

DATE	CHART NUMBER
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**PATIENT / ACCOUNT INFORMATION
THE TOLEDO CLINIC**

DOCTOR	PRIMARY CARE PHYSICIAN & CITY
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A. PATIENT INFORMATION

NAME LAST	FIRST	INITIAL	DATE OF BIRTH	AGE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER
MAIDEN NAME	ADDRESS	CITY	STATE	ZIP CODE		
HOME PHONE	CELLULAR PHONE	E-MAIL ADDRESS	MARITAL STATUS	SPOUSES NAME		
EMERGENCY CONTACT	RELATIONSHIP	PHONE	EXT	CELLULAR PHONE		
ADDITIONAL CONTACT	RELATIONSHIP	PHONE	EXT.	CELLULAR PHONE		
PREFERRED METHOD OF CONTACT <input type="checkbox"/> CELLPHONE <input type="checkbox"/> HOME PHONE <input type="checkbox"/> E-MAIL <input type="checkbox"/> TEXT	RACE <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> HAWAIIAN OR PACIFIC ISLANDER <input type="checkbox"/> WHITE <input type="checkbox"/> OTHER <input type="checkbox"/> UNKNOWN <input type="checkbox"/> DECLINED	ETHNICITY <input type="checkbox"/> HISPANIC OR LATINO <input type="checkbox"/> NOT HISPANIC OR LATINO <input type="checkbox"/> UNKNOWN <input type="checkbox"/> DECLINED	LANGUAGE <input type="checkbox"/> ARABIC <input type="checkbox"/> CHINESE <input type="checkbox"/> ENGLISH <input type="checkbox"/> FRENCH <input type="checkbox"/> JAPANESE <input type="checkbox"/> SPANISH <input type="checkbox"/> VIETNAMESE <input type="checkbox"/> UNKNOWN <input type="checkbox"/> DECLINED			

B. PERSON RESPONSIBLE FOR PAYMENT - IF PATIENT IS A CHILD, THE PERSON WHO HAS CUSTODY

NAME LAST	FIRST	INITIAL	DATE OF BIRTH	AGE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER
ADDRESS	CITY	STATE	ZIP CODE			
HOME PHONE	CELLULAR PHONE	E-MAIL ADDRESS				

C. INSURANCE INFORMATION

INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER			
ADDRESS	CITY	STATE	ZIP CODE		
NAME OF POLICY HOLDER	DOB OF POLICY HOLDER	EFFECTIVE DATE	RELATIONSHIP TO PATIENT		
INSURANCE EMPLOYER NAME	PCP CO-PAYMENT AMT	SPECIALIST CO-PAY AMT			

INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER			
ADDRESS	CITY	STATE	ZIP CODE		
NAME OF POLICY HOLDER	DOB OF POLICY HOLDER	EFFECTIVE DATE	RELATIONSHIP TO PATIENT		
INSURANCE EMPLOYER NAME	PCP CO-PAYMENT AMT	SPECIALIST CO-PAY AMT			

I CONFIRM THAT THE ABOVE INFORMATION IS CORRECT.

SIGNATURE

DATE

L-2846

HEALTH HISTORY FORM NORTHWEST OHIO ORTHOPEDICS

DATE:

PATIENT Last Name	First	Age	Height	Weight
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MEDICATION LIST	DOSE & FREQUENCY	SURGERIES	YEAR	ALLERGIES (circle yes or no)	
				Yes No	Adhesive tape
				Yes No	Antibiotics
				Yes No	Aspirin
				Yes No	Codeine
				Yes No	Demerol
				Yes No	Foods like shellfish
				Yes No	Iodine or Merthiolate
				Yes No	Latex
				Yes No	Morphine
				Yes No	Penicillin
				Yes No	Sulfa drugs
				Other:	

**List additional medications on back of form.

FAMILY HISTORY - HAS ANY BLOOD RELATIVE HAD ANY OF THE FOLLOWING? (circle yes or no and explain)

yes no	Arthritis	yes no	Stroke
yes no	Bleeding problems	yes no	Mental illness
yes no	Cancer	yes no	Stomach problems
yes no	Convulsion/epilepsy	yes no	Kidney Problems
yes no	Diabetes	yes no	Suicide
yes no	Gall bladder problem	yes no	Thyroid
yes no	High Blood Pressure	yes no	Tuberculosis
yes no	Heart Problems	yes no	Ulcers

PERSONAL HEALTH HISTORY (circle yes or no and explain briefly)

SKELETAL		SOCIAL / WORK HISTORY	
yes no	Osteoporosis	yes no	Married, single, divorces, widow
yes no	Rheumatoid arthritis	yes no	Children
yes no	Gout	yes no	Do you live alone?
yes no	Bone infection	yes no	Do you exercise?
yes no	Fracture/broken bones	yes no	Special diet?
yes no	History of falls	yes no	Do you smoke? Packs per day?
yes no	Muscle problems	yes no	Former Smoker? How long ago?
RESPIRATORY		yes no	caffeine
yes no	Asthma or Emphysema	yes no	alcohol
yes no	TB - Tuberculosis	yes no	Working/occupation?
yes no	Sleep Apnea	yes no	Workers Comp Injury?
yes no	Shortness of Breath	GASTRO-INTESTINAL	
yes no	Chronic Cough	yes no	Diabetes
yes no	Sinus Problems	yes no	Liver disease
yes no	Blood Clot in lungs	yes no	Hepatitis/type
CIRCULATORY		yes no	Ulcers
yes no	High Blood Pressure	yes no	Weight loss/gain
yes no	Heart Murmur	yes no	Swallowing difficulties
yes no	Mitral Valve Prolapse	yes no	Hiatus hernia/GERD/reflux
yes no	Heart Attack (MI)	yes no	Diarrhea or constipation
yes no	Pacemaker	NEUROLOGIC	
yes no	Angina/Chest Pain	yes no	Seizure/epilepsy
yes no	Blood Clots or bleeding	yes no	Strokes/Mini Stroke/TIA
yes no	A-Fib	yes no	Dizziness/lightheadedness
yes no	Congestive Heart Failure	yes no	Numb/tingling hands/feet
OTHER		yes no	Nervousness or anxiety
yes no	Pregnant	yes no	Depression
yes no	Cancer	OTHER PROBLEMS	
yes no	MRSA/VRE/HIV		
yes no	Thyroid Problems		

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.

Toledo Clinic Inc.'s Notice of Privacy Practices for Protected Health Information

I. Uses and Disclosures of Your Medical Information.

A. Treatment, Payment, and Operations.

Toledo Clinic, Inc. (sometimes referred to as "we" or "us") is permitted to use your medical information for purposes of treating you, to obtain payment for providing medical services to you, and to assist in its health care operations. We may also use your medical records to assess the appropriateness and quality of care that you received, improve the quality of health care, and achieve better patient outcomes. An understanding of what is in your health records and how your health information is used helps you: ensure its accuracy and completeness; understand who, what, where, why, and how others may access your health information; and make informed decisions about authorizing disclosures to others.

(i) Use of your protected health information for treatment purposes. A physician or another member of your health care team will record information in your record to diagnose your condition and determine the best course of treatment for you. We will also provide your primary physician, other health care professionals, or a subsequent health care provider, copies of your records to assist them in treating you.

(ii) Use and disclosure of your protected health information for purposes of payment. We may send a bill to you or to a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatment received, and supplies used.

(iii) Use and disclosure of your protected health information for healthcare operations. Health care operations consist of activities that are necessary to carry out our operations as a healthcare provider, such as quality assessment and improvement activities. For example, members of our medical staff, the risk or quality improvement manager, or members of the quality assurance team may use information in your health record to assess the care and outcomes in your cases and the competence of the caregivers. We will use this information in an effort to continually improve the quality and effectiveness of the health care and services that we provide.

B. Appointment Reminders. We may contact you at home to provide appointment reminders unless you specify otherwise in writing to us.

C. Other purposes for which we can use your protected health information without written authorization from you.

In addition to using your protected health information for purposes of treatment, payment, and health care operations, we may use or disclose your protected health information without your written authorization and without giving you an opportunity to object in the following situations:

(i) As Required by Law. We may use or disclose your protected health information as required by law. We will limit the disclosure to those portions relevant to the requirements of the law.

(ii) Public Health Activities. We may use or disclose your protected health information to public health entities authorized to collect information for the purposes of controlling or preventing disease (including sexually transmitted diseases), injury, or disability. We may also disclose to governmental agencies authorized to receive reports of child abuse or neglect. We may disclose protected health information to the Food and Drug Administration relative to adverse effects/events with respect to food, drugs, supplements, product or product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

(iii) Medical Surveillance of the Workplace and Work-related Injuries. We may provide your protected health information to your employer if we are asked by your employer to provide medical services to you for purposes of medical surveillance of the workplace or a work-related illness or injury.

(iv) Victims of Abuse, Neglect, or Domestic Violence. To the extent authorized or required by law, and in the exercise of our doctor's professional judgment, we believe the disclosure is necessary to prevent harm, we may disclose protected health information to law enforcement officials.

(v) Health Oversight Activities. We may disclose your protected health information to a governmental health oversight agency overseeing the health care system, governmental benefit programs, or compliance with governmental program standards.

(vi) Judicial and Administrative Proceedings. We may disclose your protected health information in response to an order of a court or a valid subpoena.

(vii) Law Enforcement Purposes. We may disclose health information for law enforcement purposes

as required by law or in response to a valid subpoena or we may provide limited information for identification or location purposes.

(viii) Information About Deceased Individuals. We may disclose your protected health information to coroners and medical examiners to carry out their official duties, and to funeral directors as necessary to carry out their duties to the deceased individual.

(ix) Organ, Eye, or Tissue Donation. We may disclose protected health information to organ procurement agencies for the purpose of facilitating organ, eye, or tissue donation or transplantation.

(x) Research Purposes. We may disclose protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

(xi) Avoidance of Serious Threat to Health or Safety. We may disclose protected health information if we believe in good faith that such disclosure is necessary to prevent or lessen a serious and immediate threat to health and safety of a person or the public.

(xii) Certain Specialized Governmental Functions. If you are Armed Forces or foreign military personnel, we may disclose your protected health information to your appropriate military command. We may disclose your protected health information to a governmental agency as authorized by the National Security Act or for the protection of the President of the United States, as required by law.

(xiii) Correctional Institutions. If you are an inmate, we may disclose your protected health information to the correctional institution or law enforcement in the course of providing care to you or the health and safety of others responsible for your custody or other inmates.

(xiv) Disclosures for Workers' Compensation. We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

D. Other uses and disclosures of your protected health information will only be made with your prior written authorization.

This includes, but is not limited to: (i) uses and

disclosures of psychotherapy notes (if applicable); (ii) certain uses and disclosures for marketing purposes, including direct or indirect remuneration to Toledo Clinic; (iii) uses and disclosures that constitute a sale of your protected health information; and (iv) other uses and disclosures not described herein. You may revoke an authorization at any time, provided you do so in writing. We will honor such a revocation except to the extent that we had already taken action in reliance upon your prior authorization.

II. Your Individual Rights. You have the following rights under federal law with respect to your protected health information and may exercise them in the following manner:

A. The Right to Request Restrictions on the Use of Protected Health Information. You have the right to request that we restrict the use of your protected health information. You have the right to request that we limit our disclosure of your protected health information to treatment, payment, and healthcare operations and disclosures to individuals (family members) involved in your care. Such a restriction, if agreed to by us, will not prevent permitted or required uses and disclosures of protected health information. We are not required to agree to any requested restriction. You also have the right to restrict certain disclosures to a health plan if and when you pay out of pocket and in full for the health care item or service.

B. The Right to Receive Confidential Communications of Protected Health Information by Alternative Means. We must accommodate a reasonable written request by you to receive communications of your protected health information by alternative means (e.g., via e-mail) or at an alternative location (e.g., at your place of employment rather than at home).

C. The Right to Inspect and Copy your Medical Records. You have the right to inspect and obtain a copy from us of your protected health information in our possession, including an electronic copy of your protected health information that we maintain electronically in a designated record. We may impose a reasonable cost-based fee for the labor involved and supplies used for creating the copy of your medical records.

D. The Right to Amend Protected Health Information. You have the right to have us amend protected health information in our possession. You must make the request in writing and provide supporting reason(s) for the requested amendment. If we grant the request, we will notify you, and we will make the correction and distribute the correction to those who need it and those whom you identify to us that you want to receive the corrected information.

E. The Right to Receive an Accounting of Disclosures of Protected Health Information. You have the right to obtain an accounting of disclosures by us of your protected health information, other than for purposes of treatment, payment, and health care operations. Depending on whether your particular doctor has incorporated electronic health records into his or her medical practice, you may have the right to obtain an accounting of all disclosures of protected health information. The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.

F. The Right to Obtain a Paper copy of this Notice Upon Request. You have the right to receive a paper copy of this Notice upon request.

G. The Right to Opt-Out of Fundraising Communications. In the event we choose to contact you for purposes of fundraising, you will be given the opportunity to opt out of such fundraising communications.

III. Our Duties to Safeguard Your Protected Health Information.

A. Our Duties to You. We are required by federal law to maintain the privacy of protected health information and to provide you with notice of its legal duties and privacy practices with respect to your protected health information. We will maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information. We have the duty to mitigate any breach of privacy regarding your protected health information. In the event of any breach of privacy regarding your protected health information, the Toledo Clinic is required to notify you.

B. Privacy Notice. The Toledo Clinic is required to abide by the terms of its Privacy Notice as currently in effect.

C. Complaints. You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may obtain and file a Patient Privacy Complaint with our Privacy Officer. You will not be retaliated against for filing a complaint.

D. Contact Person and Telephone Number. If you have questions and/or would like additional information, you may contact Toledo Clinic's Privacy Officer at 419-473-3561.

E. Effective Date. This Privacy Notice is Effective March 31, 2013.

WE RESERVE THE RIGHT TO CHANGE THE TERMS OF OUR NOTICE OF PRIVACY PRACTICES AND TO MAKE THE NEW NOTICE PROVISIONS EFFECTIVE FOR ALL PROTECTED HEALTH

INFORMATION THAT WE MAINTAIN. IF WE CHANGE OUR INFORMATION PRACTICES, WE WILL POST THE REVISED NOTICE IN THE OFFICE AND PROVIDE YOU WITH A COPY UPON REQUEST.

ACKNOWLEDGMENT OF RECEIPT OF TOLEDO CLINIC'S NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Toledo Clinic's Notice of Privacy Practices effective April 14, 2003

Staff Use Only
PATIENT CHART NUMBER _____

Signature of Patient

Printed Name of Patient

Date of Birth

Signature of Parent/Guardian of Minor

Date

Staff use only
<u>Good Faith Effort to Obtain Acknowledgment</u>
The above named patient refused to sign the acknowledgment after being requested to do so.

Staff Member Signature
Date: _____

PERSONS THAT ARE ALLOWED TO GIVE/RECEIVE MY PRIVATE HEALTH INFORMATION

METHOD OF ALLOWED RELEASE: _____ VERBAL _____ WRITTEN

_____	_____	_____
Name	Relationship	Phone#
_____	_____	_____
Name	Relationship	Phone#
_____	_____	_____
Name	Relationship	Phone#

Billing Policy

Copays are due at the time of service. I understand that I am responsible for full payment of all charges for medical services rendered by The Toledo Clinic physician(s) regardless of insurance coverage, unless a contractual agreement exists with my insurance carrier or my physician.

Signature on File

I hereby authorize The Toledo Clinic to submit to my insurance plan all covered services rendered by the physician(s) and to furnish complete information (including Medical Records, if necessary) to my plan regarding services rendered. I understand that in signing this form, the Clinic will not release to anyone, including those processing my Clinic claim, any information that the law specifically protects and for which a special consent is required. For those records to be released, I will need to sign a separate consent. I authorize and direct my insurance carrier to issue payment check(s) directly to the physician(s) rendering covered services unless otherwise notified.

Authorization Signature

I have read this form or had it read to me. I understand it.

Signature of Patient/Authorized Representative

Relationship (if other than patient)

Patient Name
Chart #

Date: _____