Steve Gardilcic, M.D.
675 Bally Row Mansfield, OH 44907
(419) 756-4999 Fax: (419) 756-4949

CONFIDENTIAL PATIENT DATA

PATIENT INFORMATION

Name: ______________________________

Address: ______________________ E-mail ______________________

City ______________________ State: __________ Zip Code: __________

Telephone (Home): ______________________________

(Work or Other). ______________________________

Birthdate: ______________________ Sex: M F Marital Status. S M W 0

Social Security Number: ______________ Employer: ______________________

Primary Physician: ______________________________

Who referred you?: ______________________________

Person to contact in emergency & Relationship: ______________________

Emergency Telephone: ______________________________

Preferred Pharmacy & Which Location: ______________________

RESPONSIBLE PARTY

Party responsible for payment: Self Spouse Parent Other

Name (if other than Self): ______________________________

Address: ______________________________

City ______________________ State __________ Zip Code: __________

PRIMARY INSURANCE

Primary Medical Insurance: ______________________________

Insured party: Self Spouse Parent Other

ID# / Social Security No.: ______________ Group/Plan No.: ______________

Name (if other than Self): ______________ Employer: ______________

Address: ______________________________

City ______________________ State __________ Zip Code: __________

SECONDARY INSURANCE

Secondary Medical Insurance: ______________________________

Insured party: Self Spouse Parent Other

ID# / Social Security No.: ______________ Group/Plan No.: ______________

Name (if other than Self): ______________ Employer: ______________

Address: ______________________________

City ______________________ State __________ Zip Code: __________

REQUIRED RELEASES/ SIGNATURES

In compliance with the Federal Consumer Protection Act, Steve Gardilcic, M.D., wishes to notify you of his policies regarding the financial responsibilities associated with services rendered to you or a member of your household/family.

1. We will furnish you with a monthly statement of your account showing both the amounts billed to you and the payments or credits to your account. The monthly invoice/bill will also provide you with a detailed aging of how long balances have been outstanding.

2. We require the patient to be responsible for insurance filing and payment problems. However, we do file many types of insurance forms for our patients. Please talk to our office staff to determine your specific responsibilities in this area.

3. ***Payment for services rendered are considered due and payable at the time you receive services***. Extended payment programs are available to you if arranged in advance and approved by the office manager.

4. We charge a finance charge on all delinquent account balances. The finance charge is computed by a periodic rate of 1.2% per month, which equates to an annual percentage rate of 14.4%. The amount on which the periodic rate is applied shall be outstanding balances which are 30 days or more old as of the date of each monthly statement after deducting all current payments and credits shown on the statement. All payments will be applied to the oldest charges first.

The undersigned hereby acknowledges to have read and agrees to the above financial credit and payment policies of Steve Gardilcic, M.D.

Date: ________ Signature: ____

REQUIRED RELEASES/ SIGNATURES

RECORDS RELEASE: I hereby authorize the release of any information by Steve Gardilcic, M.D. to my referring doctor, insurance company, and immediate family on behalf of myself and/or dependant.

ASSIGNMENT OF BENEFITS: I direct assignment of payment of medical benefits to Steve Gardilcic, M.D. for services rendered to myself and/or dependants.

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made on my behalf to Steve Gardilcic, M.D. for any services furnished to me by that physician. I authorize any holder of hospital or medical information about me to release to HCFA and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Date: ________ Signature: ____

I

Health History
(Confidential)

Name ______________________________ Date ________________

Age __________ Birthday ____________ Height __________ Weight ____________

Marital Status: _Married _Single _Divorced _Widowed Who were you referred by? ____________

What is your reason for visit? ____

SYMPTOMS Check ALL symptoms you currently have or have had persistently.

GENERAL
__Fever
__Chills
__Sweats
__Anorexia
__Fatigue
__Malaise
__Weight Loss

EYES
__Blurred vision
__Double vision
__Eye irritation
__Eye discharge
__Vision loss
__Eye pain
__Sensitivity to light

EARS, NOSE, THROAT
__Earache
__Ear discharge
__Ringing in ears
__Decreased hearing
__Nasal congestion
__Nose Bleeds
__Sore Throat
__Hoarseness
__Difficulty swallowing

CARDIOVASCULAR
__Chest pains
__Palpitations
__Fainting
__Shortness of breath
__Difficulty breathing if not in upright position
__Difficulty breathing at night
__Swelling of hands/feet

RESPIRATORY
__Cough
__Difficulty breathing
__Excessive sputum
__Bloody sputum
__Wheezing

GASTROINTEST.
__Nausea
__Vomiting
__Diarrhea
__Constipation
__Change in bowel habits
__Abdominal pain
__Black, tarry stool
__Bloody stool
__Yellow jaundice

GENITOURINARY
__Painful urination
__Blood in the urine
__Discharge
__Urinary frequency
__Hesitancy urinating
__Night frequency
__Urinary leakage

MEN only
__Erection difficulty
__Lump in testicle
__Penis discharge
__Sore on penis
__Decreased sex drive
__Other ________

WOMEN only
__Abnormal pap smear
__Breast lump
__Abnormal absence of menstrual periods
__Unusually heavy menstrual periods
__Abnormal vaginal bleeding
__Vaginal discharge
__Pelvic pain

Are you pregnant?_____

Number of children____
Date of last Menstrual period______

MUSCULE/BONES
__Back pain
__Joint pain
__Joint swelling
__Muscle cramps
__Muscle weakness
__Stiffness
__Arthritis

SKIN
__Rash
__Itching
__Dryness
__Suspicious lesion

NEUROLOGIC
__Transient paralysis
Weakness
__Tingling/ Prickling

__Seizures
__Tremors
__Dizziness

PSYCHIATRIC
__Depression
__Anxiety
__Memory loss
__Mental disturbance
__Suicidal ideation
__Hallucinations
__Paranoia

ENDOCRINE
__Cold intolerance
__Heat intolerance
__Excessive thirst
__Excessive eating
__Excessive output of urination
__Weight change

HEME/LYMPHATIC
__Abnormal bruising
__Abnormal bleeding
__Enlarged lymph nodes

ALLERGY/IMMUNO
__Hives
__Hay fever
__Persistent infections
__HIV Exposure

CONDITIONS Check ALL Conditions you are being treated for or have had in the past

AIDS
Alcoholism
Anemia
Bleeding Disorders
Cancer
High Blood Pressure
Diabetes
Epilepsy
Goiter
Gonorrhea
Gout
Heart Disease
Hepatitis
Hernia
Herpes
HIV Positive
Kidney Disease
Liver Disease
Multiple Sclerosis
Pacemaker
Prostate Problems
Psychiatric Care
Thyroid Problems
Tuberculosis

Please fill out all sections completely. Write "NO" for all that do not apply.

MEDICATIONS List medications you are currently taking

____
____
____

DRUG ALLERGIES: ______________________________

FAMILY HISTORY Has any blood relative had any of the following

	Relationship		Relationship
__Cancer	____________	__Stroke	____________
__Tuberculosis	____________	__Kidney Stones	____________
__Diabetes	____________	__Kidney Disease	____________
__Heart Disease	____________	__Anemia	____________
__High blood pressure	____________	__Other	____________

PERSONAL HISTORY

Past Urological History: ______________________________
Past Medical History: ______________________________
Past Surgical History: ______________________________

HEALTH HABITS Check which substances you use and describe how much you use.

Tobacco use:
- ☐ Current: Type and # per day____________
- ☐ Previous: Year you quit _______
- ☐ Never

Drug use:
Substance____________

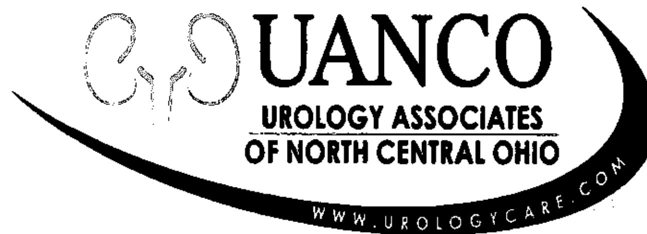
Sun Exposure: Frequently____ Occasionally_____ Rarely ____

Caffeine use: yes____ no____ # per day________
Exercise: yes____ no____
If yes: Type and # days per week: __________
Alcohol use: yes____ no____
If yes: Type and # per day:______________
Seatbelt use: yes____ no____

OCCUPATIONAL CONCERNS Check if your work exposes you to the following:

- ☐ Hazardous Substances
- ☐ Heavy lifting
- ☐ Unable to go to the bathroom on demand

Occupation: ______________________



Medical Information Technology Consultants
dba Urology Associates Facility

Patients' Rights and Responsibilities

Every patient has the responsibility for:

1. Providing full information about your condition to the people directly involved in providing care.
2. Following preparation instructions and asking questions, when lack of understanding or confusion still exists.
3. Following the office's rules and regulations, including those about smoking and safety.
4. Being considerate and respectful of the rights of other patients and office personnel and respecting the property of other persons and the office.
5. Following your physician's orders or the orders of other members of the health care team as they carry out the plan for your care.
6. Reporting any changes in your condition to the physician or another member of the health care team.
7. Prompt payment of your portion of the doctor's bill to help us continue to provide quality care.
8. Accepting personal financial responsibility for any charges not covered by his/her insurance.
9. Informing his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.
10. Providing correct information on the patient registration sheet, and to provide the nursing staff with a complete health history, including allergies, surgical history and current medications.
11. Bringing a responsible adult driver/care giver as requested.
12. Following the physician's post-operative instructions.

Every patient has the right to:

1. Respectful care with consideration for personal dignity.
2. Access to physician care regardless of race, creed, sex, national origin, or handicap.
3. Expect reasonable privacy.
4. Assurance that personal medical records will not be released without his/her consent, except as provided by law or third party payment contract.
5. Expect a safe and clean environment.
6. Know the identity and professional status of those providing services.
7. Expect a good communication by members of the health care team.
8. Refuse to participate in research.
9. Access to and communication with families, patient guardian, and visitors. Patients with special needs (foreign language, hearing impairment, religious or cultural practices) can request consideration for these needs.
10. Be informed of office rules and regulations applicable to a patient's conduct. Every patient is entitled to request assistance to resolve problems.
11. Examine and receive a full explanation of the office bill regardless of the source of payment, and to be informed of the process within the office to resolve billing questions or problems.
12. Request a second opinion if you feel it necessary as to your treatment plan and diagnosis.

13. Receive information from his/her physician about his/her illness, course of treatment, and prospects for recovery in terms that he/she can understand.
14. Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in each and to know the name of the person who will carry out the procedure or treatment.
15. Participate actively in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to refusal.
16. Reasonable responses to any reasonable requests he/she may make for service.
17. Leave the facility even against the advice of his/her physicians.
18. Reasonable continuity of care and to know in advance the time and location of appointment as well as the physician providing the care.
19. Be informed by his/her physician or a delegate of his/her physician of his/her continuing health requirements following his/her discharge from the facility.
20. Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
21. If the patient has decision-making capacity, may designate visitors of his/her choosing, whether or not the visitor is related by blood or marriage, unless: (A) No visitors are allowed; (B) The facility reasonably determines that the presence of a particular visitor is detrimental to the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility; (C) The patient has indicated to the health facility staff that the patient no longer wants this person to visit.
22. Have the patient's wishes considered for purposes of determining who may visit if the patient lacks decision-making capacity and to have the method of that consideration disclosed in the center's policy on visitation.
23. This section may not be construed to prohibit a health facility from otherwise establishing reasonable restrictions upon visitation, including restrictions upon the hours of visitation and numbers of visitors.

ANY QUESTIONS OR COMMENTS REGARDING THE PATIENT'S RIGHTS AND RESPONSIBILITIES CAN BE DIRECTED TO CHRIS KOEHLER, OFFICE MANAGER, AT 419-756-4999.

OHIO DEPT OF HEALTH PATIENT COMPLAINT NUMBER: 1-800-669-3534

ADVANCE DIRECTIVES

We are not required to honor and do not honor DNR/Advance Directives. A healthcare power of attorney will be honored. If a patient should provide his/her advance directive, a copy will be placed on the patient's medical record and transferred with the patient should a hospital transfer be ordered. If a patient wishes to receive more information regarding Advance Directives, they will be referred to the following web site:

www.franklincountyohio.gov/probate/index.cfm/

PHYSICIAN OWNERSHIP OF UROLOGY ASSOCIATES FACILITY

This is to inform you that Dr. Steve Gardilcic is the owner of Urology Associates of North Central Ohio, Medical Information Technology Consultants dba Urology Associates Facility

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Urology Associates of North Central Ohio, Inc. is permitted to make uses and disclosures of protected health information for treatment, payment and health care operations, as described in the following examples:

    a. For treatment – to call prescriptions to the pharmacy, send reminder postcards for appointments, coordinate care with other providers.
    b. For payment – information released to your insurance company for payment of services rendered, and for review requests as necessary.
    c. For health care operations - to coordinate care between physicians, test facilities and hospitals.

2. Urology Associates of North Central Ohio, Inc. is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization. [If a use or disclosure for any purpose prescribed in the Privacy Regulation is prohibited or materially limited by other applicable State law, the description of such use or disclosure must reflect the more stringent law.]

3. Other uses and disclosures will be made only with the Individual's written authorization, and the individual may revoke such authorization.

4. Urology Associates of North Central Ohio, Inc. intends to engage in (n)one or more of the following activities:

    a. Urology Associates of North Central Ohio, Inc. may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.

5. The Individual has the following rights regarding protected health information:

    a. The right to request restrictions on certain uses and disclosures of protected health information. Urology Associates of North Central Ohio, Inc. is not required to agree to a requested restriction, however.
    b. The right to receive confidential communications of protected health information, as applicable.
    c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.
    d. The right to amend protected health information, as provided in the Privacy Regulation.
    e. The right to receive an accounting of disclosures of protected health information.
    f. The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.
    g. The right to pay in full for out of pocket expenses for health care services and request that Urology Associates of North Central Ohio, Inc. not disclose his or her medical information to a health plan or other entity. Urology Associates of North Central Ohio, Inc. must comply with this request effective February 18, 2010.

h. The right to be notified of any breach of health care information. If the breach involves 500 people or less, the responsible party must notify each affected individual by written notice. This notice must contain the details of the breach, the information disclosed, and the steps being taken by the practice or entity to avoid any future breaches, as well as explaining the rights of the individual(s) in protecting their private health care information. If the breach involves more than 500 people, the Department of Health and Human Services will be notified as well as the local media outlets. Effective February 22, 2010.

6. Urology Associates of North Central Ohio, Inc. is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and Privacy practices with respect to protected health information.

7. Urology Associates of North Central Ohio, Inc. is required to abide by the terms of the Notice currently in effect.

8. Urology Associates of North Central Ohio, Inc. reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains.

9. Urology Associates of North Central Ohio, Inc. will provide individuals or patients with a revised Notice by posting on our web site and availability in our office.

10. Individuals may complain to Urology Associates of North Central Ohio, Inc. and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated. A brief description of how the individual may file a complaint follows: as outlined in the Complaint Process Policy available upon request. Complaints should be made in writing to Shari Bascom HIPAA Compliance Officer.

11. Urology Associates of North Central Ohio, Inc.'s contact person for matters relating to complaints is:

    Shari Bascom, HIPAA Compliance Officer
    419-756-4999
    675 Bally Row, Mansfield, OH 44906

12. This Notice is first in effect on [3/11/03 – The effective date must not be earlier than the date on which the Notice is printed or otherwise published].

13. Urology Associates of North Central Ohio, Inc. elects to limit the uses or disclosures that it is permitted to make, as follows: Uses and disclosures shall be as needed to facilitate and coordinate patients care and/or by specifically requested or permitted by patient.

I hereby acknowledge that I have received a copy of the Urology Associates of North Central Ohio, Inc.'s Notice of Privacy Practices.

Revised 2/1/10