DEKALB SURGICAL ASSOCIATES, P.C.
GENERAL SURGERY

DATE_____

Patient's Name _____ **Age** _____ **Date of Birth** _____

Address _____ **Apt** _____ **City** _____ **State** ____ **Zip** _____

Marital Status: **Married** ☐ **Single** ☐ **Divorced** ☐ **Widow** ☐ **Other** ☐_____ **Sex:** **Male** ☐ **Female** ☐

Ethnicity: **African American** ☐ **Asian** ☐ **Caucasian** ☐ **Hispanic** ☐ **Other** ☐_____

Preferred Language: _____

Social Security # _____ **Email Address** _____

Home Phone _____ **Cell Phone** _____

Please indicate Preferred Phone Number: ☐ **Home,** ☐ **Cell,** ☐ **Work**

***Pharmacy Name** _____ **Phone Number** _____

Patient's Employer _____ **Occupation** _____

Business Address _____ **Phone** _____ **Ext** _____

Name of Spouse _____ **Spouse's Employer** _____

******Emergency Contact*** _____***Phone*** _____ ***Relationship*** _____
(Some number other than your home)

Doctor Who Referred You Here _____ **Phone** _____

Primary Care Physician _____ **Phone** _____

Responsible Party Info (If different from patient)

Name _____ **DOB** _____ **Relationship to patient** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Social Security # _____ **Phone Number** _____

Primary Insured's Name (if different from patient) _____

Policy Holder's Birthdate _____ **Policy Holder's SS#** _____

Secondary Insured's Name (if different from patient) _____

Policy Holder's Birthdate _____ **Policy Holder's SS#** _____

Payment of co-pay, co-insurance and deductible is due at the time of service and/or prior to surgery.

Signature X _____

DEKALB SURGICAL ASSOCIATES PATIENT QUESTIONNAIRE

Name _____ Age _____ Today's Date _____

Reason for your visit: _____

PLEASE CHECK ANY OF THE FOLLOWING WHICH MAY APPLY TO YOU

High blood pressure ☐ **Prior heart attack** ☐ **Heart failure** ☐ **Chronic lung disease** ☐ **On pills for diabetes** ☐ **on Insulin** ☐

General: **Your weight?** _____ Unintended weight loss ☐ or gain ☐, fatigue ☐, fevers / chills, sweats ☐, heat intolerance ☐, insomnia ☐

Eyes:
- ☐ Loss of vision
- ☐ Cataracts
- ☐ Cataract surgery
- ☐ Glaucoma
- ☐ Intolerance of bright lights

Cardiovascular:
- ☐ High cholesterol
- ☐ Angina / chest pain
- ☐ Bypass surgery
- ☐ Angioplasty
- ☐ Irregular heartbeat / palpitations
- ☐ Poor circulation

Respiratory
- ☐ Emphysema/COPD
- ☐ Asthma
- ☐ Sleep apnea
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Hoarseness

Gastrointestinal:
- ☐ Ulcers
- ☐ Acid reflux / heartburn
- ☐ Nausea,
- ☐ Vomiting
- ☐ Gallstones
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Abdominal pain
  - ☐ Chronic
  - ☐ Acute/recent
- ☐ Difficulty swallowing
- ☐ Hepatitis
- ☐ Cirrhosis

Date of last colonoscopy_____

Urinary:
- ☐ Kidney failure/ Dialysis
- ☐ Kidney stones
- ☐ Burning or blood in Urine
- ☐ Urinary infections in the past

Last PSA date_____

Musculoskeletal:
- ☐ Arthritis in
  - ☐ Knees
  - ☐ Hips
  - ☐ Hands
  - ☐,_____
- ☐ Hip replacement
- ☐ Knee replacement
- ☐ Gout
- ☐ Osteoporosis

Gyn:
- ☐ Vaginal bleeding / Discharge
- ☐ Pelvic pain

Last period, or date of menopause _____

Last Pap date _____

Skin:
- ☐ Previous skin cancers
- ☐ Melanoma
- ☐ Recent change in a mole
- ☐ Eczema
- ☐ Psoriasis

Neurologic:
- ☐ Epilepsy/ Seizure Disorder
- ☐ Stroke (year_____),
- ☐ Headaches
- ☐ Numbness
- ☐ Weakness
- ☐ Dizziness
- ☐ Jaw pain

Psychiatric:
- ☐ Schizophrenia
- ☐ Depression
- ☐ Anxiety
- ☐ Irritability
- ☐ Other mental illness

Hematologic:
- ☐ Blood clots
- ☐ Deep vein thromboses (DVT)
- ☐ Varicose veins
- ☐ Anemia
- ☐ Easy bruising / bleeding
- ☐ On Coumadin
- ☐ +HIV

Endocrine:
- ☐ Overactive thyroid
- ☐ Underactive thyroid
- ☐ Thyroid mass
- ☐ On Prednisone or other steroid

Cancer Survivor:
- ☐ Lung ☐ Breast
- ☐ Colon ☐ Prostate
- ☐ Ovarian
- ☐ Other_____

Yr of diagnosis:_____

Do you: Smoke?
- ☐ Yes ☐ No
- ☐ Not since _____

Packs per day
☐ 1/2 ☐ 1 ☐ 2

Drink alcohol?
- ☐ None
- ☐ 1-2 drinks/day
- ☐ > 2/day
- ☐ Other_____

Do you: Use any recreational drugs?
☐ Yes ☐ No

Exercise regularly?
☐ Yes ☐ No

Family history: Father ☐ Alive ☐ Deceased Medical problems _____

Mother ☐ Alive ☐ Deceased Medical problems _____

How many Brothers ____ Sisters____ Family members with High blood pressure ☐, heart disease ☐, diabetes ☐, cancer ☐

Please provide additional information on any checked items or other medical problems: _____

Previous surgeries with dates: _____

Allergies: Penicillin ☐, iodine dye ☐, aspirin ☐, codeine ☐, sulfa ☐, latex rubber ☐, other _____

Medications (including nonprescription medications, please provide dosage and frequency if known)**:** _____

Vital Signs (nurse will complete) T _____ BP _____ P _____ Weight _____

Patient Signature Date

I understand that the above medical information will be used in making Treatment decisions and I attest that it is accurate to the best of my knowledge

Physician signature Date

I have reviewed the above medical information with the patient.

Varicose Vein Consult Form

Patient Name: _____ **Date of Birth:** _____

1. **Have you ever had vein stripping surgery?** ☐ **YES** ☐ **NO**

   If yes, when and which leg? _____

2. **Have you ever had vein injections?** ☐ **YES** ☐ **NO**

   If yes, When, Which leg? _____

3. **Have you ever had a blood clot?** ☐ **YES** ☐ **NO**

   If yes when, which leg? _____

4. **Have you ever had phlebitis?** ☐ **YES** ☐ **NO**

   If yes, which leg and when? _____

5. **Have your veins gotten progressively worse?** ☐ **YES** ☐ **NO**

6. **Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers, or swollen legs? If yes, who?** _____

   _____

7. **Do you experience any of the following in your legs? (Please circle)**

   ☐ **Aching /pain** ☐ **Swollen ankles** ☐ **Restless legs**

   ☐ **Heaviness** ☐ **Legs cramps** ☐ **Throbbing**

   ☐ **Tiredness/fatigue** ☐ **Itching /Burning** ☐ **Other**

8. **Do you take any medication for pain (Advil, Motrin)?** ☐ **YES** ☐ **NO**

   If yes, what medication and how often? _____

9. **Do you elevate your legs to relieve discomfort?** ☐ **YES** ☐ **NO**

   If yes, does it provide relief? _____

10. **Do you exercise?** ☐ **YES** ☐ **NO**

    If yes, what type and how often? _____

11. **Do you wear prescription compression stockings?** ☐ **YES** ☐ **NO**

    If yes, what type, how long have you worn and who prescribed?

    _____

12. **Have you ever had any test(s) done on your veins?** ☐ **YES** ☐ **NO**

    If yes, when, what type of test, and where on the leg?

    _____

13. **Were you diagnosed with saphenous vein reflux?** ☐ **YES** ☐ **NO**

Patient Signature: X_____ **Date:** _____

DeKalb Surgical Associates, P.C.

John S. Kennedy, M.D.,F.A.C.S., David R. Fern, M.D.,F.A.C.S., Michael S. Champney, M.D.,F.A.C.S., Andrei Stieber, M.D., F.A.C.S.

RELEASE OF INFORMATION AND PAYMENT OF BENEFITS

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities.

I hereby assign and authorize payment to DeKalb Surgical Associates, P.C. of all medical and/or surgical benefits, including major medical benefits, to which I am entitled to under any insurance policy or policies, under any self- insurance program, or under any other benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of any financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to DeKalb Surgical Associates, P.C. by any insurance policy, self insurance program or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

X_____ _____

Person providing the authorization (patient) **Date**

_____

Relationship to patient if not patient

_____

Reason patient unable to sign (minor, etc)

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DeKalb Surgical Associates, P.C.

Notice of Privacy Practices
(Revised 03/01/2013)

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Debbie Goodman, 404-508-4320

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

OPTIONAL:
4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

OPTIONAL:
5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

OPTIONAL:
6. Health-Related Benefits and Services. The practice does not receive any compensation in connection with communications with patients about its products and services, except that the practice may communicate with patients about prescription drugs or biologics and receive payment from the manufacturer that is reasonable in amount and compensate the practice for the

cost it has incurred in connection with the communication, mailing lists and/or actions related to such communication. Except for communications about drugs or biologics, the practice will first obtain the patient's authorization if the practice will receive direct or indirect payment for communication with the patient. The practice will communicate with patients about products or services and encourage the purchase or use of the product or service only for treatment purposes, or for case management, care coordination, or to recommend alternative therapies, providers or settings of care.

OPTIONAL:

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example,

investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

OPTIONAL:
5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

OPTIONAL:
6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

OPTIONAL:
7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Institutional Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to DeKalb Surgical Associates specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request** unless the disclosure is to a health plan for purposes of payment for healthcare services or healthcare operations. In this case we must agree to your request; however, you must have paid us in full "out of pocket" in order for us to grant the disclosure. We are not required to agree to your request if it relates to your treatment; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or

disclosure of your IIHI, you must make your request in writing to **Debbie Goodman, 404-508-4320.** Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Debbie Goodman, 404-508-4320** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Debbie Goodman, 404-508-4320**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures.*

All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of disclosures our practice has made of your IIHI, other than for treatment, payment or healthcare operations purposes. In order to obtain an accounting of disclosures, you must submit your request in writing to **Debbie Goodman, 404-508-4320**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than three (3) years from the date of your request. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Debbie Goodman, 404-508-4320**.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human

Services. To file a complaint with our practice, contact **Debbie Goodman, 404-508-4320**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Debbie Goodman, 404-508-4320.**

DEKALB SURGICAL ASSOCIATES, P.C.
John S. Kennedy, M.D.,F.A.C.S., David R. Fern, M.D.,F.A.C.S., Michael S. Champney, M.D.,F.A.C.S., Andrei Stieber, M.D., F.A.C.S.

RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by requesting one from our office or website, www.dekalbsurgical.com.

A copy of our "Notice of Privacy Practice" is posted on our wall in the waiting room, or you can ask the receptionist for your own printed copy.

By signing below, you acknowledge that you have read a copy of our Notice of Privacy Practice on the date indicated below.

Confidentiality Release

I, _____, hereby do give my permission to Dekalb Surgical Associates to discuss my medical case with the following relatives or friends:

1._____

2._____

3._____

The following person(s) I specifically do not wish my case to be discussed with:

1._____

2._____

3._____

Signature of Patient/Responsible Party: X_____

Print Patient Name: _____

Date: _____

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