MARK TAPSCOTT, D.O.
DISEASES OF THE COLON & RECTUM

NEW PATIENT INFORMATION SHEET

NAME____**TODAY'S DATE**_________________________

ADDRESS____**CITY/STATE/ZIP**______________________________

HOME PHONE________________________**WORK PHONE**_____________________**CELL PHONE**_______________

DATE OF BIRTH________________________**SEX M F SOCIAL SECURITY#**_______________________________

REFERRED BY_________________________**PHONE#**_________________________**MARITAL STATUS: S / M / D / W**

EMPLOYER____**OCCUPATION**___________________________

EMPLOYER'S ADDRESS____

E-MAIL ADDRESS____

- -

SPOUSE / GUARDIAN'S NAME____**DATE OF BIRTH**_________________

SOCIAL SECURITY #______________________**HOME PHONE**____________________**WORK**___________________

- -

EMERGENCY CONTACT____**PHONE**________________________________

ADDRESS____**RELATIONSHIP TO PATIENT**_____________________

- -

PRIMARY INSURANCE____**PHONE**______________________

ID / SUBSCRIBER #______________________________________**GROUP NUMBER**_______________________________

SECONDARY INSURANCE____**PHONE**______________________

ID/SUBSCRIBER #_______________________________________**GROUP NUMBER**_______________________________

- -

PLEASE READ AND SIGN

I CONFIRM THAT ALL INFORMATION ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND MY FINANCIAL OBLIGATIONS, (DEDUCTIBLES, CO PAYS, COINSURANCE, ETC.) AND AGREE TO PAY AS INDICATED.

SIGNATURE____**TODAY'S DATE**_________________________________

MEDICAL HISTORY

(PAGE 1)

PERSONAL INFORMATION:

REASON FOR VISIT____

LIST ALL MEDICATIONS PRESENTLY TAKING, INCLUDING DOSAGE AND FREQUENCY:

____

____

PLEASE STATE AMOUNT PER DAY AND NUMBER OF YEARS USING THE FOLLOWING:

COFFEE__________/____________**TEA**____________/__________________**ALCOHOL**___________/____________

NICOTINE__________/_____________**CAFFEINATED COLD DRINKS**__________________/___________________

ARE YOU ALLERGIC TO ANY FOODS OR MEDICINES? YES_____________**NO**___________**IF YES, EXPLAIN:**

____

HAVE YOU HAD ANY SURGERIES? YES___________**NO**___________**IF YES, WHAT KIND OF SURGERIES?**

____

____

FAMILY HISTORY:

IS YOUR FATHER LIVING? _________________**PRESENT AGE OR AGE OF DEATH**_________________________

CAUSE OF DEATH____

IS YOUR MOTHER LIVING? ________________**PRESENT AGE OR AGE OF DEATH**_________________________

CAUSE OF DEATH____

PLEASE INDICATE BLOOD RELATIVES THAT HAVE OR HAD ANY OF THE FOLLOWING:

DIABETES__________________ ____________________ **EPILEPSY**___________________ _____________________

ARTHRITIS__________________ ____________________**CANCER**__________________ ______________________

TUBERCULOSIS_________________ ___________________**HEART DISEASE**________________ _______________

LEUKEMIA___________________ ____________________**GOUT**__________________ ________________________

HIGH BLOOD PRESSURE_________________ ________________**ASTHMA**_________________ ________________

THYROID DISEASE_______________ ________________**ECZEMA**___________________ _____________________

KIDNEY STONES__________________ __________________**GALL STONES**__________________ ______________

PERSONAL MEDICAL HISTORY
(PAGE 2)

PLEASE CHECK IF YOU HAVE EVER SUFFERED FROM ANY OF THE FOLLOWING AND AT WHAT AGE:

EYES AND EARS:	YES	NO	AGE
WEAR GLASSES	___	___	____
DOUBLE VISION	___	___	____
HEARING LOSS	___	___	____
EYE SURGERY	___	___	____
EAR SURGERY	___	___	____
FREQUENT EAR INFEC.	___	___	____
DIFFICULTY SWALLOWING	___	___	____
NOSE:			
NOSE BLEEDS	___	___	____
HAY FEVER	___	___	____
REPEATED SINUS INFEC.	___	___	____
HEART AND LUNGS:			
HIGH BLOOD PRESSURE	___	___	____
HEART ATTACK	___	___	____
SHORTNESS OF BREATH	___	___	____
PNEUMONIA	___	___	____
HEART FAILURE	___	___	____
PALPITATIONS	___	___	____
RHEUMATIC FEVER	___	___	____
CHEST PAINS (ANGINA)	___	___	____
ASTHMA	___	___	____
COUGHING BLOOD	___	___	____
GASTROINTESTINAL:			
VOMITING OF BLOOD	___	___	____
ULCERS	___	___	____
LIVER DISEASE/HEPATITIS	___	___	____
GALLSTONES	___	___	____
WEIGHT LOSS –UNCERTAIN CAUSE	___	___	____
HEMORRHOIDS	___	___	____
RECTAL BLEEDING	___	___	____
CONSTIPATION	___	___	____
RECTAL PAIN	___	___	____

URINARY SYSTEM	YES	NO	AGE
BLOOD IN URINE	___	___	___
PROSTATE PROBLEMS	___	___	___
KIDNEY STONES	___	___	___
URINARY TRACT INFEC.	___	___	___
IMPOTENCE	___	___	___
FREQ. URINATION DURING SLEEPING HOURS	___	___	___
ENDOCRINE:			
KNOWN DIABETES	___	___	___
THYROID DISORDERS	___	___	___
MUSCLES AND BONES:			
INJURY ACCIDENT	___	___	___
OSTEOARTHRITIS	___	___	___
CANCER OF BONE	___	___	___
JOINT SWELLING	___	___	___
NECK OR BACK INJURY	___	___	___
GOUT	___	___	___
LEGS PAIN WITH WALKING	___	___	___
NERVOUS SYSTEM:			
STROKE	___	___	___
FAINTING	___	___	___
SEIZURES	___	___	___
SIGNIFICANT HEAD INJURY	___	___	___
PSYCHIATRIC:			
DEPRESSION	___	___	___
ANXIETY	___	___	___
PSYCH. COUNSELING	___	___	___
TAKEN TRANQUILIZERS	___	___	___
TAKEN ANTI-DEPRESSANTS	___	___	___
INSOMNIA	___	___	___

FEMALES ONLY:

DATE OF LAST BREAST AND PELVIC EXAM: ____

AGE AT FIRST PERIOD: ________________________FIRST DAY OF LAST PERIOD: ________________________

NUMBER OF PREGNANCIES: __________________________NUMBER OF CHILDREN: ______________________

DO YOU USE BIRTH CONTROL OF ANY TYPE? __________SPECIFY TYPE: ______________________________

DO YOU HAVE ANY OF THE FOLLOWING DURING YOUR MENSTRUAL CYCLE:

SEVERE PAIN________________HOT FLASHES____________BREAST PAIN_______________LUMPS_________

MARK TAPSCOTT, D. O.

DISEASES OF THE COLON & RECTUM
PROCTOLOGY
5555 RESERVOIR DR #203, SAN DIEGO, CA 92120 - (619) 287-2590

NAME____ DATE___________________________________

WELCOME TO DR. TAPSCOTT'S MEDICAL OFFICE. WE LOOK FORWARD TO SERVING YOUR MEDICAL NEEDS.
AS A NEW PATIENT WITH OUR OFFICE, WE WOULD LIKE YOU TO BE FAMILIAR WITH OUR OFFICE POLICIES CONCERNING YOUR SCHEDULING AND ACCOUNT WHILE YOU ARE WITH US.
PLEASE FEEL FREE TO ASK ANY QUESTIONS REGARDING THE FOLLOWING.

1. **WE REQUIRE 24-HOUR NOTICE TO CHANGE OR CANCEL A SCHEDULED OFFICE APPOINTMENT. IF YOU FAIL TO SHOW OR CANCEL YOUR APPOINTMENT WITHOUT A 24-HOUR NOTICE YOU WILL BE CHARGED $100.00. PAYMENT IS DUE BEFORE YOUR NEXT APPOINTMENT. THESE CHARGES WILL BE YOUR RESPONSIBILITY AND CANNOT BE BILLED TO YOUR INSURANCE COMPANY.**

2. **ONCE A SURGICAL /HOSPITAL PROCEDURE IS SCHEDULED THERE WILL BE A FEE OF $200.00 FOR CANCELING OR RESCHEDULING WITHOUT A 24-HR NOTICE. THIS IS TO BE PAID BY YOU NOT YOUR INSURANCE COMPANY!**

3. **OUR OFFICE WILL BILL YOUR PRIMARY INSURANCE AS A COURTESY. WE DO NOT ACCEPT LIENS OR THIRD PARTY PAYERS. ALL PATIENTS WILL RECEIVE A MONTHLY STATEMENT. THE PATIENT IS RESPONSIBLE FOR ANY AND ALL BALANCES AFTER 30 DAYS. A FEE OF $15.00 WILL BE ADDED TO YOUR ACCOUNT FOR EACH LATE PAYMENT. THE PATIENT MAY CONTACT OUR OFFICE AT ABOVE NUMBER.**

4. **THE PATIENT'S MEDICAL INSURANCE COPAY IS DUE AT EVERY VISIT AND IS COLLECTED AT THE FRONT DESK.**

5. **IN THE EVENT ANY ACTION IS TAKEN TO ENFORCE COLLECTION OF THIS ACCOUNT, THE PRESIDING PARTY WILL BE ENTITLED TO RECOVERY OF ALL LEGAL FEES INCURRED.**

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS BEEN INFORMED AND HAS READ THE FOREGOING AND IS THE PATIENT, OR IS DULY AUTHORIZED BY THE PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

SIGNATURE: ____ DATE: _______________________________

WITNESS: ____ DATE: _______________________________

AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE MARK TAPSCOTT, D.O. TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT FOR BILLING PURPOSES.

SIGNATURE: ____ DATE: ________________________________

AUTHORIZATION TO PAY BENEFITS

I DIRECT THAT PAYMENTS BE MADE DIRECTLY TO MARK TAPSCOTT, D.O. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY MY INSURANCE. I ALSO UNDERSTAND THAT ALL PAYMENTS MADE DIRECTLY TO ME, ARE TO BE FORWARDED TO THIS OFFICE.

SIGNATURE: ____ DATE: ________________________________

PATIENT RECORD OF DISCLOSURES

IN GENERAL, THE HIPAA PRIVACY RULE GIVES INDIVIDUALS THE RIGHT TO REQUEST A RESTRICTION ON USES AND DISCLOSURE OF THIS 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 HOME.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER.
(CHECK ALL THAT APPLY):

____ **HOME PHONE**

____OK TO LEAVE MESSAGE WITH DETAILED INFORMATION

_____LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

____**CELL PHONE**

____OK TO LEAVE MESSAGE WITH DETAILED INFORMATION

_____LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

____**WORK PHONE**

____OK TO LEAVE MESSAGE WITH DETAILED INFORMATION

_____LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

____**WRITTEN COMMUNICATION**

____OK TO HOME ADDRESS

____OK TO WORK ADDRESS

PATIENT SIGNATURE____DATE__________________________________

PRINT NAME____DATE OF BIRTH_________________________________

THE PRIVACY RULE GENERALLY REQUIRES HEALTHCARE PROVIDERS TO TAKE REASONABLE STEPS TO LIMIT THE USE OR DISCLOSURE, AND REQUESTS FOR PHI TO THE MINIMUM NECESSARY TO ACCOMPLISH THE INTENDED PURPOSE. THESE PROVISIONS DO NOT APPLY TO USE OR DISCLOSURE MADE PURSUANT TO AN AUTHORIZATION REQUESTED BY THE INDIVIDUAL. HEALTHCARE ENTITIES MUST KEEP RECORDS OF PHI DISCLOSURES, INFORMATION PROVIDED BELOW, IF COMPLETED PROPERLY, WE CONSIDER AND ADEQUATE RECORD.

NOTE: USES AND DISCLOSURES FOR TPO MAY BE PERMITTED WITHOUT PRIOR CONSENT IN AN EMERGENCY.

RECORD OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

TODAY'S DATE	DISCLOSED TO WHOM ADDRESS OR FAX NUMBER	DESCRIPTION OF DISCLOSURE/ PURPOSE OF DISCLOSURE	BY WHOM DISCLOSED

NOTICE OF PRIVACY PRACTICES

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.**
- **OBTAIN PAYMENT FROM THIRD PARTY PAYERS.**
- **CONDUCT NORMAL HEALTH CARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS.**

I HAVE RECEIVED, READ AND UNDERSTAND 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 OPERATIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE THEN YOUR ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

GUARDIAN OR PATIENT'S NAME____

GUARDIAN OR PATIENT'S SIGNATURE____

TODAY'S DATE____

OFFICE USE ONLY

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT ON THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, BUT I WAS UNABLE TO DO SO AS DOCUMENTED BELOW:

DATE:	INITIALS:	REASON:

NOTICE OF PRIVACY PRACTICES

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

THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA) IS A FEDERAL PROGRAM THAT REQUIRES THAT ALL MEDICAL RECORDS AND OTHER INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION USED OR DISCLOSED BY US IN ANY FORM, WHETHER ELECTRONICALLY, ON PAPER, OR ORALLY, ARE KEPT PROPERLY CONFIDENTIAL. THIS ACT GIVES YOU, THE PATIENT, SIGNIFICANT NEW RIGHTS TO UNDERSTAND AND CONTROL HOW YOUR HEALTH INFORMATION IS USED. HIPAA PROVIDES PENALTIES FOR COVERED ENTITIES THAT MISUSE PERSONAL HEALTH INFORMATION.

AS REQUIRE BY HIPAA, WE HAVE PREPARED THIS EXPLANATION OF HOW WE ARE REQUIRE TO MAINTAIN THE PRIVACY OF YOUR HEALTH INFORMATION AND HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION.

WE MAY USE AND DISCLOSE YOUR MEDICAL RECORDS ONLY FOR EACH OF THE FOLLOWING PURPOSES: TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

TREATMENT: MEANS PROVIDING, COORDINATING, OR MANAGING HEALTH CARE AND RELATED SERVICES BY ONE OR MORE HEALTH CARE PROVIDERS. AN EXAMPLE OF THIS WILL INCLUDE TEETH CLEANING SERVICES.

PAYMENT: MEANS SUCH ACTIVITIES AS OBTAINING REIMBURSEMENT FOR SERVICES, CONFIRMING COVERAGE, BILLING OR COLLECTION ACTIVITIES, AND UTILIZATION REVIEW. AN EXAMPLE OF THIS WOULD BE SENDING A BILL FOR YOUR VISIT TO YOUR INSURANCE COMPANY FOR PAYMENT.

HEALTH CARE OPERATIONS: INCLUDE THE BUSINESS ASPECTS OF RUNNING OUR PRACTICE, SUCH AS CONDUCTING QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES, AUDITING FUNCTIONS, COST MANAGEMENT ANALYSIS, AND CUSTOMER SERVICE. AN EXAMPLE WOULD BE AND INTERNAL QUALITY ASSESSMENT REVIEW.

WE MAY ALSO CREATE AND DISTRIBUTE DE-IDENTIFIES HEALTH INFORMATION BY REMOVING ALL REFERENCES TO INDIVIDUALLY IDENTIFIABLE INFORMATION.

WE MAY CONTACT YOU TO PROVIDE APPOINTMENTS REMINDERS OR INFORMATION ABOUT TREATMENT ALTERNATIVES OR OTHER HEALTH-RELATED BENEFITS AND SERVICES THAT MAY BE OF INTEREST TO YOU.

ANY OTHER USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR WRITING AUTHORIZATION.
YOU MAY REVOKE SUCH AUTHORIZATION IN WRITING AND WE ARE REQUIRED TO HONOR AND ABIDE BY THAT WRITTEN REQUEST, EXCEPT TO THE EXTEND THAT WE HAVE ALREADY TAKEN ACTINS RELYING ON YOUR AUTHORIZATION.

YOU HAVE THE FOLLOWING RIGHTS WE RESPECT TO PROTECTED HEALTH INFORMATION, WHICH YOU CAN EXERCISE BY PRESENTING A WRITTEN REQUEST TO THE PRIVACY OFFICER.

THE RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION, INCLUDING THOSE RELATED TO DISCLOSURES TO FAMILY MEMBERS, OTHER RELATIVES, CLOSE PERSONAL FRIENDS, OR ANY OTHER PERSON IDENTIFIED BY YOU. WE ARE, HOWEVER, NOT REQUIRED TO AGREE TO A REQUESTED RESTRICTION. IF WE DO AGREE TO A RESTRICTION, WE MUST ABIDE BY IT UNLESS YOU AGREE IN WRITING TO REMOVE IT.

- THE RIGHT TO REASONABLE REQUESTS TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF PROTECTED HEALTH INFORMATION FROM US BY ALTERNATIVE MEANS OR AT ALTERNATIVES LOCATIONS.
- THE RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION.
- THE RIGHT TO AMEND YOUR PROTECTED HEALTH INFORMATION.
- THE RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION.
- THE RIGHT TO OBTAIN PAPER COPY FROM US UPON REQUEST.

WE ARE REQUIRE BY LAW TO MAINTAIN THE PRIVACY OF YOUR PROTECTED HEALTH INFORMATION AND TO PROVIDE YOU WITH NOTICE OF THE LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION.

THIS NOTICE IS EFFECTIVE AS JUNE 10, 2002, AND WE ARE REQUIRED TO ABIDE BY THE TERMS OF THE NOTICE OF PRIVACY PRACTICES CURRENTLY IN EFFECT. WE RESERVED THE RIGHT TO CHANGE THE TERMS OF OUR NOTICE OF PRIVACY PRACTICES AND TO MAKE THE NEW NOTICE PROVISIONS EFFECTIVE FOR ALL PROTECTED HEALTH INFORMATION THAT WE MAINTAIN. WE WILL POST AND YOU MAY REQUEST A WRITTEN COPY OF A REVISE NOTICE OF PRIVACY PRACTICES FROM THIS OFFICE.

YOU HAVE RECOURSE IT YOU FEEL THAT YOUR PRIVACY PROTECTIONS HAVE BEEN VIOLATED. YOU HAVE THE RIGHT TO FILE A FORMAL WRITTEN COMPLAINT WITH OUR OFFICE OR WITH THE DEPARTMENT OF HEALTH & HUMAN SERVICES, OFFICE OF CIVIL RIGHTS, ABOUT VIOLATIONS OF THE PROVISIONS OF THIS NOTICE OR THE POLICIES AND THE PROCEDURES OF OUR OFFICE. WE WILL NOT RETALIATE AGAINST YOU FOR FILLING A COMPLAINT.

PLEASE CONTACT US FOR MORE INFORMATION, BY ASKING TO SPEAK TO OUR PRIVACY OFFICER OR FOR WRITTEN INQUIRES, NOTE “ATTENTION PRIVACY OFFICER”.

FOR MORE INFORMATION ABOUT HIPAA OR TO FILE A COMPLAINT:

THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF CIVIL RIGHTS
200 INDEPENDENCE AVENUE, S. W.
WASHINGTON, D.C. 20201
(202) 619-0257
TOLL FREE: 1-800-696-6775