SOUTHERN OHIO SURGICAL ASSOCIATES

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WELCOME ABOARD!

Hello, we would like to introduce you to our staff, which consists of Dr. Khoury and Dr. Georgi, both board certified surgeons. Our goal is to provide you with the most updated, cutting edge service possible. However, we are a specialty service and sometimes emergencies do arise, and put our appointments behind schedule. We apologize in advance for cases like this. Please know that you and your family's health is our top priority.

Your doctor referred you to Southern Ohio Surgical Associates for an appointment on:

_____ @ _____

You will be seeing _____. It is our pleasure to welcome you to our office. This packet includes the following information;

- Patient information form
- New patient history that includes a list of your current medications, allergies, and previous surgeries as well as current medical conditions
- HIPPA forms (required for privacy)

Please have these forms completed and bring with you to your first visit, along with your driver's license and insurance card, along with any co-pay you may have.

If you are a patient without insurance, a $50.00 down payment is required to be seen, this is not the total charge for the visit. We do have the option for payment plans, if you require further assistance.

If you have any questions, concerns or need to reschedule your appointment, please feel free to contact the office at the number listed above.

Find us on the web at www.sosamd.org

PATIENT INFORMATION FORM **NAME:**	***Marital status (circle)*** **Single/Mar/Div/Sep/Wid**	**Sex (circle)** **Male Female**
Address:		

Birth date:	***Social Security Number:***	***Home Phone:***	***Cell Phone:***

Preferred Pharmacy:	***Ethnicity (circle)*** **Hispanic/Latino/Neither**	**Race: (circle)** **Caucasian/African Am/Nat Hawaii/ Native Am/Asian**

Employer:	***Work phone:***	***Drivers License:***

INSURANCE INFORMATION

Primary Insurance:	**Patients relationship to subscriber: (circle) Self/Spouse/Child/Other**	**Copayment Amount:**
Subscribers' Name:	**Subscribers Social Security**	**Subscribers DOB**
Address:	**Policy Number:**	**Group Number:**
Secondary Insurance:	**Patients relationship to subscriber: (circle) Self/Spouse/Child/Other**	**Copayment Amount:**
Subscribers' Name:	**Subscribers Social Security**	**Subscribers DOB**
Address:	**Policy Number:**	**Group Number:**

EMERGENCY CONTACT

Name of local friend or relative not living at same address:	**Relationship to patient:**	**Phone #**
Referring Doctor:	**Primary Care Physician:**	**Preferred method of contact** **Mail Phone Email**
Email address:		

Assignment of benefits- Authorization to release information -Financial responsibility

I hereby assign all medical/surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Southern Ohio Surgical Associates, Incorporated. This order will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not payed by insurance. I hereby authorize SOSA, Inc. to release all information necessary to secure payment and to complete necessary forms for me.

_____ _____

Patient/Guardian Signature *Date*

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PATIENT NAME: _____ ***DATE:*** _____

HEIGHT: _____ ***WEIGHT:*** _____

WHAT MEDICAL PROBLEM OR CONDITION ARE YOU HERE TO HAVE EVALUATED?

_____

PLEASE LIST ALLERGIES TO MEDICATIONS: _____

REACTION THESE MEDICINES CAUSE:

_____

PLEASE PROVIDE A LIST OF CURRENT MEDICATIONS OR LIST THEM BELOW

MEDICINE	***DOSAGE***	***HOW MANY TIMES PER DAY TAKEN***	***HOW LONG HAVE YOU TAKEN***

PAST MEDICAL HISTORY: (Please list your current and past medical conditions/problems)

_____ _____

_____ _____

_____ _____

_____ _____

PAST SURGICAL HISTORY: (Please list past surgeries that you have had)

Surgery	***Date of Surgery***
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY:

DO YOU SMOKE CIGARETTES (CIRCLE) ***YES*** ***NO***
IF YES, HOW MANY PACKS PER DAY _____

DO YOU DRINK ALCOHOL (CIRCLE) ***YES*** ***NO***
IF YES HOW MUCH PER DAY/WEEK _____

DO YOU HAVE A HISTORY OF DRUG USE OR CURRENT DRUG USE (CIRCLE)
YES ***NO***

FAMILY MEDICAL HISTORY: **(PLEASE LIST FAMILY MEMBERS WITH HISTORY OF CANCER, HEART DISEASE, DIABETES, ETC.)**

ILLNESS/DISEASE	**RELATIONSHIP**
EXAMPLE: LUNG CANCER	**BROTHER**
_____	_____
_____	_____
_____	_____

PLEASE LIST ANY OTHER MEDICAL ILLNESSES OR CHRONIC CONDITIONS NOT LISTED ABOVE:

Have you or any blood relative ever had any problems with anesthesia? If so, list below and the problems that you had:

Patient Signature: _____ **Date:**_____

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PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction or uses and disclosures of their protected health information ("PHI"). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means such as sending correspondence to the individual's office instead of the individuals' homes.

I wish to be contacted in the following manner (check all that apply)

- **Home telephone _____**
- **(OK to leave message with detailed information)**
  Work telephone_____
- **(Ok to leave message with detailed information)**
- **(Leave message with call-back number only)**
- **Written communication**
- **OK to mail to my home address**
- **OK to mail to my work/office address**
- **Ok to fax to this number: _____**

_____ _____

Patient Signature **Date**

_____ _____

Print Name **Birthday**

The Privacy Rule generally requires healthcare to take reasonable steps to limit the use or disclosure of, and request for PHI to minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below. If completed properly, will constitute adequate record.

NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Disclosed to whom address of Fax Number	(1)	Description of Disclosure/purpose of disclosure	By Whom Disclosed	(2)	(3)

(1)Check this box if the disclosure is authorized (2) Type Key: T=Treatment records, P=Payment information, O=Healthcare Operations

Notice of Privacy Practices Acknowledgement
Southern Ohio Surgical Associates
1711 27th St. Braunlin Building Suite 306
Portsmouth, Ohio 45662

I understand that, under the Health Insurance Portability & Accountability Act of 1996(HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operation such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY ATTEMPTED TO OBTAIN THE PATIENTS SIGNATURE IN ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW