

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I HAVE RECEIVED A COPY OF THE Notice of Privacy Practices of Dr. Magee (Heart Institute of Northwest Ohio) and have been provided an opportunity to review it.

I give permission for you and your associates to disclose my protected health information to the following person(s). This authorization will remain in effect until I request termination in writing.

Name

Relationship

Name

Relationship

Patient's Signature

Date

Print Name

MEDICAL HISTORY

PLEASE COMPLETE EACH SECTION.

NAME: _____ APPT DATE: _____ AGE: _____
MALE / FEMALE _____ DATE OF BIRTH: _____ HEIGHT: _____ WEIGHT: _____
REFERRING PHYSICIAN _____ FAMILY PHYSICIAN _____

WHAT IS YOUR PRIMARY PURPOSE FOR YOUR OFFICE VISIT? _____
HOW LONG HAS THE CONDITION BEEN PRESENT? _____ DESCRIBE YOUR SYMPTOMS: _____

PAIN? LOCATION OF PAIN _____
(CIRCLE ALL THAT APPLY) SEVERITY: MILD / MODERATE / SEVERE
TYPE OF PAIN? ACHING / BURNING / SHARP / DULL / CRAMPING
WHAT MAKES THE PAIN BETTER? SITTING / STANDING / LYING DOWN / OTHER _____
WHAT MAKES THE PAIN WORSE? SITTING / STANDING / WALKING / OTHER _____

BLEEDING? LOCATION _____ BULGE? LOCATION _____

NUMBNESS? LOCATION _____ SWELLING? LOCATION _____

FOR VARICOSE VEIN PATIENTS: ARE YOU CURRENTLY USING COMPRESSION STOCKINGS Y / N ?
FOR HOW LONG? OVER 3 MONTHS / OVER 6 MONTHS? / OVER ONE YEAR.
HAVE YOU PREVIOUSLY WORN COMPRESSION STOCKINGS? Y / N HOW LONG? _____
HAVE YOU TRIED ANTI INFLAMMATORY MEDICATIONS (IBUPROFEN, MOTRIN, ADVIL) Y / N ?
IF YES, WHICH MEDICATION _____ FOR HOW LONG? _____

CHECK ALL ILLNESS YOU HAVE BEEN TREATED FOR IN THE PAST OR ARE IN TREATMENT FOR PRESENTLY:

_____ ANEMIA	_____ ANEURYSM	_____ ANGINA	_____ ARTHRITIS
_____ ASTHMA	_____ ATRIAL FIB	_____ BLADDER INFECTION	_____ BLOOD CLOTS
_____ BLOOD PRESSURE: HIGH / LOW		_____ CHOLESTEROL (HIGH)	_____ BRONCHITIS
_____ CANCER – TYPE _____			_____ CATARACTS
_____ CIRRHOSIS	_____ COPD	_____ CROHN'S DISEASE	_____ COLITIS
_____ DEPRESSION	_____ DIABETES	_____ DIVERTICULITIS	_____ EMPHYSEMA
_____ GALLBLADDER	_____ REFLUX	_____ HEART MURMUR	_____ HEART DISEASE
_____ CONGESTIVE HEART FAILURE		_____ HEART ATTACK	_____ HEADACHES
_____ HEPATITIS A / B / C		_____ HERNIA	_____ KIDNEY STONES
_____ KIDNEY INFECTIONS		_____ PHLEBITIS	_____ SEIZURES
_____ STROKE	_____ TUBERCULOSIS	_____ THYROID DISEASE	_____ OTHER

CHECK ALL SURGERIES YOU HAVE HAD: _____ NONE _____ APPENDIX _____ ANEURYSM REPAIR
_____ C-SECTION _____ CARDIAC CATH _____ CATARACT _____ COLON RESECTION
_____ COLOSTOMY _____ HERNIA _____ HEART BYPASS _____ HYSTERECTOMY
_____ LUNG _____ GALLBLADDER _____ HIP REPLACEMENT _____ KNEE REPLACEMENT
_____ PACEMAKER _____ THYROID _____ TONSILLECTOMY _____ TUBAL LIGATION
_____ VEIN STRIPPING

WHEN WAS YOUR LAST COLONOSCOPY? _____ MAMMOGRAM? _____
CHEST X-RAY? _____ EKG? _____

SOCIAL HISTORY

PLEASE COMPLETE EACH SECTION.

WHAT TYPE OF WORK DO YOU DO? _____
CAFFEINE (CUPS/CANS/DAY) _____ TOBACCO (PACKS PER DAY) _____ YEARS _____
QUIT? _____ WHAT YEAR? _____
ALCOHOL CONSUMPTION (TYPE) _____ AMOUNT? _____

FAMILY HISTORY (LIST ANY SIGNIFICANT ILLNESSES OF FAMILY MEMBERS)

FATHER: LIVING? _____ HEALTH PROBLEMS _____
DECEASED? AGE OF DEATH _____ CAUSE? _____
MOTHER: LIVING? _____ HEALTH PROBLEMS _____
DECEASED? AGE OF DEATH _____ CAUSE? _____
SIBLINGS: LIVING? _____ HEALTH PROBLEMS _____
DECEASED? AGE OF DEATH _____ CAUSE? _____
LIVING? _____ HEALTH PROBLEMS _____
DECEASED? AGE OF DEATH _____ CAUSE? _____
LIVING? _____ HEALTH PROBLEMS _____
DECEASED? AGE OF DEATH _____ CAUSE? _____

DRUG ALLERGIES: _____

DO YOU HAVE A HISTORY OF ALLERGY / REACTION TO X-RAY DYE, SEAFOOD OR IODINE? _____

MEDICATIONS: None _____

Medication	Dose / Frequency
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____
11. _____	_____
12. _____	_____

OTHER HISTORY

PLEASE CIRCLE ANY PROBLEM YOU HAVE, OR HAVE BEEN TREATED FOR IN THE PAST.

GENERAL: FEVER CHILLS WEIGHT LOSS NIGHT SWEATS CHANGE IN APPETITE FATIGUE

EYES: CATARACTS DOUBLE VISION PAIN ON EXPOSURE TO LIGHT LOSS OF VISION

EAR/NOSE/THROAT: HEARING LOSS SINUS CONGESTION NASAL POLYPS HOARSENESS

RESPIRATORY: COUGHING UP BLOOD EMPHYSEMA BRONCHITIS SHORTNESS OF BREATH
CHRONIC COUGH DIFFICULTY SWALLOWING

CARDIOVASCULAR: HIGH BLOOD PRESSURE HEART DISEASE HEART MURMUR
ANGINA CHEST PAINS RHEUMATIC FEVER

GASTROINTESTINAL: PAIN WITH SWALLOWING HEARTBURN BELCHING GAS ABDOMINAL PAIN
DUODENAL OR GASTRIC ULCER LIVER DISEASE JAUNDICE HEPATITIS A, B, C
GALLBLADDER DISEASE CONSTIPATION DIARRHEA BLACK STOOLS BLOOD IN STOOLS
CHANGE IN BOWEL HABITS INDIGESTION NAUSEA VOMITING

GENITOURINARY: KIDNEY OR BLADDER INFECTIONS BLOOD IN URINE KIDNEY STONES
INCONTINENCE ENLARGED PROSTATE SEXUAL DYSFUNCTION
SEXUALLY TRANSMITTED DISEASE HOMOSEXUAL ACTIVITY

GYNECOLOGIC: ABNORMAL MENSTRUAL BLEEDING IRREGULAR PERIODS PAINFUL INTERCOURSE
FREQUENT PELVIC INFECTIONS ENDOMETRIOSIS DATE OF LAST MENSTRUAL CYCLE _____

MUSCULOSKELETAL: PAINFUL OR SWOLLEN JOINTS PAINFUL OR SWOLLEN MUSCLES

NEUROLOGICAL: FREQUENT HEADACHES MIGRAINES EPILEPSY SEIZURES
PASSING OUT OR DIZZY SPELLS NUMBNESS OR TINGLING OF ARMS / LEGS STROKE

SKIN AND BREAST: BREAST LUMPS BREAST CANCER BREAST DISCHARGE MELANOMA TATTOOS

EMOTIONAL: DEPRESSION ANXIETY EXCESSIVE NERVOUSNESS

BLOOD: ANEMIA BLEEDING DISORDER TRANSFUSION OF BLOOD / BLOOD PRODUCT

ENDOCRINE: DIABETES THYROID DISEASE

ALLERGIC / IMMUNOLOGIC: LUPUS HIV / AIDS

CANCER: ANY TYPE OF PREVIOUS CANCERS _____

FINANCIAL POLICY
HEART INSTITUTE OF NORTHWEST OHIO, INC.

Please read this document carefully and sign the bottom indicating that you understand and agree to comply with these policies.

Our office automatically files your insurance claims. Complete and accurate information regarding all insurance carriers will be needed at each visit.

All co-pays and deductibles are due at the time of service.

We will accept cash, checks, Visa, MasterCard and money orders as payment for services rendered.

If there is no insurance carrier at the time of service, you will be responsible for full payment. Contact our billing department to arrange payment.

To accommodate the needs of our patients, we have enrolled in numerous managed care insurance programs. While we are pleased to be able to provide this service to you, it is not realistic for us to keep track of all individual requirements of each plan. Each plan has different restrictions regarding how often services may be rendered and more importantly, type of contract your employer has negotiated.

You will be billed in full for any services that your insurance carrier denies or any balances due after we have received payment from your insurance carrier. Please call your insurance carrier if you question the amount of payment made. **DO NOT ASSUME THAT YOU HAVE FULL COVERAGE AND THE ENTIRE BILL WILL BE PAID.**

Patients who receive insurance payments from their insurance carrier are required to forward payment to this office in a timely manner.

It is your responsibility to contact your insurance carrier if payment has not been received within 60 days of date of service.

We may give out your patient health information for our payment continuity of care or our health care operations.

Medical Forms: Forms that need to be filled out for disability, loans (i.e., car, house, etc.), family medical leave, etc. for the patient will be charged \$10.00 per form and must be paid before the form is completed. Forms cannot be completed as you wait. Please allow 7-10 days to be completed.

Aged Accounts: Accounts not paid in a timely manner may be turned over to a collection agency.

I request that payments from my insurance company be made on my behalf to The Heart Institute of Northwest Ohio, Inc. for any services furnished to me by their physicians. I authorize this practice to release any medical information needed to determine benefits payable for services rendered to the Health Care Financing Administration and its agents.

Signature: _____

Date: _____