****PLEASE USE ONLY BLACK INK****

Name:_____ **Date of birth:** _____

Medications: (Include dosage and frequency)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

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

High Blood Pressure	no yes	Cancer	no yes	Thyroid Disease	no yes
High Cholesterol	no yes	Type: _____		Bleeding Disorder	no yes
Diabetes	no yes	Polio	no yes	Any metal in your body	no yes
Diabetes only in pregnancy	no yes	Glaucoma	no yes	If yes, where?	
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 Press	no yes	Are you receiving:	
Breast Cancer	no yes	Hemorrhoids	no yes	Radiation therapy	no yes
Chickenpox	no yes	Asthma	no yes	Chemotherapy	no yes
Scarlet Fever	no yes	Hives or Eczema	no yes	Oral steroid medications	no yes
Pneumonia	no yes	AIDS or HIV	no yes	Pregnancy Status:	
Rheumatic Fever	no yes	Infectious Mono	no yes	____Pregnant	
Heart Attack	no yes	Bronchitis	no yes	____Not pregnant	
Arthritis	no yes	Mitral Valve Prolapse	no yes	____Chance of being pregnant	
Venereal Disease	no yes	Fibromyalgia	no yes	Other:	
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	_____	

Are you allergic to IVP (contrast dye for radiology procedures)? _____ No ____ Yes

Any allergies to medications?

____ No ____ Yes If yes, which medications and what reaction?

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 (removal of gallbladder)	no yes

Other:

_____ _____
_____ _____

Previous Hospitalizations:

Hospital:	Date:	Reason:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

EKG _____ Chest X-ray _____
Cholesterol _____ Stool Cards/Hemoccults _____
Breast Exam _____ Prostate/Rectal Exam_____
Mammogram _____ PSA _____ Pap/Pelvic _____
Flexible Sigmoidoscopy _____ Colonoscopy _____

Immunization History: Please list to the best of your ability the date of your last (we at least need the year):

Tetanus _____ Hepatitis B _____ Smallpox _____
Influenza _____ Chickenpox _____ Pneumovax _____

Family History:

	Please give year of birth:	Medical Problems:	Cause of Death if Deceased:
Father			
Mother			
Paternal (Dad's) Grandparents	Father Mother		
Maternal (Mom's) Grandparents	Father Mother		
Paternal Uncle(s)			
Paternal Aunt(s)			
Maternal Uncle(s)			
Maternal Aunt(s)			
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? **How many packs per day? _____**
____ 5 or less ____ 6 to 10 ____ 11 to 20 ____ 21 to 30 ____ 31 or more
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? ____ Yes ____ No
If yes, with: ____ Men only ____ Women only ____ Both men and women
Have you ever had an STD (sexually transmitted disease)? ____ Yes ____ No
If yes, select which one(s):
__Chlamydia __Gonorrhea __ Syphillis __Herpes __ HPV __ Genital Warts __ HIV/AIDS __ Trichomonas

Alcohol Information:
Did you have a drink containing alcohol in the past year? ____ No ____ Yes
If yes:
How often?
____ Monthly or less
____ 2 -4 times per month
____ 2-3 times per week
____ 4 or more times per week
How many drinks on a typical drinking day?
____ 1 – 2
____ 3 - 4
____ 5 - 6
____ 7 - 9
____ 10 or more
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

Social History:
Do you use illicit or street drugs? ____ No ____ Past use ____ Yes: Type? _____
Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed ____ Cohabitating
Children: How many? _____ Sons: _____ Daughters: _____
Are you employed? ____ No ____ Yes If yes, _____ part-time or _____ full-time? Occupation? _____
Are you currently a student? ____ No ____ Yes If yes, _____ part-time or ____ full-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? ____ No ____ Yes
Do you travel outside of the United States? ____ No ____ Yes If yes, where? _____
Do you use smoke detectors? ____ No ____ Yes
Do you have any pets? ____ 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: (_____)_____ Sex: _____M _____F Date of Birth: _____/_____/_____

Cell Phone: (_____)_____ SS#: _____-_____-_____

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!

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

Please provide us with your pharmacy information:

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

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

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: _____

NORTHEASTERN OHIO MEDICAL SPECIALISTS, INC.
NOTICE OF PRIVACY PRACTICES

This notice serves to inform you of our practice policy regarding the use and disclosure of your private health information. It is also designed to give you an understanding of your rights to access of your private health information and restrict unauthorized access.

The terms of this Notice of Privacy Practices are effective April 14, 2003. Northeastern Ohio Medical Specialists, Inc. will share patient health information as is necessary to provide quality health care and receive reimbursement for those services as permitted by law. Our office is required by law to maintain the privacy of our patients' health information and to provide patients with this Notice of Privacy Practices. Our office will abide by the terms of this Notice so long as it remains in effect and we reserve the right to change the terms of this Notice of Privacy Practices as necessary. A copy of any revised notices will be available in our office, or, by mail to your address on file upon request to:

Colin S. Moorhead, MD
470 White Pond Drive, Suite 100
Akron, OH 44320

USES AND DISCLOSURES OF YOUR HEALH INFORMATION

Our office is committed to maintain the confidentiality of your health information. However, your health information may be used and disclosed as customary and reasonable for purposes of treatment, payment, and health care operations and pursuant to a signed authorization form. You have the right to revoke that authorization in writing unless any action has been taken in reliance on the authorization.

Treatment, Payment and Health Care Operations. Except as otherwise provided, or with your signed consent, our office will use and disclose your health information for purposes of treatment, payment, and as otherwise necessary and permitted by law, for our health care operations. This may include disclosure to another health care provider who, at the request of your physician, becomes involved in your treatment, or for purposes of approval of reimbursement from your health plan.

Business Associates. At times, it may be necessary for us to provide your health information to certain outside persons or organizations that assist us with our health care operations, such as auditing, accreditation, legal services, etc. These business associates are required to sign an agreement stating their fiduciary responsibilities in using this private health information.

Family and Friends. If authorized by you, we will share your private health information with friends and family members to the extent that you authorize. In the case where you are incapacitated and we feel that disclosing limited health information is in your best interest, we will disclose such information to family and/or close friends for purposes of communication and decision-making.

Appointments and Services. Our office may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits issues. You have the right to request an alternate method of communications in writing and may send your request to:

Colin S. Moorhead, MD
470 White Pond Drive, Suite 100
Akron, OH 44320

Other uses and disclosures of your individual health information, permitted or required by law, may be made without your consent or authorization are as follows:

1. Any purpose required by law;
2. Public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations;
3. As required by law if we suspect child abuse or neglect; we may also release your individual health information as required by law if we believe you are a victim of abuse, neglect, or domestic violence;
4. If necessary, to the Food and Drug Administration;
5. To your employer when we have provided health care to you at the request of you employer;
6. If required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings;
7. If required by a court or administrative ordered subpoena or discovery request; in most cases you will have notice of such release;
8. To law enforcement officials;
9. To coroners and/or funeral directors consistent with law;
10. If necessary to arrange an organ or tissue donation or transplant;
11. If you are a member of the military as required by armed forces services; we may also release your individual health information if necessary for national or intelligence activities; and
12. To workers' compensation agencies.

YOUR RIGHTS

1. *Restrictions on Use and Disclosure of Individual Health Information.* You have the right to request restrictions on some of our uses and disclosures of your health information. We retain the right to refuse such restrictions if we believe such termination is appropriate. In the event of a refusal by us, we will notify you. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to:

Colin S. Moorhead, MD
470 White Pond Drive, Suite 100
Akron, OH 44320

2. *Access to Individual Health Information.* You have the right to inspection and copying your health information maintained by our office. Such a request must be made in writing. Please see our written practice policy regarding copying patient records and fees associated. You may obtain a request for access form from our office. In certain circumstances, you may not be permitted access (e.g., psychotherapy notes, information compiled for legal action, or information subject to prohibition by law). Depending on the circumstances, you may request a review of the decision to deny access.

3. *Amendments to Individual Health Information.* You have the right to request in writing that your health information maintained by our office be amended or corrected. Please contact **Colin S. Moorhead, MD** for questions about amendments to your health information.

4. *Accounting for Disclosures of Individual Health Information.* You have the right to request in writing to receive an accounting of certain disclosures made by us of your health information after April 14, 2003.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with:

Colin S. Moorhead, MD
470 White Pond Drive, Suite 100
Akron, OH 44320

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. in writing. There will be no retaliation for filing a complaint.

ADDITIONAL INFORMATION

If you have questions or need additional assistance regarding this Notice, you may contact:

Colin S. Moorhead, MD
470 White Pond Drive, Suite 100
Akron, OH 44320
330-869-8530
330-869-8539 Fax

If you would like a copy of this Notice of Privacy Practices, please ask the receptionist.

NORTHEASTERN OHIO MEDICAL SPECIALISTS, INC.

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. If you do not bring payment to your visit and we have to bill you, you will be assessed a $10 processing fee.
    - For medical care <u>not covered</u> under your insurance, payment in full is due at the time of visit.
2. If you have insurance that we <u>do not participate in</u>, our office is happy to file the claim upon request; however, payment in full is expected at the time of service.
3. If you are unable to pay for necessary medical care please keep in mind we do offer a budgeting plan upon request.
4. 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.
5. If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company member services department (the number should be listed on the insurance card).
6. 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.
7. We request that if you must cancel your appointment that you do so 24 hours prior to your appointment. No-show appointments for follow-ups will incur a $25 fee, history and physical appointments will incur a $50 fee.
8. If you need any forms filled out, there will be a fee of $25 for established office patients and a fee of $50 for hospital-only patients. This must be paid when the forms are given to us and they will be completed within one week (provided the needed documents are available) plus mail time if need be.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to the physician's billing manager.