Jefferson Surgical CLINIC

Thank you for choosing Jefferson Surgical Clinic for your health care needs.

Dr. Mark Schmidt's office is located at 5372 Fallowater Lane, Roanoke, VA. Directions and a map are enclosed.

We are enclosing several forms for you to complete prior to your appointment. **Please bring these completed forms at the time of your appointment and give them to the receptionist when you sign in.** Please arrive 15 minutes prior to your appointment time so we can review your documents and gather additional information if necessary. If you have not completed your paperwork, you will need to arrive 30 minutes prior to your appointment.

Your form packet includes:

Patient Information and Acknowledgement of Receipt of Privacy Notice/Consent

Consent and Authorization

Patient Medical History

Current Medications and Allergies

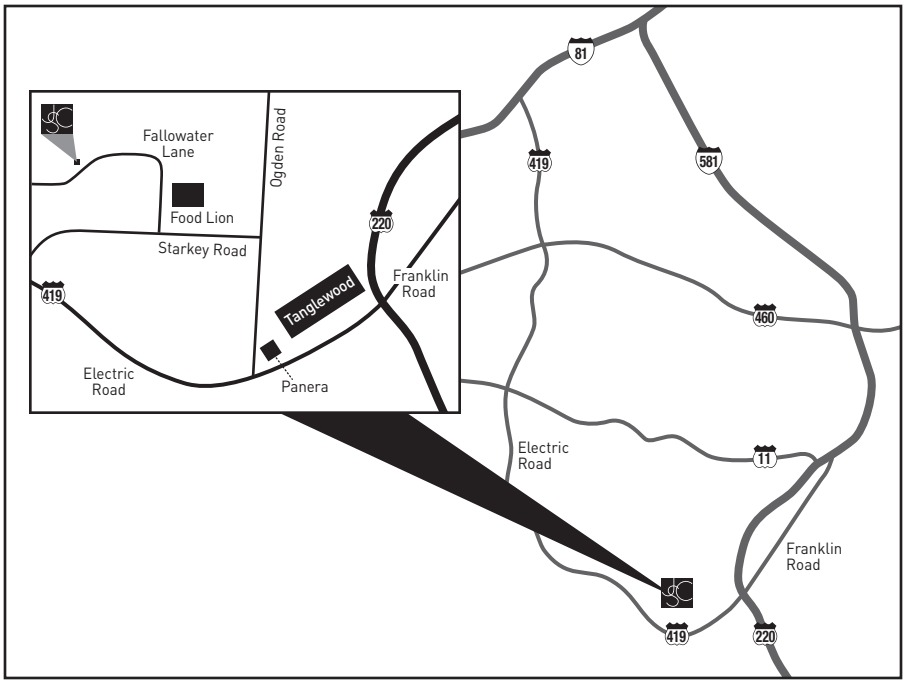
Notice of Privacy Policy

In addition to these completed forms, please bring your current insurance cards and your driver's license or valid picture ID. If your insurance requires a referral from your primary care physician, it is your responsibility to obtain that referral prior to arriving for your appointment. Any copayment required by your insurance company will be collected when you sign in.

Please call our office at 540.283.4942 or 540.283.6000 should you have questions prior to your appointment.

Jefferson Surgical
CLINIC

5372 Fallowater Lane
Roanoke, VA 24018
540.283.6000



From US 220 North:

- Exit at Franklin Road/Electric Road
- Go left on Route 419/Electric Road
- Turn right on Ogden Road (just past Panera Bread), then left on Starkey Road.
- Next turn right on Fallowater Lane
- 5372 Fallowater Lane is on your right

From I-81:

- Merge onto I-581 South/US 220 South via Exit 143 toward Airport/Roanoke
- Drive past downtown Roanoke and continue on US 220 to the Tanglewood Mall area
- Exit at Franklin Road/Electric Road
- Go right on Route 419/Electric Road
- Turn right on Ogden Road (just past Panera Bread), then left on Starkey Road.
- Next turn right on Fallowater Lane
- 5372 Fallowater Lane is on your right

Jefferson Surgical CLINIC

PATIENT INFORMATION

PLEASE PRINT AND COMPLETE ALL INFORMATION

Patient Name: _____
Last First Middle Maiden

Address: _____
Street or P.O. City State ZIP

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SS#: _____ DOB: _____ Sex: ____ Marital Status: _____

Race: _____ Hispanic: ☐Yes ☐No Language: _____

Employer: _____ Retired: ☐Yes ☐No

Patient E-Mail: _____ Pharmacy: _____

Family Physician: _____ Referred By Physician: _____

Spouse or Parent/Guardian (if minor)

Name: _____ DOB: _____ SS#: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE/CONSENT

I have been presented with a copy of this practice's NOTICE OF PRIVACY POLICIES, detailing how my information may be used and disclosed as permitted under federal and state law.

I hereby authorize Jefferson Surgical Clinic, Inc. to release any and all information pertaining to my health care, test results, procedures, billing and/or accounting, appointment needs or any other information contained in my records to the following person(s) or agency:

___ Spouse — Name: _____

___ Parents — Name: _____

___ Other — (Please Specify): _____

___ No One

I further authorize any Jefferson Surgical Clinic, Inc. representative to contact me in one or more of the following ways:

By phone: ___at home ___at work ___cell

By leaving a message: ___at home ___at work ___cell

Other: ___postal mail ___e-mail ___text

I authorize Jefferson Surgical Clinic (JSC) to charge my credit card for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account. I understand that JSC personnel will not have access to my credit card. Only the last four digits of my card number will be shown in the system. I understand that Jefferson Surgical Clinic, Inc. may release any information to those persons whom I have designated. They may receive this information without a separate consent or prior notification. I also understand that this relates to ALL the above-mentioned information. IF I WISH TO MAKE ANY CHANGES TO THE STATUS OF THIS FORM, I MUST DO SO IN WRITING.

Patient Signature: _____ Date: _____

If not signed by the patient, please indicate relationship to the patient (e.g., spouse, parent)

Relationship: _____ Witness: _____

Jefferson Surgical CLINIC

Name: _____ DOB: _____ Today's Date_____

CONSENT AND AUTHORIZATION

1. **Consent to Treatment:** I, the undersigned, do consent to the physicians of Jefferson Surgical Clinic, Inc. to administer any and all treatments deemed necessary for diagnostic or treatment purposes while in their care. This consent is given for a period of one year, ending one year from the date signed below.

2. **Consent to HIV Testing:** In case a health care worker of this Clinic, during your care, is punctured by a needle or is directly exposed to fluids that may transmit the HIV virus, in accordance with Section 32.1-45.1 of the Virginia Code, you will be deemed to have consented to the Clinic's right to draw blood for testing for the HIV virus and the release of such test results to the Clinic and the worker who suffered the exposure. All positive test results will be disclosed to the Department of Health. Other persons to whom the results may be disclosed include health care providers involved in your care or treatment, emergency medical services personnel, others who have access to the record for quality assurance, your parent(s) if you are a minor, or your spouse.

3. **Consent for Virginia Jurisdiction:** The relationship between the undersigned Patient and Jefferson Surgical Clinic shall be in accordance with and governed by the laws of the Commonwealth of Virginia in effect as of the date of this Registration. The Patient hereby consents to the personal jurisdiction of any state or federal courts located within the Commonwealth of Virginia.

4. **Authorization of Benefits:** I authorize the release of any medical information necessary to process my insurance claims for services rendered by Jefferson Surgical Clinic, and request payment to be made directly to Jefferson Surgical Clinic. I accept responsibility for all charges incurred at Jefferson Surgical Clinic.

5. **Consent to Medical Photography:** I consent for medical photographs to be made of me or my child (or person for whom I am legally responsible). By consenting to these medical photographs, I understand that I will not receive payment from any party for them. I understand the photograph(s) may be used in my medical record and for purposes of medical teaching.

6. **Authorization to Release PHI for Participation in Electronic Prescription Database:** I authorize the use or disclosure of my individual Protected Health Information (PHI) as described below, with the understanding that this authorization is voluntary and may be revoked at any time by notifying JSC, in writing, except to the extent it has already taken action in reliance on this authorization. This authorization covers individual prescription (present and future) PHI and prescription history disclosed by the physicians and other employees of Jefferson Surgical Clinic, P.C. (JSC) as well as to employees and agents of Sure Script and SRSsoft. The purpose of this disclosure of PHI is to permit JSC to provide prescription and prescription history information to a national electronic clearing house of such information to facilitate accessibility to and exchange of such information among my various health care providers and third-party pharmacy program payors for purposes of my treatment, reimbursement for prescriptions, and for any related purpose. If the organization authorized to receive the PHI is not a health plan, health care clearing house or health care provider covered by federal privacy regulations, the released PHI may no longer be protected from further use or disclosure by federal privacy regulations and may be subject to redisclosure by the recipient(s). I understand that I may see and receive a copy of the information described above if I request it in writing, I have the right to a copy of this consent, I have a right to refuse to sign this consent, and acknowledge that this consent will expire on termination of my status as a patient of Jefferson Surgical Clinic, P.C.

I have read and understand the consent information above. I understand any changes to the above consents must be made in person or in writing.

Patient Name (please print): _____

Patient Signature: _____ **Date:** _____

As the patient's ☐ Parent ☐ Legal Guardian or ☐ Power of Attorney, I am authorized to sign on behalf of the above named patient.

Authorized Signature: _____ **Date:** _____

Jefferson Surgical CLINIC

Name: _____ DOB: _____ Today's Date_____

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

DATE OF LAST PHYSICAL EXAM: _____ AGE: _____

CHIEF COMPLAINT: What is the main reason for your visit today? (Describe your problem in detail)

_____

_____

_____

History of Present Illness

Please answer the following questions

Location of the problem

___Abdomen ___Back ___Leg

Other _____

_____

_____

Front Back

On a scale of 1-10, with 10 being the most severe, choose the number that best describes the problem.

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

When did you first notice the problem?

☐2 days ago ☐2 weeks ago ☐1 month ago

Other _____

Does anything help or make the problem worse?

__Moving around __Standing up __Lying on my side

Other _____

How long does the problem last?

☐30 minutes ☐1 hour ☐It is always there

Other _____

Is anything else occurring at the same time?

☐YES ☐NO If yes, please explain.

__Nausea __Rash __Headaches

Other _____

Is the problem constant or variable?

☐Dull, then sharp ☐Very sharp, then leaves ☐Always there

Other _____

Does the problem interfere with your normal functions?

☐YES ☐NO If yes, please explain.

_____

_____

Physician use only: (Comments/Notes)

# Answer	Level of Service
1-2	1 or 2
4+	3-5

Past Medical, Family & Social History

List all serious illnesses in your immediate family. (Example: Diabetes, Tuberculosis, Breast Cancer, Heart Disease, etc.)

_____

_____

_____

List any personal past illness and / or surgeries and when they occurred.

Illness or Surgery Date

_____ _____

_____ _____

_____ _____

Do you smoke? ☐YES ☐NO

If yes, how much? _____

Do you drink? ☐YES ☐NO

If yes, how much? _____

Are you on any medications? ☐YES ☐NO (If yes, list all.)

_____

_____

Are you on a special diet? ☐YES ☐NO (If yes, please explain.)

_____

Do you have allergies? ☐YES ☐NO (If yes, please explain.)

_____

Physician use only: (Comments/Notes)

# Answer	Level of Service
0	1 or 2
1-2	3
3	3-5

Jefferson Surgical CLINIC

Name: _____ DOB: _____ Today's Date_____

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following systems? Check Yes or No.
Please explain any Yes answers in space provided.

Constitutional Symptoms
Fever ☐ Y ☐ N
Chills ☐ Y ☐ N
Headache ☐ Y ☐ N
Other _____

Eyes
Blurred vision ☐ Y ☐ N
Double vision ☐ Y ☐ N
Pain ☐ Y ☐ N
Other _____

Allergic / Immunologic
Hay fever ☐ Y ☐ N
Drug allergies ☐ Y ☐ N
Other _____

Neurological
Tremors ☐ Y ☐ N
Dizzy spells ☐ Y ☐ N
Numbness / Tingling ☐ Y ☐ N
Other _____

Endocrine
Excessive thirst ☐ Y ☐ N
Too hot / cold ☐ Y ☐ N
Tired / sluggish ☐ Y ☐ N
Other _____

Gastrointestinal
Abdominal pain ☐ Y ☐ N
Nausea / Vomiting ☐ Y ☐ N
Indigestion / Heartburn ☐ Y ☐ N
Other _____

Cardiovascular
Chest pain ☐ Y ☐ N
Varicose veins ☐ Y ☐ N
High blood pressure ☐ Y ☐ N
Other _____

Integumentary
Skin rash ☐ Y ☐ N
Boils ☐ Y ☐ N
Persistent itch ☐ Y ☐ N
Other _____

Musculoskeletal
Joint pain ☐ Y ☐ N
Neck pain ☐ Y ☐ N
Back pain ☐ Y ☐ N
Other _____

Ear / Nose / Throat / Mouth
Ear infection ☐ Y ☐ N
Sore throat ☐ Y ☐ N
Sinus problem ☐ Y ☐ N
Other _____

Genitourinary
Urine retention ☐ Y ☐ N
Painful urination ☐ Y ☐ N
Urinary frequency ☐ Y ☐ N
Urinary incontinence ☐ Y ☐ N
Other _____

Respiratory
Wheezing ☐ Y ☐ N
Frequent cough ☐ Y ☐ N
Shortness of breath ☐ Y ☐ N
Other _____

Hematologic / Lymphatic
Swollen glands ☐ Y ☐ N
Blood clotting problem ☐ Y ☐ N
Other _____

Psychologic
Are you generally satisfied with your life? ☐ Y ☐ N
Do you feel severely depressed? ☐ Y ☐ N
Have you considered suicide? ☐ Y ☐ N
Other _____

Physician use only: (Comments/Notes)

# Answer	Level of Service
0-1	1 or 2
2-9	3
10+	4-5

Physician's Signature: _____ Date: _____

Jefferson Surgical CLINIC

Name: _____ DOB: _____ Today's Date_____

CURRENT MEDICATIONS

List all medications you are currently taking and their dosage and frequency.
Please also list herbal and OTC medications.

Name of Medication	Dose	Frequency	Date Started	Prescribed By

ALLERGIES

Allergic To	Type of Reaction

Attach additional paper if needed.

Jefferson Surgical CLINIC

NOTICE OF PRIVACY POLICY

This notice, effective April 1, 2003, describes how information about you may be used and disclosed and how you can get access to this information. The physicians and staff of Jefferson Surgical Clinic are committed to treating and using your protected health information responsibly. This Notice of Privacy Policy describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice of Privacy Practices covers all departments within our practice, and any physicians, providers, and staff who treat you at any of our locations.

Each time you visit the physician, a record of your visit is made. These records contain personal information and medical information and are used for your direct care and treatment. It's also used to produce an accurate bill for the services you receive, helps improve the care we give and strengthens the operations of our organization.

Your Health Information Rights
Although your medical record is the physical property of Jefferson Surgical Clinic, the information in it belongs to you. You have the following rights with respect to your health information:

You can inspect and get a copy of your health information that may be used to make decisions about your care, subject to a few limited exceptions. You may request copies of your health information, in writing, from medical records personnel at Jefferson Surgical Clinic. We may charge a fee for the costs of copying, mailing or other supplies associated with your request.

If you feel the health information is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, our practice. Your request must be made in writing and include the reason for your request. We may deny your request if you ask us to amend information that was not created by us. We may also deny your request to amend information if we believe the information to be accurate and complete.

You may request a restriction or limitation on the health information we use or disclose about you for treatment, payment or our operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. We are not required to agree to your request. In your request, you must tell us:

- What information you want to limit.
- Whether you want to limit our use, disclosure or both.
- Who you want to receive your medical information.

You can request an accounting of your health information disclosures, except for those needed to carry out treatment, payment or our operations. Other exceptions include, but are not limited to:

- For national security and intelligence.
- Use by law enforcement officials or correctional institutions.

Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003.

The first list you request within a 12-month period will be free.

You can revoke your authorization to use or disclose health information, unless disclosure has already occurred.

You can request communications of your health information by alternative means, at alternative locations or in a confidential manner. For example, you can ask that we contact you only at work or by mail. We will accommodate all reasonable requests.

You can request a paper copy of this notice even if you have agreed to receive the notice electronically.

Our Responsibilities
Jefferson Surgical Clinic is required by law and is committed to:

- Maintain the privacy of your health information.
- Provide you with this notice of our legal duties and privacy practices with respect to health information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction and, in most cases, allow you to request a review of our decision.

We reserve the right to change our privacy practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will amend this notice and post a copy of the revised notice.

This notice will contain on the first page the effective date. In addition, the first time you register at our practice for health care services as patient, we will offer you a copy of the current notice in effect.

For More Information or to Report a Problem
If you have questions and would like additional information, you may contact Beth Bankston, Jefferson Surgical Clinic's Privacy Officer, at 540-283-6000. If you believe your privacy rights have been violated, you can file a complaint with Jefferson Surgical Clinic's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201

Jefferson Surgical CLINIC

NOTICE OF PRIVACY POLICY

Permitted Uses and Disclosures Which Do Not Require Your Written Consent or Authorization

We will use your health information for treatment, which means the provision, coordination or management of the health care services we provide. For example, information obtained by a nurse, physician or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his/her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will use your health information for payment, an activity necessary for us to receive reimbursement for the services we provide to you. For example: a bill may be sent to you, an insurance company or other payer. The information on, or accompanying, the bill may include information that identities you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health care operations, such as quality assessments, evaluating practitioner performance, cost management and general administrative activities. For example: members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide, and provide training to our staff.

Some services are provided in our practice through contracts with business associates, We may disclose your health information to our business associates so they can perform the job we've asked them to do. Our contracts require business associates to appropriately protect the privacy and security of your health information.

We may disclose health information relevant to your care or payment for your care to a family member, other relatives, a close personal friend or any other person you identify.

During the initial visit, we may ask you to identify those whom you would like to receive information about you.

We may use or disclose health information to notify or assist in notifying a family member, personal representative, or another person responsible for your care about your location and general condition.

We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the practice. In leaving a message on an answering machine, we will only leave our name and the appointment's time and date.

We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use sign-in sheets in certain locations to check you into the practice. We also may call your name in the waiting area. If you do not wish to sign the sign-in sheet or have your name called, please tell the receptionist and we will make adjustments to meet your request.

We may also disclose health information as permitted or required by law, such as in the following circumstances:

- to the extent required by worker's compensation or other similar programs.
- to a health oversight agency for audits, investigations and inspections
- to public health or legal authorities charged with maintaining health records and preventing or controlling disease, injury or disability.
- to the FDA relative to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs or replacement.
- to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. We will always ask for your specific authorization if the researcher will have access to your name, address or other information that reveals who you are or will be involved in your care at one of our facilities.
- to research, public health and health care operations in a limited, non-identifiable, data set.
- to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant. Organs will only be procured with written authorization.
- to a coroner or medical examiner and to funeral directors as necessary to carry out their duties.
- to a law enforcement official or in response to a court order, subpoena, warrant, summons or similar process.
- to authorized federal officials for intelligence, counterintelligence and other national security activities.
- if you are a member of the armed forces, as required by military command authorities.
- to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct investigations.
- If you are an inmate of a correctional institution, to the institution or agents for your health and the health and safety of other individuals.
- A Group Health Plan may disclose protected health information to a plan sponsor.

Other uses and disclosures of medical information not covered by this notice, required for emergency treatment or permitted by the laws that apply to us will be made only with your written authorization. If you authorize disclosure, you may revoke that, in writing, at any time.

If you revoke your authorization, we will not use or disclose your medical information for the reasons covered by your prior written authorization. Please understand we are unable to take back disclosures we already made with your prior authorization, and that we are required to retain our records of the care that we provide to you.