

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

Dr. Charles Daniel's office is located at 1234 Franklin Road, S.W., Roanoke, VA. Directions and a map are enclosed. We offer handicapped parking at 1229 3rd Street, S.W. All other parking is across from our main Walnut Avenue entrance.

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

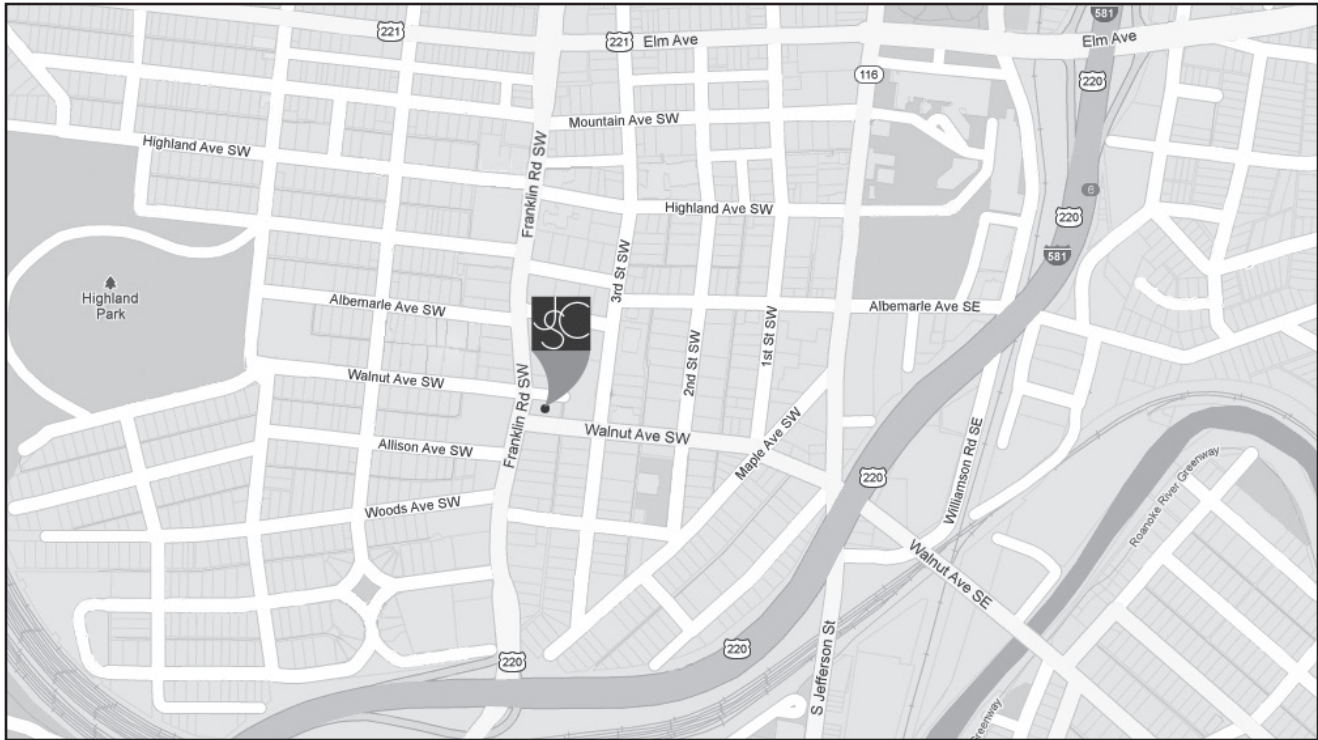
Current Medications and Allergies

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 540.283.6026 or 540.283.6000 should you have questions prior to your appointment.

**Main Office**  
**1234 Franklin Road**  
**Roanoke, VA 24016**  
**540.283.6000**



**From I-81:**

- Merge onto I-581 South/US 220 South via Exit 143 toward Airport/Roanoke
- Take the VA-24/Elm Avenue exit (Exit 6)
- Take the ramp toward Downtown
- Merge onto Elm Avenue Southeast
- Turn left onto US-220 Franklin Road Southwest
- Turn left onto Walnut Avenue
- Turn right into the first parking lot on your right
- Jefferson Surgical Clinic is at the corner of Franklin Road and Walnut Avenue

**From US 220 North/I-581 North:**

- Take the Franklin Road Southwest exit
- Turn right at the first traffic light onto Walnut Avenue
- Turn right into the Jefferson Surgical Clinic parking lot
- Jefferson Surgical Clinic is at the corner of Franklin Road and Walnut Avenue

**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: <input type="checkbox"/> Yes <input type="checkbox"/> No Language: _____				
Employer: _____				Retired: <input type="checkbox"/> Yes <input type="checkbox"/> No
Patient E-Mail: _____			Pharmacy: _____	
Family Physician: _____			Referred By Physician: _____	

<b>Spouse or Parent/Guardian (if minor)</b>		
Name: _____	DOB: _____	SS#: _____

<b>Emergency Contact:</b> _____	Relationship: _____	Phone: _____
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**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: \_\_\_\_\_

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: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date \_\_\_\_\_

## FEMALE UROLOGIC HISTORY

CHARLES D. DANIEL, M.D.

Please answer the following questions as thoroughly as possible:

### 1. Has the force of your urinary stream changed?

Yes  No

If yes, please describe the change in your urinary stream: \_\_\_\_\_  
 \_\_\_\_\_

### 2. Have you experienced any of the following?

(Please check under either "yes" or "no")

	<u>YES</u>	<u>NO</u>
Abnormal menses	___	___
Difficult or painful voiding	___	___
Feeling of incomplete emptying	___	___
Blood in urine	___	___
Urinary hesitancy	___	___
Urinary incontinence	___	___
Getting up at night to urinate	___	___
Low urine output	___	___
Excessive urination	___	___
Urinary urgency	___	___
History of renal failure	___	___
Suprapubic/Pelvic pain	___	___
Flank pain	___	___
Abdominal pain	___	___
<b>History of:</b>		
Stones	___	___
Urinary tract infections	___	___
Sexually transmitted diseases	___	___
Genitourinary surgery	___	___
Urologic malignancy	___	___
Urologic trauma	___	___

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date \_\_\_\_\_

**PATIENT MEDICAL HISTORY**  
CHARLES D. DANIEL, M.D.

REFERRING PHYSICIAN NAME & PHONE: \_\_\_\_\_

PRIMARY PHYSICIAN NAME & PHONE: \_\_\_\_\_

Please help us obtain accurate information for your medical records by completing this form:

List ALL allergies to medications, food, etc. Please include reaction.

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LIST ALL OPERATIONS:

Types of surgery:

Date:

Surgeon:

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CONTINUED ON NEXT PAGE

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date \_\_\_\_\_

**PATIENT MEDICAL HISTORY (continued)**

<b>Medical Illnesses (check either yes or no):</b>			<b>Additional History:</b>	<b><u>YES</u></b>	<b><u>NO</u></b>
<b><u>ILLNESS</u></b>	<b><u>YES</u></b>	<b><u>NO</u></b>			
Diabetes	___	___	Do you smoke?	___	___
Heart Disease	___	___	How much per day? _____		
High Blood Pressure	___	___	How long have you smoked? _____		
High Cholesterol	___	___	Do you use alcohol?	___	___
Heart Murmur	___	___	How much per day? _____		
Angina/Chest Pain	___	___	How long have you used alcohol? _____		
Heart Attack	___	___	Have you ever had a problem with anesthesia?	___	___
Stroke	___	___	Has anyone related to you ever had a problem with anesthesia?	___	___
Atrial Fibrillation	___	___	Have you ever had a heart catheterization?	___	___
Liver Disease	___	___	Have you had cardiac stents?	___	___
Epilepsy	___	___	Do you have a cold now?	___	___
Asthma	___	___	If female, could you be pregnant?	___	___
Glaucoma	___	___	Number of children? _____		
Other: _____			Ages of children? _____		

**Family History (mark yes or no & type of relationship):**

<b><u>ILLNESS</u></b>	<b><u>YES</u></b>	<b><u>NO</u></b>	<b><u>RELATIONSHIP</u></b>
Diabetes	___	___	_____
High Blood Pressure	___	___	_____
Heart Disease/Attack	___	___	_____
Stroke	___	___	_____
Thyroid Disease	___	___	_____
Sudden Death	___	___	_____
Breast Cancer	___	___	_____
Testicular Cancer	___	___	_____
Uterine Cancer	___	___	_____
Ovarian Cancer	___	___	_____
Colon Cancer	___	___	_____
Kidney Cancer	___	___	_____
Prostate Cancer	___	___	_____
Bladder Cancer	___	___	_____
Kidney Stones	___	___	_____
Genitourinary Malignancy	___	___	_____
Renal Stone Disease	___	___	_____
Genitourinary Illness	___	___	_____
Renal Failure	___	___	_____
Other: _____			_____

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date \_\_\_\_\_

**REVIEW OF SYSTEMS**  
 CHARLES D. DANIEL, M.D.

Please check Yes or No for the symptoms you currently have.

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Chills	___	___	Too Hot	___	___
Fatigue	___	___	Too Cold	___	___
Fever	___	___	Enlarged Breast Tissue	___	___
Weight Loss	___	___	Vision Loss	___	___
Chest Pain/Pressure	___	___	Blurred Vision	___	___
Leg Swelling	___	___	Nausea	___	___
Irregular Beat	___	___	Blood in Stool	___	___
Arthritis	___	___	Vomiting	___	___
Amputations	___	___	Bowel Changes	___	___
Bone Pain	___	___	Yellowing of the Skin or Eyes	___	___
HIV/AIDS	___	___	Blood in Urine	___	___
Hepatitis	___	___	Frequent Urination	___	___
Weakness	___	___	Urinary Incontinence	___	___
Numbness	___	___	Hemophilia/Bleeding Disorders	___	___
Dizzy Spells	___	___	Memory Loss	___	___
Rash	___	___	Personality Change	___	___
Scar	___	___	Depression	___	___
Trouble Swallowing	___	___	Shortness of Breath with Activity	___	___
Cancer of Head & Neck	___	___	Shortness of Breath Lying Down	___	___
Excessive Thirst	___	___	Shortness of Breath	___	___

Signature: \_\_\_\_\_





## 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

## 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 identifies 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.