COLUMBUS ADULT MEDICINE

2326 18th Street, Suite 210, Columbus, IN 47201 • (812) 372-8426

Financial Policy

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you. A clear understanding of our financial policy is important to our professional relationship. If you have any questions about your statement, please call 372-8426.

We require payment at the time of service. However, we do participate with some insurance companies. Please contact our billing office to verify if your insurance is one with which we participate. Insurance policies have deductible and/or co-insurance, and these will be the responsibility of the patient along with any uncovered services. These are payable at the time of service.

We also participate in Medicare. This means that we will bill Medicare for all your services and that Medicare will pay us. You will be responsible for any co-insurance or deductible or any service not covered by Medicare. We will also bill to any Medicare supplement carriers you may have.

If insurance has not paid within 60 days, payment of your bill remains your responsibility. Any balance remaining after your insurance company settles your claim is your responsibility.

Any portion of the account that is the patientís responsibility will be billed to you. Bills are due within 30 days from the date of service or last payment date.

We take your healthcare seriously and will accommodate your appointment requests to the best of our ability. When an appointment is scheduled, we are guaranteeing our physicians will assist you with your questions and concerns. New patients who fail to show or cancel within 24 hours of their appointment, will be subjected to a $50 charge on their account. This fee must be paid before scheduling a future appointment. Established patients will be assessed a $25 charge for similar reasons.

COLUMBUS ADULT MEDICINE HISTORY

Appointment Date_____

Name_____ Preferred Name_____

Birth date_____

Referred By_____

Family Physician_____

Preferred Pharmacy
(Store/location)_____

What concerns do you have that you would like us to address today?

MEDICATIONS—List all regularly used prescription and non-prescription drugs, vitamins, and herbs
❑ I have a separate list of medications I will show you. ❑ I take no medications or supplements routinely.

Drug / Dose / How often taken	Reason taken	Drug / Dose / How often taken	Reason taken

ALLERGIES ❑ Latex ❑ Iodine ❑ None

Allergy	Reaction	Allergy	Reaction

MEDICAL HISTORY
Please note any problems you are currently being treated for or have been treated for in the past.
If you check YES, please circle specific problem or write it in.
Yes No

❑ ❑ Alcoholism
❑ ❑ Allergies or asthma
❑ ❑ Alzheimer's
❑ ❑ Anemia/Blood disorder
❑ ❑ Arthritis/Fibromyalgia/Chronic Pain
❑ ❑ Asthma/Emphysema/Lung Disease
❑ ❑ Blood clots legs or lungs (DVT or Embolus)
❑ ❑ Cancer (what type) _____
❑ ❑ Depression/Anxiety/Mental Illness
❑ ❑ Diabetes
❑ ❑ Environmental Allergies
❑ ❑ Glaucoma
❑ ❑ Gout
❑ ❑ Hepatitis/HIV/AIDS
❑ ❑ Heart Disease
❑ ❑ Heart Disease, onset after age 55
❑ ❑ High Cholesterol
❑ ❑ High Blood Pressure
❑ ❑ Inheritable (genetic) diseases
❑ ❑ Kidney Stones
❑ ❑ Migraine Headaches
❑ ❑ Osteoporosis
❑ ❑ Recurrent Kidney/Bladder infections
❑ ❑ Seizures/Epilepsy
❑ ❑ Stomach/Bowel Problems (IBS, Reflux, Ulcers)
❑ ❑ Stroke
❑ ❑ Suicide
❑ ❑ Thyroid Disease (under or overactive)
❑ ❑ Other:

Yes No

SURGERIES ❑ None

❑ ❑ Appendectomy Date _____
❑ ❑ Cataract Surgeries Date _____
❑ ❑ Gallbladder surgery Date _____
❑ ❑ Heart operation/angioplasty Date _____
❑ ❑ Hernia repair Date _____
❑ ❑ Hysterectomy Date _____
❑ ❑ Lung operation Date _____
❑ ❑ Prostate operation Date _____
❑ ❑ Stomach/colon surgery Date _____
❑ ❑ Vascular surgeries/aneurysm Date _____
❑ ❑ Other (fill in following table):

Procedure	Year	Procedure	Year

Yes No
❑ ❑ Ever advised to have an operation which has not been performed?
If so, what surgery was recommended
_____

PREVIOUS HOSPITALIZATIONS (and date, separate from surgeries)

1.

2.

3.

4.

TESTS/IMMUNIZATIONS

Vaccination	Date last done	Test	Date last done	Test	Date last done
Hepatitis A		Bone Density		Endoscopy (EGD)	
Hepatitis B		Chest X-ray		Mammogram	
Pneumonia		Colonoscopy		Pap Smear	
Shingles/Zostavax		Echocardiogram		Sigmoidoscopy	
Tetanus/dT/Tdap		Electrocardiogram		Treadmill	

SOCIAL HISTORY/HABITS/SAFETY

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Yes *No*

❑ ❑ Tobacco use? # packs/day_____
Age started smoking_____

❑ ❑ Prior tobacco use? Year quit_____
Number of years smoked_____
Average # packs/day_____

❑ ❑ Drink alcohol regularly? # drinks/day____
❑ Wine ❑ Beer ❑ Liquor

❑ ❑ Use of illicit drugs previously?

❑ ❑ Exercise regularly (at least 3x/week)

❑ ❑ Eat a healthy, balanced diet
Particular type diet_____

❑ ❑ Caffeinated drinks? #drinks/day_____
❑ Coffee ❑ Soda ❑ Tea

Yes *No*

❑ ❑ Salt intake? ____none ____minimal
____significant ____excessive

❑ ❑ High fiber intake?

❑ ❑ Calcium supplement_____mg

❑ ❑ Always wear your seatbelt

❑ ❑ Contact with blood or body fluid at work

❑ ❑ Past blood transfusions

❑ ❑ Multiple sexual partners in past?

❑ ❑ Ever engage in homosexuality?

❑ ❑ Use skin protection with sun exposure

❑ ❑ Regular dental exams

❑ ❑ Regular eye exams

Occupation:

Hobbies:

Spouse's occupation if married:

FAMILY HISTORY: Note all family members affected.

M=Mother, F=Father, S=Sister, B=Brother, C=Child, GM=Grandmother, GF=Grandfather, A=Aunt, U=Uncle

Yes	*No*	
❑	❑	Alcoholism
❑	❑	Allergies or asthma
❑	❑	Anemia
❑	❑	Arthritis
❑	❑	Birth defects/Mental retardation
❑	❑	Blood clots legs or lungs (DVT or Embolus)
❑	❑	Breast Cancer
❑	❑	Colon Cancer
❑	❑	Lung Cancer
❑	❑	Ovarian Cancer
❑	❑	Pancreatic Cancer
❑	❑	Colon Cancer, onset before age 60
❑	❑	Other Cancer
❑	❑	Osteoporosis
❑	❑	Depression/Mental Illness
❑	❑	Diabetes
❑	❑	Emphysema/lung disease
❑	❑	Glaucoma
❑	❑	Gout
❑	❑	Hepatitis/HIV/AIDS
❑	❑	High Cholesterol
❑	❑	High Blood Pressure
❑	❑	Heart Disease, onset before age 55
❑	❑	Heart Disease, onset after age 55
❑	❑	Inheritable (genetic) diseases
❑	❑	Kidney Stones
❑	❑	Osteoporosis
❑	❑	Seizures
❑	❑	Stomach/duodenal ulcers
❑	❑	Stroke
❑	❑	Suicide
❑	❑	Thyroid disease
❑	❑	Tuberculosis
❑	❑	Other:

REVIEW OF SYSTEMS

Please check any of the following problems that you may have. If no problems in a category, check "none". Indicate the name of any health care professional that is currently treating that problem.

GENERAL ❑None
❑ Fever/chills/night sweats
❑ Loss of interest in eating
❑ Weight loss 10+ pounds
❑ Weight gain 10+ pounds
❑ Tiredness ❑ Lack of energy
❑ Other_____

HEAD ❑None
❑ Headaches

Neck
❑ Neck pains
❑ Neck lumps
❑ Enlarged thyroid/goiter
❑ Other _____
Cared for by_____

EYES ❑None
❑ Blurred vision
❑ Double vision
❑ Loss of vision
Cared for by_____

EARS ❑None
❑ Frequent earaches/infections
❑ Hearing difficulties
❑ Ringing/buzzing in ear
❑ Vertigo/motion sickness
Cared for by_____

NOSE ❑None
❑ Allergies
❑ Frequent nose bleeds
❑ Sinus congestion
❑ Sinus drainage
❑ Other _____
Cared for by_____

THROAT/MOUTH ❑None
❑ Dental problems
❑ Hoarseness/voice changes
❑ Mouth sores
❑ Sore throat
❑ Swellings on gums or jaw
❑ Other _____
Cared for by_____

Neck
❑ neck pains
❑ neck lumps
❑ enlarged thyroid/goiter
❑ Other _____
Cared for by_____

LUNGS ❑None
❑ Coughing up sputum
❑ Coughing up blood
❑ Excessive/frequent cough
❑ Shortness of breath
❑ Wheezing
❑ Other_____
Cared for by_____

HEART ❑None
❑ Chest pain ❑ Palpitations
❑ Fluid retention
❑ Swelling of legs
❑ Other_____
Cared for by_____

BREAST ❑None
❑ Breast lump/mass
❑ Breast tenderness
❑ Nipple discharge
❑ Other_____
Cared for by_____

DIGESTIVE/INTESTINAL ❑None
❑ Abdominal pain
❑ Belching ❑ Bloating
❑ Heartburn ❑ Indigestion
❑ Nausea ❑Vomiting
❑ Diarrhea ❑ Constipation
❑ Blood in stool
❑ Other_____
Cared for by_____

GENITOURINARY ❑None
- ❑ Burning with urination
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Frequent urine infections
- ❑ Leak urine with cough/sneeze
- ❑ Leak urine with urgency
- ❑ Leak urine with cough/sneeze
- ❑ Urination at night

How often? _____

FOR MEN ONLY ❑None
- ❑ Erectile difficulties

FOR WOMEN ONLY ❑None
- ❑ Change in periods
- ❑ Hot flashes
- ❑ Vaginal dryness
- ❑ Other_____

Cared for by_____

BACK ❑None
- ❑ Back pain
- ❑ Other_____

Cared for by_____

MUSCOLOSKELETAL ❑None
- ❑ Joint pain ❑ Joint swelling
- ❑ Muscle pains
- ❑ Leg pain while walking
- ❑ Other_____

Cared for by_____

NEUROLOGICAL ❑None
- ❑ Difficulty in walking
- ❑ Dizziness
- ❑ Fainting
- ❑ Lightheadedness
- ❑ Memory loss
- ❑ Numbness/tingling sensations
- ❑ Seizures
- ❑ Tremors/hands shaking
- ❑ Weakness
- ❑ Other_____

Cared for by_____

MOOD ❑None
- ❑ Anxious or ❑ nervous
- ❑ Sad, down, depressed
- ❑ Lack of interest in activities
- ❑ Difficulty concentrating
- ❑ Sleep too much or ❑ too little
- ❑ Irritable, moody, cry easily
- ❑ Suicidal thoughts
- ❑ Decrease in sexual desire
- ❑ Other_____

Cared for by_____

ENDOCRINE ❑None
- ❑ Hot flashes ❑ night sweats
- ❑ Heat or ❑ cold intolerance
- ❑ Excessive hair growth or ❑loss
- ❑ Abnormal thirst
- ❑ Other_____

Cared for by_____

BLOOD/LYMPH ❑None
- ❑ Anemia (or history of)
- ❑ Bruising or ❑ bleeding easily
- ❑ Enlarged lymph nodes
- ❑ Other_____

Cared for by_____

SKIN ❑None
- ❑ Dry skin
- ❑ Itching
- ❑ Previous skin cancer
- ❑ Rash
- ❑ Unusual/change in moles
- ❑ Other_____

Cared for by_____

ALLERGIES ❑None
- ❑ Environmental allergies

Cared for by_____

Thank you for taking the time to fill out the above information.

NOTICE OF PRIVACY PRACTICES

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:

The Privacy Officer or Office Manager for assistance.

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.

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.

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.

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

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

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

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 with your authorization

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)

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.

6. 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.

7. 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.

8. 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.

9. 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.

10. 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 the **Privacy Officer** 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**; 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 the **Privacy Officer**. 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 the **Privacy Officer** 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 the **Privacy Officer**. 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 certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to the **Privacy Officer**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. 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 the **Privacy Officer**.

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 the **Privacy Officer**. 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 the **Privacy Officer.**