PLEASE USE ONLY BLACK INK

Name: **Today's Date** **Date of Birth**

Medications

Please bring with you all medications that you are currently taking in their bottles
This includes any vitamins, supplements, inhalers, etc...

Medical History: (Have you eve had the following?)

High Blood pressure	no	yes	Cancer	no	yes
High Cholesterol	no	yes	Type:		
Diabetes	no	yes	Polio	no	yes
Diabetes pregnancy only	no	yes	Glaucoma	no	yes
Coronary artery disease	no	yes	Hernia	no	yes
Colon Cancer or Polyps	no	yes	Transfusion	no	yes
Inflammatory Bowel Disease	no	yes	Back Trouble	no	yes
Crohn's Disease	no	yes	Low Blood Pressure	no	yes
Breast Cancer	no	yes	Hemorrhoids	no	yes
Chickenpox	no	yes	Asthma	no	yes
Scarlet Fever	no	yes	Hives or Eczema	no	yes
Pneumonia	no	yes	AIDS or HIV	no	yes
Rheumatic Fever	no	yes	Infectious Mono	no	yes
Heart Attack	no	yes	Bronchitis	no	yes
Arthritis	no	yes	Mitral Valve Prolapse	no	yes
Venereal Disease	no	yes	Fibromyalgia	no	yes
Anemia	no	yes	Hepatitis	no	yes
Bladder Infections	no	yes	Ulcer	no	yes
Epilepsy	no	yes	GERD	no	yes
Migraines	no	yes	GI Bleed	no	yes
Tuberculosis	no	yes	Kidney Disease	no	yes
Thyroid Disease	no	yes	Any metal in	no	yes
Bleeding Disorder	no	yes	your body		
Pregnancy Status:	no	yes	If yes, where?		
_____ pregnant	no	yes	Are you receiving:		
_____ not pregnant	no	yes	Radiation therapy	no	yes
_____ Chance of pregnancy	no	yes	Chemotherapy	no	yes
			Oral steroid medication	no	yes
Are you allergic to IVP (contrast dye for radiology procedures)?				no	yes
Any allergies to medications?				no	yes

If yes, which medications and reactions?

Medication:	Reaction:

Previous surgeries:

Colectomy (removal of entire colon)	no	yes	Hysterectomy(removal of uterus)	no	yes
Mastectomy (removal of breast)	no	yes	If yes, do you still have both ovaries?	no	yes
Splenectomy(removal of spleen)	no	yes	Cholecystectomy		
Other:	no	yes	(removal of gallbladder)	no	yes

Previous Hospitalizations:

Hospital:	Date:	Reason:

Preventative Medicine: Please list to the best of your ability the date of your last:

EKG		Pap/Pelvic		PSA	
Cholesterol		Flexible Sigmoidoscopy		Colonoscopy	
Breast Exam		Chest X-Ray			
Mammogram		Stool cards/Hemoccults			
		Prostate/Rectal Exam			

Family History:

Structured Medical Problems *

PLEASE MARK "U" FOR AGE OF DIAGNOSIS IF NOT KNOWN

	Year of birth	Age at death	Diabetes (X) box	At what age? (approx.)	Hypertension (X) box **TYPE**	At what age:	Heart Attack	At what age	Cancer (X) box **TYPE**	At what age? (approx.)	High Cholesterol (X) box	Age
Father												
Mother												
Paternal Grandpa												
Grandma												
Maternal Grandpa												
Grandma												
Paternal Uncle(s)												
Paternal Aunt(s)												
Maternal Uncle(s)												
Maternal Aunt(s)												
Siblings												
Children												

Any Additional Health Problems:

Father: _____

Mother: _____

Paternal Grandpa: _____

Paternal Grandma: _____

Maternal Grandpa: _____

Maternal Grandma: _____

Paternal Uncles: _____

Paternal Aunts: _____

Maternal: Uncles: _____

Maternal Aunts: _____

Siblings: _____

_____

Children: _____

Tobacco Information: Are you a:_____Never smoked_____Current smoker_____Former smoker

_____Use chew_____Use pipe tobacco_____Smoke cigars If you are a current smoker:

How often do you smoke cigarettes?
___Every day? ___Some days, but not every day How many cigarettes a day do you smoke?
___5 or less ___6 to 10 ___11 to 20 ___21 to 30 ___31 +

How soon after waking up do you smoke your first cigarette?
___Within 5 minutes_____6 – 30 minutes_____31 – 60 minutes_____after 60 minutes
How long have you been smoking? _____

Are you interested in quitting?
___Ready to quit ___Thinking about quitting_____Not ready to quit
If a former smoker/tobacco user, **how long since you quit**? _____

Sexual History:
Have you had vaginal, oral or anal sex within the past 12 months: If yes, with:
_____Men only_____Women only _ Both men and women

Have you ever had an STD (sexually transmitted disease)? (circle) No/Yes If yes, circle which one(s):
Chlamydia Gonorrhea Syphillis Herpes HPV Genital Warts
HIV/Aids Trichomoniasis

Alcohol Information:
Did you have a drink containing alcohol in the past year?_____No____Yes

If yes: How often?	How many drinks on a typical drinking day?
___Monthly or less	___1-2
___2 -4 times per month	___3-4
___2-3 times per week	___5-6
___4 + per week	___7-9
	__ 10 +

How often did you have 6 or more drinks on one occasion in the past year?
_____Never__Less than monthly Monthly___Weekly_Daily or almost daily_

Immunization History: Please list to the best of your ability the year of your last:
Tetanus_____ Hepatitis B _____ Smallpox_____
Influenza _____ Chickenpox _____ Pneumovax _____

Social History
Do you use illicit or street drugs? (circle) No/Yes/ Pastuse; Type? _____
Marital Status: (circle) Single/Married/Divorced/Widowed/Cohabitating

Are you employed?_____No ___Yes If yes(circle)part-time or full-time?

Occupation?_____Are you currently a student?(circle) No/Yes; If yes, (circle) Full/ Part time

Do you exercise?_____No Yes How often, what type? _____

Do you use caffeine?_____No _____Yes If yes, is it more than 3 cups per day? ____

Do you travel outside of the United States? (circle) No or Yes If yes, where? _____

Do you use smoke detectors? (circle) No/Yes

Do you have any pets? (circle) No/Yes; If yes, what type/how many? _____

Northeastern Ohio Medical Specialists INC.

PATIENT: Name: _____ _____ _____
Last First M.I.

Address: _____ _____ _____ _____
Street City State Zip Code

Home Phone: (_____)_____ Cell Phone: (_____)_____
Can we leave a message: Y/N If so: Brief or Extended

SS#: _____-_____-_____

Sex: _____M_____F Date of Birth: _____/_____/_____

Employer Name: _____ Work Phone: (_____)_____

Address: _____ _____ _____ _____
Street City State Zip Code

Email address: _____

IF MARRIED, SPOUSE'S INFORMATION:

Name: _____ SS#: _____-_____-_____ Date of Birth: _____/_____/_____

Employer Name: _____ Work Phone: (_____)_____

Cell Phone: (_____)_____

NEAREST RELATIVE or (if a minor) RESPONSIBLE PARTY:

Name: _____ Phone: (_____)_____

Relationship: _____ Secondary Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip: _____

FOR PATIENTS 17 years of age or younger:

Primary Insurance Holder: _____ Date of Birth: _____/_____/_____

Social Security Number: _____-_____-_____ Employer: _____

Secondary Insurance Holder: _____ Date of Birth: _____/_____/_____

Social Security Number: _____-_____-_____ Employer: _____

◇ ◇ ◇ ***If you are a female and would like a chaperone to accompany you during any exam,*** ◇ ◇ ◇
◇ ◇ ◇ ***please let the Medical Assistant know.*** ◇ ◇ ◇

Primary Insurance Company: _____

Secondary Insurance Company: _____

Tertiary Insurance Company: _____

PLEASE GIVE YOUR INSURANCE CARD(S) AND PHOTO ID TO RECEPTIONIST FOR COPYING. THANK YOU!

Please provide us with your pharmacy information:

Local Pharmacy Name/Location: _____ *Phone Number:* _____

Mail Order Pharmacy Name: _____ *Phone Number:* _____

Do you have any of the following? If so, please allow us to scan a copy into our files.

Living Will: Y / N **Power of Attorney: Y / N** **Do Not Resuscitate Order (DNR): Y / N**

NORTHEASTERN OHIO MEDICAL SPECIALISTS, INC.

Authorization for Treatment, Assignment of Benefits and Information Release

I hereby request and consent to treatment and services reasonable and proper by today's standards provided by a physician of Northeastern Ohio Medical Specialists, Inc. (NEOMS), and authorize payment directly to the physician of the Medical and/or Surgical benefits, if any, otherwise payable to me by Medicare or any other insurance company, for his/her services, and I assume responsibility for any unpaid balance including non-covered services except as limited by law. I also hereby authorize the physician to release any information to Health Care Financing Agency or its agents, to third party payors and anyone assisting the provider in obtaining payment including billing, coding and collection agents, provider's attorney(s), consultants, and to my insurance company as acquired in the course of my examination and treatment. This authorization will remain in effect until revoked by me in writing.
I have reviewed and accepted the above Authorization, Assignment and Information Release:

Receipt of Notice of Privacy Practice/Written Acknowledgement Form

I have been offered and made available a copy of NEOMS, Inc. Privacy Practices. I know I may receive a copy at any time, including any revisions.

( ) I authorize my protected health information to be disclosed to the following person(s), with the understanding that I can revoke this authorization in writing at any time:

1. Name of Person Relationship

2. Name of Person Relationship

3. Name of Person Relationship

( ) I do not authorize my protected health information to be disclosed to anyone except those required by law that is stated in the privacy policy.

Our Financial Policy

I have received a copy of the Financial Policy. I have reviewed and accepted the Financial Policy.

Prescription History Consent

I grant permission for NEOMS, Inc. to access and view my prescription history from external sources.

I agree to all of the above:

Signature of Patient/Responsible Party **Date**

( ) Patient unable to sign due to:

Financial Policy

We are committed to providing you with the best medical care; if you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. Our office participates with a variety of insurance plans. It is your responsibility to:
    - Bring your insurance card to every visit.
    - Be prepared to pay your co-payment, if applicable, at each visit. Payment can be made by cash, check or credit card.
    - For medical care not covered under your insurance, payment in full is due at the time of visit.
2. If you are unable to pay for necessary medical care please keep in mind Partners Physician Group does offer a budgeting plan upon request.
3. If the patient is a minor (18 years and younger), the parent or guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at the time of service, bringing necessary referrals and insurance card.
4. Specific coverage issues should be directed to your insurance company member services department (the number should be listed on the insurance card).
5. If you fail to make a payment in full for services that are rendered to you within 90 days, your outstanding balance will be sent to a collections agency. You will be responsible for the fees assessed by the collections agency.
6. We request that if you must cancel your appointment that you do so 24 hours prior to your appointment. No-show appointments will incur a $25-50 fee.
7. Form fees are set by Partners Physician Group. They can range from $20-47 for most average forms. This fee is charged if you are not seen for a visit.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about billing, including financial arrangements, should be directed to Partners Physician Group at 877-700-1131

AKRON GENERAL

Notice of Privacy Practices

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

Akron General is committed to protecting your health information. This Notice tells you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of your health information. We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your health information. We are required to abide by the terms of this Notice so long as it remains in effect.

The privacy practices described in this Notice will be followed by all health care professionals, employees, medical staff, trainees, students, and volunteers of the Akron General Health System entities specified at the end of this Notice.

Uses & Disclosures of Your Health Information

The following categories describe different ways that we may use and disclose your health information.

Treatment. We may use or disclose your health information as necessary to provide you with medical treatment or services. For example, we may use your health information to provide health care to you, and we may consult with other health care providers about your treatment.

Payment. We may use and disclose your health information so that the treatment you receive at Akron General or another provider, such as an ambulance company, may be billed and payment collected from you, an insurance company, or another third party. For example, we may share your health information to request payment and receive payment from your health insurer, and to confirm that your health insurer will pay for your treatment. As another example, we may share your health information with the person who you told us is primarily responsible for paying for your treatment, such as your spouse or parent.

Health Care Operations. We may use and disclose health information about you that is necessary for the operations of Akron General. These uses and disclosures are made to assist us with providing quality care to our patients, for medical staff activities, for education and training purposes, and for our general business activities. For example, we may use your health information to evaluate the quality of services provided to you and to evaluate the performance of our staff providing care to you. Also, the entities covered by this Notice may share information with each other for their joint health care operations.

Appointment Reminders. We may use and disclose your health information to contact you with appointment reminders.

Treatment Alternatives. We may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose your health information to tell you about health-related benefits or services that may be of interest to you.

Fundraising Activities. We may contact you to provide information about Akron General-sponsored activities, including fundraising programs and events. For this purpose, we may use your contact information, such as your name, address, and phone number and the dates you received treatment or services at Akron General, as well as the department in which you received treatment or services, your treating physician, and the outcome of the treatment or service you received. You have the right to opt-out of receiving fundraising materials/ communications. If we do contact you for fundraising activities, the communication you receive will have instructions on how you may ask for us not to contact you again for fundraising purposes.

Facility Directory (Hospitals Only). If you are hospitalized, we may include your name, location in the hospital, general health condition, and religious affiliation (should you choose to provide one) in a patient directory without receiving your permission unless you tell us you do not want your information in the directory. Information in the directory will only be shared with individuals who ask for you by name or with members of the clergy; however, religious affiliation will only be shared with members of the clergy. You can choose not to have information released from the facility directory. If you do not want Akron General to release your information, from the facility directory,

please inform the person assisting you during registration and/or admission.

Family, Friends, and Others Involved in Your Care or Payment for Your Care. With your approval, we may disclose your health information to designated family, friends, and others who are involved in your care or in payment for your care in order to facilitate that person's involvement. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited health information with such individuals without your approval. We also may disclose limited health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates. We may provide your health information to outside persons or organizations who assist us with our health care operations. In all cases, these business associates are required to appropriately safeguard the privacy of your information.

Research. Federal regulations permit use of health information in medical research, either with your authorization or when the research study at Akron General is reviewed and approved by an Institutional Review Board before any medical research study begins. In some situations, limited information may be used before approval of the research study to allow a researcher to determine whether enough patients exist to make a study scientifically valid.

As Required by Law. We may disclose your health information as required by federal or state law.

Public Health Activities. We may disclose your health information for public health activities, such as (1) to report vital statistics (e.g., births, deaths); (2) to report communicable diseases to local, county, state, and federal health officials; (3) to report child abuse or neglect; and (4) to provide notification of product recalls.

To Avert a Serious Threat to Health or Safety. We may use and disclose your health information to avert a serious threat to your health or safety or the health and safety of the public or another person.

Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law. These oversight activities may include, for example, audits, investigations, inspections, and licensure that are necessary for oversight of the health care system, government benefit programs, and compliance with government programs and civil rights laws.

Lawsuits and Disputes. We may disclose your health information to courts and attorneys when we get a court order, subpoena, or other lawful instructions from those courts or public bodies. We may also disclose your health information to defend ourselves against a lawsuit brought against us.

Law Enforcement. We may disclose your health information to a law enforcement official for law enforcement purposes, such as (1) in response to a valid court order, subpoena, or search warrant; (2) to identify or locate a suspect, fugitive, witness, or missing person; and (3) to report a crime that occurred on our premises.

National Security and Intelligence Activities. We may disclose your health information to authorized federal officials so they may conduct intelligence, counter-intelligence, and other national security activities.

Coroners, Medical Examiners, and Funeral Directors. We may disclose your health information to coroners, medical examiners, and funeral directors as authorized or required by law as necessary for them to carry out their duties.

Organ and Tissue Donation. If you are an organ donor, we may disclose your health information to organizations that handle organ procurement or transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation or transplantation.

Inmates or Individuals in Custody. We may disclose your health information to a correctional institution if you are an inmate or under the custody of law enforcement officials, as authorized or required by law.

Military. We may disclose your health information to the military, if you are a member of the armed forces, as authorized or required by law.

Protective Services for the President and Others. We may disclose your health information to authorized federal officials so they may conduct special investigations or provide protection to the U.S. President or others.

Workers' Compensation. We may disclose your health information to workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Communication for Marketing Purposes and Sale of Health Information. If we wish to market health-related products or services to you or receive financial assistance in making the communication, or, if costs are reimbursed to us in exchange for sharing your health information, we will ask for your written authorization before using or disclosing any of your health information for these purposes.

Psychotherapy Notes. Most uses and disclosures of psychotherapy notes will be made only with your written authorization.

Other Uses of Health Information. Other uses and disclosures of your health information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer using the contact information at the end of this Notice. However, we are unable to take back any disclosures we have already made with your authorization.

Rights That You Have

The records we maintain about your care are the property of Akron General. You have the following rights, however, regarding the health information we maintain about you.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this Notice at any time. Copies of this Notice are available throughout Akron General or by contacting the Privacy Officer using the contact information at the end of this Notice.

Right to Inspect and Copy. You have the right to inspect and/or copy your health information. You are required to submit your request in writing to your caregiver or the appropriate medical records department. We may charge you a reasonable fee for copying your medical records. We may deny your request to inspect or copy your health information in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed.

If we maintain an electronic copy of your health information, and you request an electronic copy of your record, we will provide you with access to the electronic information in the electronic format requested by you, if it is readily producible, or, if not, in a readable electronic format as agreed to by Akron General and you. If requested, we will transmit an electronic copy to an entity or person you designate.

Right to Request Amendments. If you feel that health information about you is incorrect or incomplete, you have the right to ask us to amend the information. You may request an amendment for as long as we maintain the information. To request an amendment, you must submit your written request, along with an explanation as to why the amendment is needed, to the Privacy Officer using the contact information at the end of this Notice. If we accept your request we will tell you and amend your records. We cannot change what is in the record, but we will supplement the information. If we deny your request, we will provide you with a written explanation of why we did not make the amendment and explain your rights.

Right to an Accounting of Disclosures. You have the right to request a list of instances in which we have disclosed your health information. The list will not include (1) uses or disclosures made for treatment, payment, and health care operations; (2) information given to your family or friends with your permission or in your presence without objection; (3) disclosures made directly to you; (4) instances when you have given us a written authorization for the release of health information; or (5) information released for national security purposes or given to correctional institutions. To obtain this list, you must make a request in writing to the Privacy Officer using the contact information at the end of this Notice. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The first accounting you request in a 12-month period will be free. For additional lists, we may charge you for the cost of producing the list.

Right to Request Restrictions. You have the right to request that we place additional restrictions on our use and disclosure of your health information, including uses and disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. To request a restriction, you must tell your caregivers or contact the Privacy Officer using the information listed at the end of this Notice. You may be asked to submit your request in writing. We are not required to agree to your request. If we do agree, we will notify you in writing and will honor our agreement unless the information is needed to provide you emergency treatment or we are required or permitted by law to disclose it.

If you or another family member or person on your behalf have paid your health care provider in full for a particular health care service or item and specifically request that we not disclose information about this health care item or service to your health plan for payment or healthcare operations purposes, we will agree to this

request. We generally cannot restrict disclosure of information needed for health care treatment purposes.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To make such a request, you must tell your caregivers or contact the Privacy Officer using the information listed at the end of this Notice. We will honor reasonable requests. However, if we are unable to contact you using the requested methods or locations, we may contact you using any information we have.

Right to Notice of a Breach. If Akron General or any of its Business Associates or the Business Associates' subcontractors experiences a breach of your health information (as defined by HIPAA) that compromises the privacy or security of your health information, you will be notified of the breach and about any steps you should take to protect yourself from potential harm resulting from the breach.

Changes to this Notice

Akron General is required to abide by the terms of this Notice. However, we may change our notice at any time. The new notice will be effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice on Akron General's website, www.akrongeneral.org, and you may request a copy of the Notice currently in effect at any time through the entity at which you receive treatment or services or by contacting the PrivacyOfficer.

Complaints

If you think that we may have violated your privacy rights, or you disagree with a decision we made about your health information, you may file a complaint with our Privacy Officer using the contact information listed below. You also may send a written complaint to the Secretary of the Department of Health and Human Services. We will not punish you or retaliate against you if you file a complaint about our privacy practices:

Akron General Privacy Officer
1 Akron General Ave.
Akron, OH 44307
Phone: 330.344.4722
Email:privacyofficer@akrongeneral.org

Effective Date: This Notice of Privacy Practices is effective September 16, 2013.

The following entities have adopted and agree to follow this Notice:
Akron General Medical Center
Lodi Community Hospital
Edwin Shaw Rehab, LLC, Inc.
Akron General Partners, Inc.
Partners Physician Group
Akron Surgical Associates, LLC
Montrose Sleep Center, LLC
Community Health Ventures, Inc.
Visiting Nurse Service, Inc.
Hospice Care Ohio
Visiting Nurse Equipment & Supplies
Visiting Hours, Inc.
CHV Home Medical Equipment Company, LLC
Advanced Infusion Services, Ltd.
Akron General Foundation
All affiliates of Akron General Health System