MINIMALLY INVASIVE
ABDOMINAL SURGERY SPECIALISTS
A PART OF THE NICHOLSON CLINIC

Date: ____________________

Please fill out using black or dark blue ink, print legibly and detail as much as possible. Thank You.

PLEASE LIST YOUR FULL LEGAL NAME:

LAST: ______________________________ FIRST: ________________________ MIDDLE: ________________

STREET ADDRESS: ____

CITY: ______________________________ STATE: __________________ ZIP CODE: ______________________

PLEASE ENTER YOUR CONTACT INFORMATION:

1st Choice: ☐Home ☐Mobile ☐Work (____) ________ - ____________

2nd Choice: ☐Home ☐Mobile ☐Work (____) ________ - ____________

3rd Choice: ☐Home ☐Mobile ☐Work (____) ________ - ____________

E-MAIL: ____

EMERGENCY CONTACT NAME: ______________ RELATIONSHIP: __________ PHONE # ______________

Emergency contact may receive information about my medical condition? (Please ☑ one) ☐ Yes ☐ No

SSN: ________________________ DOB: _____/_____/_____ AGE: _______ GENDER: ☐ F ☐ M

MARITAL STATUS (Optional): ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Other ________________

Which best describes your ethnicity? Hispanic/Latino Origin Non-Hispanic/Non-Latino Origin

Which best describes your race? Asian Black American Indian/Alaska Native Native American/Pacific Islander White Other

EMPLOYER: ____ OCCUPATION: ________________________

PRIMARY CARE PHYSICIAN: ____ Phone: ________________

REFERRING DOCTOR: ____ Phone: ________________

Address: ____

My physician(s) may receive information from Abdominal Surgery Specialists regarding my surgery? (Please ☑ one) ☐ Yes ☐ No

PLEASE INCLUDE A FRONT & BACK COPY OF YOUR INSURANCE CARD

INSURANCE INFORMATION: (Please be very detailed – incomplete data may delay processing.)

INSURANCE CO.: ___________________________________ PLAN TYPE: HMO PPO POS

ADDRESS: ____ ID#: ______________________________

GROUP #: ____ PHONE #: ___________________________

NAME OF INSURED: ____________________________________ INSURED'S DOB: _____________________

RELATIONSHIP TO PT: __________________________________ SS# (IF OTHER THAN PT): _____________

EMPLOYER NAME: ____

SECONDARY INSURANCE CO.: ____________________________ PLAN TYPE: HMO PPO POS

ADDRESS: ____ ID#: ______________________________

GROUP #: ____ PHONE #: ___________________________

GROUP #: ____ PHONE #: ___________________________

NAME OF INSURED: ____________________________________ DOB: ______________________________

RELATIONSHIP TO PT: __________________________________ SS# (IF OTHER THAN PT): _____________

EMPLOYER NAME: ____

____ ____________________

PATIENT OR RESPONSIBLE PARTY **DATE**

ABDOMINAL SURGERY SPECIALISTS
MINIMALLY INVASIVE
A PART OF THE NICHOLSON CLINIC

Date: ____________________

HEALTH AND MEDICAL HISTORY

(Fill out as completely as possible.)

HEIGHT:______________ CURRENT WEIGHT: _________________________

HAVE YOU EVER HAD *(Please check each that apply)*

☐ Gallbladder Surgery	Year________________________	Type______________________________
☐ Spleen Surgery	Year________________________	Type______________________________
☐ Esophagus Surgery	Year________________________	Type______________________________
☐ Stomach Surgery	Year________________________	Type______________________________
☐ Hernia Repair Surgery	Year________________________	
☐ Caesarian Section	Year________________________	
☐ Abdominal Hysterectomy	Year________________________	
☐ Prior Weight Loss Surgery	Year________________________	

HEALTH AND WELLNESS INFORMATION: (For any "yes" answers list a diagnosing or treating physician.)

DESCRIPTION		YES	NO	YEAR	DIAGNOSING PHYSICIAN
Abdominal Pain		☐	☐	_______	______________________________
Shortness of Breath		☐	☐	_______	______________________________
Snoring		☐	☐	_______	______________________________
Sleep Apnea Syndrome		☐	☐	_______	______________________________
CPAP		☐	☐	_______	______________________________
BiPAP		☐	☐	_______	______________________________
Asthma		☐	☐	_______	______________________________
Indigestion/Heartburn		☐	☐	_______	______________________________
Gastroesophageal Reflux		☐	☐	_______	______________________________
Degenerative Joint	☐ Lower Back	☐	☐	_______	______________________________
Disease/Pain	☐ Hips	☐	☐	_______	______________________________
	☐ Knees	☐	☐	_______	______________________________
	☐ Ankles	☐	☐	_______	______________________________
Edema/Swelling	☐ Legs	☐	☐	_______	______________________________
	☐ Ankles	☐	☐	_______	______________________________
Congestive Heart Failure		☐	☐	_______	______________________________
Stroke		☐	☐	_______	______________________________
Heart Disease		☐	☐	_______	______________________________
Heart Attack		☐	☐	_______	______________________________
Hypertension (High Blood Pressure)					
	☐ Self	☐	☐	_______	______________________________
	☐ Family History	☐	☐	_______	______________________________
Diabetes	☐ Self	☐	☐	_______	______________________________
	☐ Family History	☐	☐	_______	______________________________
High Cholesterol/Hyperlipidemia		☐	☐	_______	______________________________
Hernia		☐	☐	_______	______________________________
Depression		☐	☐	_______	______________________________
Bipolar Disorder		☐	☐	_______	______________________________
Panic Disorder		☐	☐	_______	______________________________
Anorexia		☐	☐	_______	______________________________
Bulimia		☐	☐	_______	______________________________
Schizophrenia		☐	☐	_______	______________________________
Chronic Fatigue		☐	☐	_______	______________________________
Chest Pain		☐	☐	_______	______________________________
Urinary Incontinence (Leaking when you cough or sneeze)		☐	☐	_______	______________________________
Cirrhosis		☐	☐	_______	______________________________
Hepatitis		☐	☐	_______	______________________________
COPD/Emphysema		☐	☐	_______	______________________________
Pulmonary Embolism		☐	☐	_______	______________________________
Colitis		☐	☐	_______	______________________________

MINIMALLY INVASIVE ABDOMINAL SURGERY SPECIALISTS
A PART OF THE NICHOLSON CLINIC

Date: ____________________

Chron's Disease/Ulcerative Colitis	☐	☐	_______	______________________________
Hepatitis B or Hepatitis C	☐	☐	_______	______________________________
Migraine Headaches	☐	☐	_______	______________________________

DO YOU HAVE A HEART CONDITION: ☐ YES ☐ NO If yes, please describe:______________________________

____

DO YOU HAVE ANY OTHER UNDERLYING MEDICAL CONDITIONS? ☐ YES ☐ NO, If yes, please describe:____________________

____

IS YOUR FATHER LIVING? ☐ YES ☐ NO CAUSE OF DEATH:______________________________

IS YOUR MOTHER LIVING? ☐ YES ☐ NO CAUSE OF DEATH: ______________________________

____

RECENT TESTING:

PHYSICAL	☐ YES	☐ NO	DATE: ______________
CHEST X-RAY	☐ YES	☐ NO	DATE: ______________
UPPER GI	☐ YES	☐ NO	DATE: ______________
ECHOCARDIOGRAM	☐ YES	☐ NO	DATE: ______________
EKG	☐ YES	☐ NO	DATE: ______________

INDICATE ANY NEGATIVE RESULTS: ____

____

GENERAL AND LIFESTYLE INFORMATION:

DO YOU SMOKE? ☐ YES ☐ NO

HAVE YOU SMOKED? ☐ YES ☐ NO

YEAR QUIT ____________________

DO YOU USE ALCOHOL? ☐ YES ☐ NO

HOW OFTEN? ☐ DAILY ☐ WEEKLY ☐ OCCASIONALLY ☐ RARELY

HAVE YOU EVER HAD A PROBLEM WITH SUBSTANCE ABUSE? ☐ YES ☐ NO

PLEASE TAKE A MOMENT AND TELL US HOW YOU HEARD ABOUT OUR PROGRAM:

________ INTERNET/ABDOMINAL SURGERY SPECIALISTS WEBSITE

________ INTERNET/NICHOLSON CLINIC WEBSITE

________ TV/RADIO/MAGAZINE ADVERTISEMENT

________ PCP/REFERRING DOCTOR

________ INSURANCE COMPANY

________ FRIEND / FAMILY MEMBER

________ CURRENT PATIENT, IF SO WHO?____

☐ **I REALIZE I AM RESPONSIBLE FOR CHARGES INCURRED FOR MY CARE SHOULD MY INSURER FAIL TO REIMBURSE IN AN ACCEPTABLE AND TIMELY MANNER.**

______________________________ ______________ ______________

PATIENT SIGNATURE **DATE OF BIRTH** **DATE**

We often make referrals to medical providers that may be out of network with your insurance plan because we believe them to be quality providers. As a standard of this office, we may refer to Texas General Hospital, Baylor Surgicare Garland, Medical City Frisco, Sleep Therapy Associates of Texas, M3 Sleep Services of Texas, Surgeons of North Texas PA, GNC Medical PA, and Premier Surgical Assistants PC. The surgeons associated with this practice may or may not have a personal investment in these or other healthcare facilities. You are invited to discuss this with us or our office staff if you desire.

Nick Nicholson, M.D.
Thomas Roshek, M.D.
Julie Kilgore, MD
Brian Long, MD

MINIMALLY INVASIVE
ABDOMINAL SURGERY SPECIALISTS
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Date: ____________________

Heartburn/ Reflux Questionnaire

Patient Name: ________________________________ **Date of Birth**: ____________

Instructions: please check the box to the right of each question using the scale below.

Scale

0 No symptoms

1 Symptoms noticeable but not bothersome

2 Symptoms noticeable and bothersome, infrequent

3 Symptoms bothersome every day

4 Symptoms affect daily activity

5 Symptoms interfere with daily activities

Question	0	1	2	3	4	5
How bad is your heartburn?						
Heartburn when lying down?						
Heartburn when standing up?						
Heartburn after meals?						
Does heartburn change your diet?						
Does heartburn wake you from sleep?						
Do you have difficulty swallowing?						
Do you have pain with swallowing?						
If you take medication, does this affect your daily life?						
How bad is the regurgitation?						
Regurgitation when lying down?						
Regurgitation when standing up?						
Regurgitation after meals?						
Does regurgitation change your diet?						
Does regurgitation wake you from sleep?						

Instructions: Please answer the questions below by **circling** the appropriate response.

- How long have you been dealing with the symptoms above? 5 years 10 years 15+ years Other
- Have you tried medications to treat your symptoms in the past without relief? Yes No

Instructions: Please indicate which medications you have attempted in the past by **checking √** the duration of therapy.

Medication	5 yrs	10 yrs	15+ yrs	Other	Medication	5 yrs	10 yrs	15+ yrs	Other
Pepcid®					Aciphex®				
Famotidine					Rabeprazole				
Prilosec®					Prevacid®				
Omeprazole					Lansoprazole				
Dexilant®					Zegerid®				
Dexlansoprazole					Sodium Bicarb				
Protonix®					Tums®				
Pantoprazole					Rolaids®				
Zantac®					Pepto Bismol®				
Ranitidine					Other Medication				

Patient Signature: ________________________________ **Date**: ________________

FOR OFFICE USE ONLY
Reviewed by ________________________________ **Date** ________________

MINIMALLY INVASIVE
ABDOMINAL SURGERY SPECIALISTS
A PART OF THE NICHOLSON CLINIC

Date: ____________________

PATIENT MEDICATIONS

NAME: ______________________________________ **DATE OF BIRTH:** ________________ **ALLERGIES:** ______________________________
PHARMACY NAME: ____ **PHARMACY PHONE:** __________________________________

Vitamin Supplements: (please circle all that apply) Never Occasionally Daily
Multiple Vitamin Iron Calcium Vitamin D Vitamin B-12 (weekly) Other:

Tobacco: Never Rarely Occasionally Frequently Quit (Month/Year):

Alcohol: Never Rarely Occasionally Frequently

CPAP/BIPAP: Never Occasionally Every Night

MEDICATION NAME/STRENGTH	ROUTE	DOSE	PURPOSE	DATE STARTED	DATE STOPPED	REVIEWED BY MEDICAL STAFF DATE/INITIALS	
SAMPLE 200mg	*By mouth*	*1xday*	*Blood Pressure*	*May 2009*			
OVER THE COUNTER MEDICATIONS:							

DATE UPDATED: ______________ **PATIENT INITIALS:** _____________ **DATE UPDATED:** ______________ **PATIENT INITIALS:** _____________
DATE UPDATED: ______________ **PATIENT INITIALS:** _____________ **DATE UPDATED:** ______________ **PATIENT INITIALS:** _____________
DATE UPDATED: ______________ **PATIENT INITIALS:** _____________ **DATE UPDATED:** ______________ **PATIENT INITIALS:** _____________

Date: ____________________

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 CAREFULLY

YOUR PRIVATE HEALTH INFORMATION (PHI)

Each time you have contact with a healthcare provider, a record of your contact is prepared. This record may contain information such as signs, symptoms, results of examinations or tests, diagnoses, treatment, or future care plans. Your medical record is the physical property of Minimally Invasive Abdominal Surgery Specialists and Nicholson Clinic, but you have certain rights regarding the use and disclosure of your private health information (PHI). Abdominal Surgery Specialists and Nicholson Clinic however, have the right to use and disclose your PHI in the process of providing treatment, receiving payment and performing other regular healthcare operations such as:

- Documenting and describing the care you received for legal purposes
- Communicating with other healthcare providers involved in your care Educating healthcare professionals
- Medical Research
- Providing information for government and public health entities
- Evaluating and improving the care you receive and the outcomes achieved
- Billing and verification of services provided to you
- Conducting other routine healthcare operations

Protecting your privacy and maintaining the security of your PHI is an important responsibility of this practice. We are required by law to maintain privacy and confidentiality of your PHI, notify you of your rights in regards to your PHI, inform you of these privacy practices prior to gaining consent to treat, and notify you of changes/revisions to this Notice of Privacy Practices.
You may file a complaint with the Abdominal Surgery Specialists if you suspect any privacy rights violation. We will investigate the inquiry and inform you of the finding. In addition, you have the right to file a complaint with the Secretary of the Department of Health and Human Services.

EXAMPLES OF DISCLOSURE OF YOUR (PHI)

Healthcare delivery and treatment:

Your PHI may be provided to other healthcare professionals, such as other physicians, specialists, therapists, hospital based providers, and or other healthcare providers.

Billing and payment:

Your PHI is utilized to justify the level of care delivered to you and the charges incurred for the services. This information generally accompanies the bill and is sent to your payers and other third-party administrators.

Other healthcare operations:

You PHI may be disclosed to other businesses in order for my practice to perform its day-to-day operations. These may include business associates such as vendors, contractors used for credentialing and peer review, patient satisfaction surveys, utilization review, billing and claims management, medical research, disease control, quality improvement initiatives, management services organizations, laboratories, free standing diagnostic facilities, transcription services, and legal counsel. All business associates are required to appropriately protect the confidentiality of your PHI.

Treatment:

We may instruct a specialist to contact you to schedule an appointment or to provide you with information on treatment.

Other uses and disclosures:

We may utilize and disclose your PHI with others concerned with your health such as family members, relatives, caregivers, employers, and funeral directors. In addition, we may disclose your PHI through other communications and reports required to be made by healthcare professionals such as the public health department, law enforcement, the Food and Drug Administration, organ procurement organizations, corrections institutions, and workers compensation, where applicable.

Other disclosures of PHI not permitted or required by law will be made only with your written authorization You may revoke your authorization at any time provided that the revocation is in writing, except to the extent that Abdominal Surgery Specialists and Nicholson Clinic has already taken action in reliance on your prior authorization.

MINIMALLY INVASIVE
ABDOMINAL SURGERY SPECIALISTS
A PART OF THE NICHOLSON CLINIC

Date: ____________________

PATIENT CONSENT FORM REGARDING PHI

I understand that as part of my healthcare, Minimally Invasive Abdominal Surgery Specialists and Nicholson Clinic originates and maintains health records that may describe my health history, symptoms, examination and test results, diagnoses, treatment and/or plans for future care.

Notice of Privacy Practices of Abdominal Surgery Specialists provides specific information and description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review this prior to signing this consent.

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior consent, except as otherwise provided by law.

Listed below are individual(s) to whom I <u>authorize</u> use and/or disclosure of my PHI.

____

____

I request the following <u>restrictions</u> on the use and/or disclosure of my PHI.

____

By signing below and unless otherwise indicated, I request that information regarding my self-pay procedures not be disclosed to my health insurance company.

I have reviewed and understand the privacy practices of Abdominal Surgery Specialists as stated in *the Notice of Privacy Practices* dated April 1, 2003, and hereby consent to the uses and disclosures of my PHI so stated.

_______________________________________ ________________

Signature of Patient or Legal Representative Date of Birth

_______________________________________ ________________

Print Name of Patient or Legal Representative Date

I request that changes to the *Notice of Privacy Practices* be sent to me at the following address:

____

____

MINIMALLY INVASIVE
ABDOMINAL SURGERY SPECIALISTS
A PART OF THE NICHOLSON CLINIC

Date: ____________________

Email Informed Consent Form

Conditions for the Use of Email

It is the policy of Abdominal Surgery Specialists and Nicholson Clinic to make all email messages sent or received that concern the protected health information ("PHI"), a part of that patient's medical and financial records. Abdominal Surgery Specialists and Nicholson Clinic strive to protect and maintain patient PHI. However, there are numerous risks associated with email communication, which may include but not limited to misaddressed or undelivered emails, risk associated with use of employer owned email address, and/or delay in response time. Abdominal Surgery Specialists and Nicholson Clinic cannot fully guarantee the security and confidentiality of email communications. Thus, patients must consent to the use of email for confidential medical information after having been informed of the above risks. Consent to the use of email includes agreement with the following conditions:

- All emails to or from the patient concerning diagnosis and/or treatment will be made a part of the patient's records. As a part of medical record, other individuals, such as other physicians, nurses, other entities, such as other health care providers and insurers, may have access to email messages contained in medical records.
- Abdominal Surgery Specialists and Nicholson Clinic may forward email messages within the facility as necessary for diagnosis, treatment, and reimbursement. However, emails to entities unassociated with the patient's care, will not be forwarded, unless proper patient consent is received,
- Abdominal Surgery Specialists and Nicholson Clinic and its employees will make every effort to read and respond promptly to patient emails. **Because** Abdominal Surgery Specialists and Nicholson Clinic **cannot assure patients that recipients will read email messages promptly, patients must not use email in a medical or other emergency.**
- If a patient's email requires or invites a response, and the recipient does not respond within a reasonable time, the patient is responsible for following up to determine whether the intended recipient has received the email and when the recipient will respond.
- Because some medical information is so sensitive that unauthorized disclosure can be very damaging, **patients should not use email for communications concerning diagnosis or treatment of the following: AIDS/HIV infection; other sexually transmissible or communicable diseases; mental health or developmental disability; or alcohol and drug abuse.**
- Because employees do not have a right of privacy in their employer's email system, patients should not use their employer's email system to transmit or receive confidential medical information.
- Abdominal Surgery Specialists and Nicholson Clinic will take reasonable steps to protect the confidentiality of patient email, but is not liable for improper disclosure of confidential information not caused by Abdominal Surgery Specialists and Nicholson Clinic's gross negligence or wanton misconduct.
- If the patient consents to the use of email, the patient is responsible for informing Abdominal Surgery Specialists and Nicholson Clinic of any types of information that the patient does not want to be sent by email other than those set out above.
- Patient is responsible for protecting patient's password or other means of access to email sent or received from Abdominal Surgery Specialists and Nicholson Clinic to protect confidentiality. Abdominal Surgery Specialists and Nicholson Clinic is not liable for breaches of confidentiality caused by patient.

Any further use of email by the patient that discusses diagnosis or treatment by the patient constitutes informed consent to the foregoing. You may withdraw consent to the future use of email at any time by email or written communication to Abdominal Surgery Specialists and Nicholson Clinic, attention:

Stephanie G: HIPAA Compliance Officer
5500 Democracy Dr. #150
Plano, Tx 75024
Stephanie@Nicholsonclinic.com

I have read the above risk factors and conditions for the use of email, and I hereby consent to the use of email for communications to and from Abdominal Surgery Specialists and Nicholson Clinic regarding my medical treatment.

______________________	______________________	____________
Signature of Patient	Email Address	Date
______________________	______________________	
Printed Name of Patient	Date of Birth	

Segments of this consent were obtained from HIPAA Documents Resource Center CD, 6th ed.

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MINIMALLY INVASIVE
ABDOMINAL SURGERY SPECIALISTS
A PART OF THE NICHOLSON CLINIC

Date: ____________________

Authorization Form to Appeal an Insurance Determination

To: ____________________________________

____

____

Member Name: ____________________________________ Date:________________________

Member ID#: ______________________________________ Date of Birth: __________________

I hereby authorize ____________________________ to appeal my insurance carrier's determination concerning all denials of claims or incorrect payment of claims, on my behalf, as my designated representative. I understand that communication may contain:

> All medical and financial information containing my insurance file, including but not limited to treatment for STD, alcoholism and drug abuse, abortion, mental health disorder and HIV status related to my examination, treatment, and hospital confinement in connection with the determination which is being appealed.

By signing below, I understand this information is privileged and confidential and will only be released as specified in this authorization or as permitted by law. This authorization is valid for a period of one year.

____

Signature of Member or Legal Guardian/Representative

____

Signature of witness or Designated Representative

____

Name and Title of Witness/Designated Representative (Printed)