Notice of Privacy Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding your health record information

Whenever you visit a hospital, physician, or healthcare provider, you are establishing a healthcare record with that provider. Your health record contains notes about your visit, including your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. Your healthcare or medical record serves many purposes.

- Plan your care and treatment
- Obtain payment from a third party, such as an insurance company
- Communication among the health professionals who contribute to your care
- Legal document describing the care you received
- A means by which a third party payer can verify that services billed were actually provided
- A tool in education for health professionals or a source of data for medical research
- Source of information for public health officials
- Source of data for facility planning and marketing

Understanding what is in your record and how your health information is used helps you to ensure its accuracy. It also helps you understand who may access your health information and under what conditions. It helps you make more informed decisions when authorizing disclosure to others.

Your health information rights

The physical record of your health is the property of Dr. Kurt C. Garren. However, the underlying information belongs to you. You have the right to:

- Request restrictions on certain uses and disclosures of you information: however, we do not have to comply with your request
- Obtain a paper copy of the notice of information practices upon request
- Inspect and obtain a copy of your health record, except in limited circumstances (You may be charged a reasonable fee for copying)
- Request amendment of your healthcare record
- Obtain an annual accounting of disclosures of your health information (You may be charged a reasonable fee for copying)
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

We do not have to honor your request for restrictions on activities that are otherwise allowable by law.

If we deny your request, you will receive notification of our denial along with a written basis for our denial. Any request for restrictions on use of disclosure must be made in writing. We will notify you within 30 days of our decision. We may request an additional 30 days to consider your request.

Our responsibilities

We are required to:

- Maintain the privacy of your health information
- Provide you with a Notice of Privacy Practices that describes our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of Dr. Kurt C. Garren, M.D. Inc. regarding our Notice of Privacy Practices
- Notify you if we will not agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices at any times and to make any new provisions effective for all the protected health information we maintain. Prior to making any significant changes in our privacy practices, we will change our Notice of Privacy Practices if any of our information practices change.

The office of Dr. Kurt C. Garren will not use or disclose your health information without your authorization, except as described in this notice.

As a condition of treatment (except for emergency treatment), you are required to sign a consent form for use and disclosure of Protected Health Information for purpose of payment, treatment and healthcare operations. We use information about you for treatment, to obtain payment, and to evaluate the quality of care you receive. In certain instances, we may use or disclose your information that is not for payment, treatment or healthcare operations when required or authorized by law.

Complaints: if you believe your privacy rights have been violated, you can file a complaint with the office of Dr. Kurt C. Garren. You may either send a written complaint to 515 Union Ave., Suite 157, Dover, OH 44622 or you may call the office at (330) 343-9600 during normal business hours. You may also file a complaint with the Secretary of U.S. Department of Health and Human Services in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

Acknowledgement of Receipt of Notice:

Please sign below to acknowledge that you received a copy of this Notice of Privacy Practices.

______________________	____________________________	______________
Patient Name (Print)	**Patient name signed**	**Date**
______________________	____________________________	______________
Parent if patient is under age	**Parent's signature**	**Date**

Person to release to:	Rx Information	Appointments	All Information

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. It is very important information. Please complete every item. It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Full Name____**Appt. Date**____________________

Male_______**Female**_______**Date of Birth**____________________**Height**_____________**Weight**___________

Pharmacy Preference (include location)____

Primary Care Physician____________________________**Referring Physician**____________________________

Chief Complaint____

Please list current medications below:

Name of Medication	Dosage	How often taken

Please list all medication allergies below:

Name of medication	Type of Reaction

Have you had any other surgeries or currently have any surgical implants? (examples: defibrillator, pacemaker, stints, etc)____

____

Patient Health History

DIRECTION OF FEED

Marking Instructions

- Use only a number 2 pencil.
- Fill in the complete oval as shown below.
- Fill in date on the line when MM/YR is present.

Correct Mark ⬬ **Incorrect Marks** ◐ ✓ ✗

Name: ______________________

Date of Appt: ______________________

1. Race *(Mark Only One)*

- American Indian or Alaskan Native ○
- Asian ○
- Black or African American ○
- Decline to State ○
- Native Hawaiian or Other Pacific Islander ○
- Some Other Race ○
- White ○

2. Ethnicity *(Mark Only One)*

- Decline to State ○
- Hispanic or Latino ○
- Not Hispanic or Latino ○

3. Preferred Language *(Mark Only One)*

- English ○
- Spanish ○

4. Preferred method of receiving office reminders *(Mark Only One)*

- Opt Out ○
- Home Phone ○
- Work Phone ○
- Mobile Phone ○
- Other Phone ○
- Home Fax ○
- Work Fax ○
- Mail ○
- Patient Portal ○

5. Food Allergies or Intolerances

	Yes		Yes
Eggs	○	Yeast – Baker's	○

6. Cancers

	Date Diagnosed	Yes
Bladder	MM / YR	○
Bone	MM / YR	○
Brain	MM / YR	○
Breast	MM / YR	○
Cervical	MM / YR	○
Colon	MM / YR	○
Esophagus	MM / YR	○
Ewing's Sarcoma	MM / YR	○
Hodgkin's Disease	MM / YR	○
Kaposi Sarcoma	MM / YR	○
Kidney	MM / YR	○
Larynx	MM / YR	○
Leukemia	MM / YR	○
Liver	MM / YR	○
Lung	MM / YR	○
Lymphoma	MM / YR	○
Multiple Myeloma	MM / YR	○
Ovarian	MM / YR	○
Pancreas	MM / YR	○
Pheochromocytoma	MM / YR	○
Polycythemia Vera	MM / YR	○
Prostate	MM / YR	○
Rectum	MM / YR	○
Skin – Basal Cell	MM / YR	○

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6. Cancers *(continued)*

	Date Diagnosed	Yes
Skin -- Malignant Melanoma	MM / YR	○
Skin -- Squamous Cell	MM / YR	○
Skin -- Unknown Type	MM / YR	○
Stomach	MM / YR	○
Testicular	MM / YR	○
Throat	MM / YR	○
Thyroid	MM / YR	○
Uterine	MM / YR	○

7. Past Health History

	Date Diagnosed	Yes
High Blood Pressure (Hypertension)		○
Pregnant – Pregnancy Has Been Confirmed		○
Encephalopathy		○
Neuralgia		○
Neuritis		○
Paralysis		○
Progressive Neurologic Disorder		○
Radiculitis		○
Intravenous Drug Abuse		○
Autoimmune Disorder		○
HIV Positive (Asymptomatic)		○

8. Past Surgeries

	Procedure Date	Yes
Colectomy – Total		○
Colonoscopy	MM / YR	○
Hysterectomy		○
Mastectomy – Details Unspecified		**Yes**
Left Separate		○
Right Separate		○
Both at Same Time		○
Mastectomy – Modified Radical		**Yes**
Left Separate		○
Right Separate		○
Both at Same Time		○
Mastectomy -- Radical		**Yes**
Left Separate		○
Right Separate		○
Both at Same Time		○
Mastectomy – Simple		**Yes**
Left Separate		○
Right Separate		○
Both at Same Time		○

EXAMPLE TO FILL IN DATES
If you have had paralysis in December of 1990, fill in the oval and write the date as shown below.
Paralysis 12/90 ⬬

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9. Mark any back injuries you have had:

	Injury Date	Yes
Thoracic injury of the back		○
Lumbar injury of the back		○
Ruptured disc – L1-2		○
Ruptured disc – L2-3		○
Ruptured disc – L3-4		○
Ruptured disc – L4-5		○
Ruptured disc – L5-S1		○
Ruptured disc – S1-2		○
Ruptured disc – Specific location unknown		○
Wound (gun shot) to back		○
Wound (stab wound) to back		○
Vertebral fracture – Lumbar		○
Vertebral fracture – Thoracic		○
Vertebral fracture – Location unspecified		○

10. Immunizations — Immunization Date

Diptheria – Tetanus – Pertussis (DTP)

MARK EITHER: — Yes

- Completed series — MM / YR ○
- OR
- #4 of series — MM / YR ○
- #5 of series — MM / YR ○

Haemophilus Influenza Type B Conjugate Vaccine (HIB)

MARK EITHER: — Yes

- Had series in past ○
- OR
- #2 of series ○
- #3 of series ○
- Booster ○

Hepatitis A (HAV) — Yes

- #2 of series — MM / YR ○
- Booster — MM / YR ○

Hepatitis B Vaccine (HBV)

MARK EITHER: — Yes

- Had the series ○
- OR
- #3 of series ○
- #4 of series ○
- Repeat series was administered ○
- Booster ○

Influenza Vaccine — Yes

- Never received this vaccine ○
- Has received this vaccine — MM / YR ○
- Declined vaccine ○

Measles – Mumps – Rubella (MMR)

MARK EITHER: — Yes

- Completed the series ○
- OR
- First or only MMR vaccination ○
- Second MMR vaccination ○

10. Immunizations *(continued)* — Immunization Date

Pneumococcal Conjugate Vaccine (PCV)

(Pneumonia vaccine given as a child) — Yes

- Booster — MM / YR ○

Pneumococcal Polysaccharide Vaccine (PPV)

(Pneumonia vaccine given as an adult) — Yes

- Primary PPV immunization ○
- Revaccination ○

Polio – Inactivated Polio Virus (IPV)

MARK EITHER: — Yes

- Completed the series — MM / YR ○
- OR
- #3 of series — MM / YR ○
- #4 of series — MM / YR ○

Rotavirus Vaccine

MARK EITHER: — Yes

- Has received 2 or more doses ○
- OR
- #2 of series ○
- #3 of series ○

Varicella (VZV)

MARK EITHER: — Yes

- Has received 1 or more doses — MM / YR ○
- OR
- #1 or only immunization — MM / YR ○
- #2 — MM / YR ○

11. Most Recent Diagnostic/Screening Tests

	Test Date	Yes
Colonoscopy		○
Fecal Occult Blood Testing (FOBT)		○
Sigmoidoscopy – Flexible		○
Pap Smear		○
Mammography		○

12. Current Smoking Status

(Mark one of the following) — Yes

- Never smoked ○
- Former smoker ○
- Current every day smoker ○
- Current some day smoker ○

13. Use of tobacco products in the past that are no longer used.

(Mark if applicable) ○

Thank you for completing this questionnaire!

Patient Health History

DIRECTION OF FEED

Marking Instructions

- Use only a number 2 pencil.
- Fill in the complete oval as shown below.

Correct Mark ⬬ Incorrect Marks

Name: ______________________

Date of Appt: ______________________

1. Are you allergic to any of the following?

	Yes		Yes
Adhesive tape	◯	Metal	◯
Iodine	◯	Seafood	◯
Latex	◯	Contrast Dye	◯

2. Mark if you have been diagnosed with any of the following:

	Yes		Yes
Breast Cancer	◯	Gastrointestinal Reflux	◯
Lung Cancer	◯	Hepatitis	◯
Skin Cancer	◯	Stomach Ulcer	◯
Throat Cancer	◯		
Prostate Cancer	◯	Are you pregnant?	◯
Other Cancer	◯	Prostate Enlargement	◯
Migraine Headache	◯	Renal Failure	◯
Cataracts	◯	Stroke	◯
Glaucoma	◯		
Nasal Allergies	◯	Anxiety	◯
		Depression	◯
Sleep Apnea	◯	Diabetes	◯
		Thyroid Dysfunction	◯
Blood Clots/DVT	◯	Anemia	◯
High/Elevated Cholesterol	◯	Hemophilia	◯
Heart Attack	◯		
High Blood Pressure	◯	HIV	◯
Asthma	◯		
Chronic Bronchitis	◯		
Emphysema	◯		
Tuberculosis	◯		

3. Mark family members who have been diagnosed with any of the following:

	None	Mother	Father	Brother	Sister
Problems with Anesthesia	◯	◯	◯	◯	◯
Thyroid Cancer	◯	◯	◯	◯	◯
Lung Cancer	◯	◯	◯	◯	◯
Unspecified Cancer	◯	◯	◯	◯	◯
Hearing Loss before age 20	◯	◯	◯	◯	◯
Hearing Loss after age 20	◯	◯	◯	◯	◯
Heart Disease	◯	◯	◯	◯	◯
High Blood Pressure	◯	◯	◯	◯	◯
Asthma	◯	◯	◯	◯	◯
Stroke	◯	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯	◯
Bleeding/Clotting Problem	◯	◯	◯	◯	◯

4. Mark if retired. Yes ◯

5. Tobacco Use:
Mark your tobacco use.

◯ None ◯ Cigarettes
◯ Smokeless Tobacco ◯ Cigars

Give the closest amount of cigarettes you smoke in an average day.

◯ 1/2 pack ◯ 2 packs
◯ 1 pack ◯ 3 packs
◯ 1 1/2 packs

Alcoholic Beverages - *A drink is 1 shot of liquor or 1 glass of wine or 1 bottle/can of beer.*

◯ Less than 12 drinks/yr
◯ 1-13 drinks/mo
◯ 4-14 drinks/wk
◯ >2 drinks/day

6. Do you use drugs recreationally? Yes ◯

7. Caffeine Use (coffee, tea, chocolate, cola, other caffeinated drinks):

◯ None ◯ 2-3 per day
◯ 1 per day ◯ 4 or more

8. Are you exposed to second hand smoke? Yes ◯

9. Mark if patient attends daycare. Yes ◯

10. Will you accept transfusion of blood products if necessary? Yes ◯

11. Home Living Situation (mark all that apply).

◯ Alone ◯ With spouse
◯ With children ◯ In nursing home
◯ With mother ◯ With father
◯ In assisted living ◯ Other

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12. Do you now have or have you recently had any of the following?

	Yes
Fever	○
Sleeping problems	○
Unintentional weight loss	○
Unintentional weight gain	○
Blurred vision	○
Itchy eyes	○
Loss of vision	○
Painful eye	○
Dizziness	○
Ear drainage	○
Hearing loss	○
Ear pain	○
Ringing in the ears	○
Nasal congestion	○
Frequent nosebleeds	○
Post-nasal drainage	○
Belching sour material into throat	○
Hoarseness or other voice changes	○
Mouth ulcers	○
Partials or dentures	○
Blacking out or fainting	○
Chest pain	○
Heart murmur	○
Irregular heartbeats	○
Leg cramps	○
Swelling of ankles	○
Frequent non-productive cough	○
Frequent productive cough	○
Shortness of breath	○
Snoring (excessive)	○
Wheezing	○
Abdominal pain	○
Diarrhea	○
Heartburn	○
Nausea	○
Trouble swallowing	○
Painful swallowing	○
Vomiting	○
Painful joints	○
Stiffness in joints	○
Swelling of joints	○

12. Do you now have or have you recently had any of the following? *(continued)*

	Yes
Change in sense of smell	○
Change in sense of taste	○
Headache	○
Severe face pain	○
Seizures	○
Tremor	○
Appetite is increased	○
Fatigue	○
Cold feeling	○
Bleed excessively after injury	○
Bruise easily	○
Masses (lumps) in armpit	○
Masses (lumps) in neck	○
Masses (lumps) in groin	○
Hives	○
Sneezing	○

Thank you for completing this questionnaire!