Council Bluffs Surgical Associates, P.C.

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Cleo Beckham, PA-C

Patient Information

Patient Name: _____ Marital Status: M S D W
Last First MI Maiden Circle One

Address: _____
Street Apt # City State Zip Code

Employer: _____ E-Mail: _____

Soc Sec #: _____ Date of Birth: _____ Age:_____ Sex: M F
Circle One

Phone: Home: _____ Work: _____ Cellular: _____

Primary/Family Physician: _____ Referring Physician: _____

Spouse Information

Spouse Full Name: _____ Date of Birth: _____

Spouse Employer: _____ Work Phone: _____

Soc Sec #: _____ E-Mail: _____ Cellular: _____

Parent or Guardian Information If Under 18 Years of Age

Father's Name: _____ Date of Birth: _____

Address: _____ Home Phone:_____
Street Apt # City State Zip Code

Employer: _____ Work Phone:_____

Soc Sec #: _____ E-Mail: _____ Cellular: _____

Mother's Name: _____ Date of Birth: _____

Address: _____ Home Phone:_____
Street Apt # City State Zip Code

Employer: _____ Work Phone:_____

Soc Sec #: _____ E-Mail: _____ Cellular: _____

HIPAA Release of Information

Please complete the names & phone numbers where we can contact you or leave a message.

(Exception: X-Ray, Path and/or Lab results will be given only to the patient or the designated person(s).

Please contact me as follows: (check at least one)

❑ Home/Cell Telephone: (_____) _____
- ❑ Leave message with appointment date & time ❑ Leave message with call back number only ❑ Do not leave message

❑ Work Telephone: (_____) _____
- ❑ Leave message with appointment date & time ❑ Leave message with call back number only ❑ Do not leave message

❑ Written Communication: (_____) _____
- ❑ Mail to my home address: _____
- ❑ Mail to my work address: _____

If we are unable to reach you, who, if anyone/or what designated person(s), may we disclose medical and or billing information?

- ❑ Spouse: _____ ❑ Fiancé: _____
- ❑ Parent(s): _____ ❑ Adult Child: _____
- ❑ Adult Children: _____ ❑ Sibling(s): _____
- ❑ Sibling(s): _____ ❑ Other (Relative/Friend): _____
- ❑ Other (Relative/Friend): _____ ❑ Other (Relative/Friend): _____

Emergency Contact Information

Relationship: _____

Address: _____ Phone:_____

Patient Allergy Information

Medication Allergies: _____

Any food, metal, latex, adhesive allergies: _____

Office Visit Information:

Reason for Visit: _____

Date of Symptoms: _____

Seen in ER: ❑ Yes ❑ No Where? _____ When?_____

If this is an injury, is the injury related to an on-the-job accident? ■ Yes ■ No (Check One)

If Yes: a) Have you reported the accident to your employer? ❑ Yes ❑ No

b) Were you referred by a Work Comp doctor? ❑ Yes ❑ No

If No: a) Was this a car accident? ❑ Yes ❑ No

b) Did the injury occur on another person's property? ❑ Yes ❑ No

Workmen's Compensation Information:

Company Name: _____ Phone #: _____

Address: _____
Street Apt # City State Zip Code

Supervisor Name: _____ Date of Injury: _____

Have you missed any work due to the injury? _____ What symptoms: _____

What were you doing at the time of injury? _____

Do you have an attorney representing you in the above injury? ❑ Yes ❑ No

If Yes: Attorney Name: _____ Phone #: _____

Address: _____
Street City State Zip Code

Motor Vehicle Accident Information:

Date of Accident: _____

Do you have an attorney representing you in the above injury? ❑ Yes ❑ No

If Yes: Attorney Name: _____ Phone #: _____

Address: _____
Street City State Zip Code

Insurance Information: (copy of insurance card is needed)

Insurance Name: _____ Policy Holder_____
Primary Name Date of Birth

Insurance Name: _____ Policy Holder_____
Primary Name Date of Birth

If patient is a minor, please print name of parent or guardian responsible for bill: _____

Address: _____
Street City State Zip Code

Pharmacy Information:

Pharmacy Preferred: (Name) _____

_____

Pharmacy Location: _____ Phone #: _____

Notice of Council Bluffs Surgical Associates, P.C. Practices

Notice of Payment Policy

I acknowledge the receipt of the Payment Policy effective 07/01/09 from Council Bluffs Surgical Associates, P.C.

Notice of Privacy Practices

I acknowledge receipt of the Notice of Privacy Practices effective February 1, 2005 from Council Bluffs Surgical Associates, P.C.

Authorization for Consent to Treatment

I, the undersigned, give permission to treat and assign to Council Bluffs Surgical Associates, P.C., all medical benefits, if any, otherwise payable to me for services rendered. I also understand that I am financially responsible for all charges not paid by my health benefits provider. I hereby authorize the doctor to release all information necessary to secure the payment and authorize the use of this signature (or copy thereof) to provide necessary medical information to my insurance carrier upon their request.

I, knowing that I have a condition requiring diagnosis, treatment, or related medical care do hereby consent to such care, medical examination(s), operation(s), procedure(s), therapy sessions, photographs, and/or treatment by my attending physician(s), their assistant(s) or designee(s) as may be necessary in their professional judgement. I further acknowledge that no guarantees have been made to me as to the results of such care, medical examination(s), operation(s), procedure(s), therapy sessions and/or treatment.

Patients, Parent/Legal Guardian
or Power of Attorney Signature: _____ Date:_____

Council Bluffs Surgical Associates, P.C.

201 Ridge Street • Suite 214 • Council Bluffs, Iowa 51503 • 712-396-4320 • Fax: (712) 396-4328

HEALTH HISTORY
Confidential

Patient Name: _____ Date: _____

Age:_____ Date of Birth:_____ Sex: M F Date of last physical exam: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

What is the reason for your visit? _____

Primary Physician: _____ Referring Physician: _____

REVIEW SYMPTOMS: Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Weight gain
- ☐ None

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders
- ☐ None

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ None

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Food Intolerances (greasy, fried)
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Swallowing problems
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ None

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins
- ☐ None

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Sore throat
- ☐ Sores in mouth or throat
- ☐ Vision-Flashes
- ☐ Vision-Halos
- ☐ None

SKIN
- ☐ Bruise easily
- ☐ Change in moles
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal
- ☐ None

MEN ONLY
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other
- ☐ None

WOMEN ONLY
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Menopause
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other
- ☐ None

Date of last menstrual period:_____
Date of last Pap Smear:_____
Date of last mammogram:_____
Do you use birth control? _____

Have you been hit, slapped, kicked or otherwise physically injured by someone? ☐ Yes ☐ No
If Yes, explain: _____

Any other symptoms not listed: _____

CONDITIONS: Check (✓) conditions you have or have had in the past.
- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ DVT
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ PE
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Transfusions
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

Any other conditions not listed: _____

CURRENT MEDICATIONS (Include prescription, over-the-counter and herbals):

NAME OF MEDICINE	DOSE	HOW OFTEN TAKEN	REASON FOR TAKING	LENGTH OF TIME TAKEN

ALLERGIES: List any allergies you have to Medications, foods or environment: _____

_____

_____

Do you have a **LATEX** sensitivity or allergy? ..... ☐ Yes ☐ No
Following a medical, surgical or dental procedure, have you ever had any unexplained itching, hives, swelling or anaphylactic reaction? ..... ☐ Yes ☐ No
Have you had symptoms such as sneezing, coughing, rash or hives when handling rubber products, balloons, latex gloves or Band-Aid's? ..... ☐ Yes ☐ No

Please complete the TABLE below for any PRIOR cancer, radiation, treatment, or chemotherapy that you may have had:					
	Don't know	No	Yes	Year	Kind of cancer or Type of disease / condition
Prior Cancers:					
Prior Radiation Treatment (not dental x-rays or for broken bones):					
Prior Chemotherapy:					

FAMILY HISTORY:
Are you Adopted? ☐ Yes ☐ No Are you a Twin? ☐ Yes ☐ No What type of twin? ☐ Identical ☐ Fraternal ☐ Don't know
Excluding yourself, how many of each of the following blood-related family members do you have? **Remember to include those who are no longer living.**
Include only **full** brothers or sisters. Brothers:_____ Sisters:_____ Sons:_____ Daughters:_____

FAMILY HISTORY – Fill in health information about your immediate family.				
Relation	**Age**	**State of Health**	**Age at Death**	**Cause of Death**
Father				
Mother				
Brothers				
Sisters				
Grandparents				

Check (✓) if your blood relatives had any of the following:	
Disease	**Relationship to you**
☐ Allergies	
☐ Anemia	
☐ Arthritis, Gout	
☐ Asthma, Hay Fever	
☐ Cancer	
☐ Diabetes	
☐ Heart Disease, Strokes	
☐ High Blood Pressure	
☐ Kidney Disease	
☐ Malignant Hyperthermia	
☐ Tuberculosis	

HOSPITALIZATIONS/SURGERIES			**PREGNANCY HISTORY**	
Year	**Hospital**	**Reason for Hospitalization nand Outcome**	**Year of Birth**	**Complications (if any)**

Have you had any reaction to anesthesia? ☐ Yes ☐ No
Do you take any anticoagulants *(i.e. Aspirin, Coumadin, Plavix)* ? If so, please list: _____
_____
Do you have a pacemaker, defibrillator or stent of any kind If so, please list: _____
_____
Have you ever had a chest x-ray? ☐ Yes ☐ No Date: _____
Flu Vaccine? ☐ Yes ☐ No Date:_____ Pneumovax? ☐ Yes ☐ No Date:_____
Tetanus? ☐ Yes ☐ No Date:_____
Do you use seat belts? ☐ Yes ☐ No If you have children do you use a car safety seat? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

HEALTH HABITS: Check (✓) which substances you use and describe how much you use.	
☐ Caffeine	
☐ Tobacco	
☐ Street Drugs	
☐ Alcohol	
☐ Other	

SERIOUS ILLNESS / INJURIES	**DATE**	**OUTCOME**

OCCUPATIONAL CONCERNS: Check (✓) if your work exposes you to the following:
☐ Stress
☐ Hazardous Substances
☐ Heavy Lifting
☐ Other
Your occupation:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Council Bluffs Surgical Associates, P.C.

Payment Policy

Thank you for choosing us as your general surgeons. We are committed to providing you with quality care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment arrangement are expected to be made at your visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, a payment is due at the visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered service.** Please be aware that some - and perhaps all - of the service you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must make payment arrangements for services at the time of the visit. Aesthetic Services-Payment is due at the time of service. (Care Credit Available)

4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission.** We will submit your health insurance claims and assist you in any way we reasonably can help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim the balance will automatically be billed to you.

7. **Nonpayment.** Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from the practice. Our physicians will only be able to treat you on an emergency basis.

8. **Forms.** Fee of $15.00 is due upon completion of Disability and/or Attending Physician Forms.

9. **Return Checks.** A $45.00 service fee will be added to all checks returned for insufficient funds. If your check is returned, you will be required to prepay in full by Cash, Visa, MasterCard or Discover for additional services.

10. **Method of Payment.** We accept Cash, Checks/Debit, Visa, MasterCard and Discover. Care Credit is available for Aesthetic services. Payment plans may be arranged on an individual basis.

    Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

    I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party **Date**

201 Ridge Street, Suite 214 Council Bluffs, IA 51503 712-396-4320 * Fax 712-396-4328

Privacy Notice

Council Bluffs Surgical Associates, P.C.
201 Ridge Street, Suite 214
Council Bluffs, Iowa 51503
Phone: (712) 396-4320 Fax: (712) 396-4328

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.

This notice applies to Council Bluffs Surgical Associates, P.C.

Council Bluffs Surgical Associates, P.C. will share your health information with each other, as necessary, to carry out treatment, payment and health care options.

Understanding your Health Record/Information

Every time you visit a hospital, physician, or other health care provider, a record of your visit is made. This record may include your symptoms, examination and test results, diagnosis, treatment and plans for future care or treatment. Your medical provider uses this information – often referred to as your health record – to plan your care and treatment. The many health care professionals who assist in your care communicate through your health record. Your health information is also used by insurance companies to verify that services we billed for were actually provided. Although your health record belongs to the health care provider or facility that compiled it, you do have certain rights with regard to your health information.

Your Rights

You have a right to expect that your health information will be kept secure and used only for legitimate purposes.

- You have a right to understand how your health information may be used and disclosed by Council Bluffs Surgical Associates, P.C.
- You have a right to receive this privacy notice that tells you how your health information may be used or disclosed.
- You have a right to ask questions about any health privacy issue and have those questions clearly and promptly answered.
- You have a (limited) right to know who has seen your health information, and for what purpose. If you make additional requests for such an accounting during any 12-month period, we may charge you a reasonable, cost-based fee.
- You have a right to see and to keep a copy of all of your health records (except psychotherapy notes). Your request for a copy of your records must be in writing. We may charge you a reasonable, cost-based, copying fee.
- You have a right to ask for correction – or inclusion of a statement of disagreement – for anything in your records that you feel is in error. Your request must be in writing and include supporting documentation.
- You have a right to authorize – or refuse – additional uses of your health information, such as for fundraising, marketing, or research.
- You have a right to request extra protections for health information you consider especially sensitive, and to request that we communicate with you by alternative means.

Our Responsibilities

We also have certain responsibilities. These include:

- Maintaining the privacy of your health information
- Providing you with a copy of this notice
- Abiding by the terms of this notice
- Notifying you if we are unable to agree to a requested amendment or restrictions
- Accommodating reasonable requests you may have to communicate health information by alternative means or at alternative locations.

If our information practices change, we may change this notice. If we do so, the change will be effective for information gathered both before and after the effective date of such change. However, before we change our practices, we will post a copy of our new notice at Council Bluffs Surgical Associates, P.C. The effective date of our notice will always appear at the end of the notice.

We will not use or disclose your health information without your authorization, except as described in this Notice.

Disclosures for Treatment, Operations Payment and Health Care.

We may use or disclose your information for treatment, payment and health care operations without your permission. However, if state law requires us to obtain your written permission to use or disclose your health information for treatment, payment or health care operations, we will do so.

We will use or disclose your health information for treatment.

For example: Information obtained by a nurse, physician, or other members of your health care team will be recorded in your record and used to determine the course of your treatment. Health care team members will communicate with one another personally and through the health care record to coordinate your care. We may provide your physician or other health care provider with copies of reports that may help that may help determine your future treatment. We may also disclose your information to another health care provider for its payment purposes or its health care operations.

We will use or disclose your health information for payment.

For example: We may send your bill to you or your insurance company. Your bill may contain information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use or disclose your health information for health care operations and internal business practices.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use the information in your health record to assess the care and outcomes in your case and others like it . This information is used in our ongoing efforts to improve the quality and effectiveness of the health care and service we provide.

We will use or disclose your health information in order to avert a serious threat to health or safety.

Specialized Governmental Functions: We may disclose your health information for military and veterans activities, national security, and intelligence activities, and similar special government functions as required or permitted by law.

Correctional Institutions: If you are an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and safety of other individuals.

Law Enforcement: We may disclose your health information for law enforcement purposes as required by law or in response to a valid subpoena, court order or other binding authority.

Disclosures Required by Law: We may use or disclose your health information as required by law provided such use or disclosure complies with and is limited to the relevant requirements of such law.

Health Oversight Agencies: We may disclose your health information to an appropriate health oversight agency; public health authority or attorney involved in health oversight activities.

Judicial and Administrative Proceedings: We may disclose your health information for judicial or administrative proceedings as required or permitted by law or in response to a valid subpoena, court order or other binding authority.

For More Information or to Report a Problem:

If you have questions or would like additional information, you may contact the Privacy Officer at Council Bluffs Surgical Associates, P.C. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer, or with the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint.

Effective February 1, 2005