? _____ Glasses of wine / week _____ Mixed drinks /week _____

Current employment: _____
If retired, what kind of work did you do? _____

FAMILY HISTORY: Have any members of your immediate family had?

	Relationship
High blood pressure	_____
Heart disease	_____
Stroke	_____
Diabetes	_____
Blood clots	_____
Cancer	_____
Anesthetic problems	_____

HEALTH QUESTIONS (Circle all that apply to you, or circle "none" if no symptoms)

GENERAL:

Losing weight Yes No How much? _____

Appetite loss Fatigue Chills Fevers None

EYES:

Vision loss – one eye Double vision Vision loss – both eyes Blurring None

EARS/NOSE/THROAT:

Difficulty swallowing Painful swallowing Hoarseness

Nosebleeds Sore throat Earache Sores in the mouth None

ENDOCRINE:

Thyroid problems Heat intolerance Cold intolerance Weight change

Excessive urination Excessive thirst None

NEUROLOGIC:

Sudden arm/leg weakness, paralysis, or numbness Inability to speak

Severe headaches Poor balance Loss of coordination Falling down

Seizure Fainting Severe dizziness Room spinning

Sudden vision loss Double vision None

SKIN:

Skin cancer Poor wound healing Rash

Slowly healing ulcers or changing moles None

LUNGS:

Wheezing Sleep disturbances due to breathing Cough

Shortness of breath at rest Coughing up blood Chest Discomfort

Excessive sputum Excessive snoring History of tuberculosis None

CARDIOVASCULAR:

Difficulty breathing Palpitations Chest pain or discomfort

Racing/skipping heart beats Swelling of legs Lightheadedness

Fainting Shortness of breath with exertion Leg cramps with exertion

Heart murmur Weight gain Abnormal cholesterol level

Has anyone in your family had heart problems before age 60? _____ None

GASTROINTESTINAL:

Loss of appetite Abdominal pain Vomited blood

Blood in your stools Change in bowel habits Heartburn Indigestion

Nausea Vomiting Diarrhea Dark tarry stools Ulcers

Constipation Yellow skin color None

GENITOURINARY:

Frequent urination Blood in urine Painful urination

Inability to empty bladder Night time urination Poor erections

Trouble starting urinary stream Inability to control bladder None

MUSCULOSKELETAL:

Joint swelling Joint pain Muscle cramps Muscle aches

Back pain Muscle weakness Gout Arthritis None

PSYCHIATRIC:

Anxiety Depression None

BLOOD/LYMPHATIC:

Skin discoloration Bleeding Enlarged lymph nodes

Abnormal bruising Night sweats None

ALLERGIC/IMMUNOLOGIC:

Seasonal allergies Hives or rash HIV exposure None

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

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.

We are required by law to maintain the privacy of your health information and to give you notice of our legal duties and privacy practices with respect to your protected health information. This Notice summarizes our duties and your rights considering your protected health information. Our duties and your rights are set forth more fully in 45 C.F.R., part 164. We are required to abide by the terms of the Notice that is currently in effect.

USES AND DISCLOSURES OF INFORMATION THAT WE MAY MAKE WITH YOUR WRITTEN AUTHORIZATION

We may use or disclose protected health information for the following purposes without your written authorization. These examples are not meant to be exhaustive.

- | | | |
|-------------------------------------|---|--------------------------------|
| * Treatment | * Health Oversight Activities | * Research |
| * Payment | * Judicial and Administrative | * Worker's Compensation |
| * Healthcare Operations | * Law Enforcement | * Marketing |
| * Required by Law | * National Security | * Business Associates |
| * Threat to Health or Safety | * Public Health Activities | * Military |
| * Abuse or Neglect | * Coroners and Funeral Directors | * Inmates or Persons in |
| * Communicable Diseases | * Organ Donation | * Police Custody |

USES AND DISCLOSURES OF INFORMATION THAT WE MAY MAKE UNLESS YOU OBJECT

We may use and disclose protected health information in the following instances without your authorization unless you object. If you object, please notify the Privacy Contact identified below.

* **Persons Involved in Your Health Care.** We may disclose information to a member of your family, relative, close friend, or other person identified by you who is involved in your health care or the payment of your health care. We will limit disclosure to the information relevant to that person's involvement in your health care or payment.

* **Notification.** We may use or disclose protected health information to notify a family member or other person responsible for your care of your location and condition. Among other things, we may disclose protected health information to a disaster relief agency to help notify family members.

USES AND DISCLOSURES OF INFORMATION THAT WE MAY MAKE WITH YOUR WRITTEN AUTHORIZATION

We will obtain a written authorization from you before using or disclosing your protected health information for purposes other than those summarized above. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below.

YOUR RIGHTS CONCERNING YOUR PROTECTED HEALTH INFORMATION

You have the following rights concerning your protected health information. To exercise any of these rights you must submit a written request to the Privacy Contact identified below.

- | | |
|---|--|
| * Right to Request Additional Restriicts | * Right to Request Amendment to Record |
| * Right to Receive Communications by Alternative Means | * Right to an Accounting of Certain Disclosures |
| * Right to Inspect and Copy Records | * Right to a Copy of this Notice |

CHANGES TO THIS NOTICE

We reserve the right to change the terms of our Notice of Privacy Practices at any time, and to make the new Notice provisions effective for all protected health information that we maintain. If we materially change our privacy practices, we will prepare a new Notice of Privacy Practices, which shall be effective for all protected health information that we maintain. We will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the current Notice in our reception area, or by contacting the Privacy Contact identified below.

COMPLAINTS

You may complain to us or to the Secretary of Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Contact identified below. All complaints must be in writing. We will not retaliate against you for filing a complaint.

PRIVACY CONTACT

If you have any questions about this Notice or if you want to object to or complain about any use or disclosures or exercise any right as explained above, please contact our Privacy Officer:

Cardiothoracic & Vascular Associates
333 N. 1st St. #280 * Boise ID 83702 * (208) 345-6545

CARDIOTHORACIC & VASCULAR ASSOCIATES

FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

Dear Patient:

Thank you for choosing the physicians at Cardiothoracic & Vascular Associates as your healthcare provider. We appreciate the opportunity to provide you with professional specialized care.

The following is our financial policy. We believe having financial matters clear from the onset is preferable to encountering difficulties later on. If you have any questions or concerns about our payment policies, please do not hesitate to talk with our billing department.

Payment for services is due at the time service is rendered. We accept cash, checks, debit cards, MasterCard, Visa and Discover. We will submit an insurance claim on your behalf if we have all your insurance information. If your insurance carrier changes, please notify the Billing Department immediately.

You must understand the following:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you—not your insurance company. Please make sure our receptionist has all of your correct information on file when you sign in at each visit.
2. Prior to your surgery you will meet with our patient representative to review your surgical charges. Please understand this is only an estimate and your procedure could change once the physician begins the surgery. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services, along with unpaid deductibles, coinsurance and co-payments, are due at the time of treatment.
3. You are responsible for knowing your insurance benefits. Does your insurance require a referral? Do our physicians participate in your plan? What facilities participate in your plan? If we can be of any assistance, please let us know and we will be happy to help you.
4. Accounts not paid within 90 days may be forwarded to a billing company where additional fees may be accrued.
5. CVA reserves the right to charge a \$20 service fee for checks returned due to insufficient funds.
6. If you have inadequate or no insurance coverage, advance planning for payment before surgery will be required. The fee for surgery will normally include your postoperative office visits for a period up to 90 days.
7. You are responsible for any and all collection fees, legal fees and court costs associated with efforts to collect payment on your account.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems with our Billing Department so that we can assist you in the management of your account.

Print Patient Name

Date

Patient Signature