

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. Please fill out every item. It is important for your doctor to know that you have carefully reviewed every are of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish.

Name (First, Middle Initial, Last) _____ Appt. Date _____

Male _____ Female _____ Date of Birth _____ Ht.: _____ Wt: _____

Pharmacy Preference (Include Location) _____

Primary Care Physician _____ Referring Physician _____

Chief Complaint: _____

Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications) No _____
 Yes _____ (if yes, please list below and include dosages)

Name of Medication	Dosage	How often take

Are you Allergic to ANY medications: No _____ Yes _____ (if yes, please list below)

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATION

Have had problems with anesthesia (being numbed or put to sleep) No _____ Yes _____

Please list any surgical implants: _____

Have you had any ear nose or throat surgery? No _____ Yes _____ Please list Type and Date

Have you had any other surgeries? No _____ Yes _____ Please list Type and Date

Have you ever been hospitalized for non-surgical reasons? No _____ Yes _____ If yes please explain

Appointment Date _____ **Time** _____

___ **Dover Office—400 Medical Park Dr. Suite 103 Dover, Ohio 44622**

___ **Newcomerstown Office—232 Cross St. Newcomerstown, Ohio 43832**

___ **Millersburg Office—890 Wooster Rd. Millersburg, Ohio 44654 (across from hospital.)**

Please bring paperwork to your appointment. Self pay patients please bring \$100 for payment towards account balance. Self pay patients will receive 40% discount.

Notice of Privacy Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding your health record information

Whenever you visit a hospital, physician, or healthcare provider, you are establishing a healthcare record with that provider. Your health record contains notes about your visit, including your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. Your healthcare or medical record serves many purposes.

- Plan your care and treatment.
- Obtain payment from a third party, such as an insurance company.
- Communication among the health professionals who contribute to your care.
- Legal document describing the care you received.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool in education for health professionals or a source of data for medical research.
- Source of information for public health officials.
- Source of data for facility planning and marketing.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy. It also helps you to understand who may access your health information and under what conditions. It helps you make more informed decisions when authorizing disclosure to others.

Your health information rights

The physical record of your health is the property of Dr. Kurt C. Garren. However, the underlying information belongs to you. You have the right to:

- Request restrictions on certain uses and disclosures of your information; however, we do not have to comply with your request.
- Obtain a paper copy of the notice of information practices upon request.
- Inspect and obtain a copy of your health record, except in limited circumstances. (You may be charged a reasonable fee for copying.)
- Request amendment of your healthcare record.
- Obtain an annual accounting of disclosures of your health information. (You may be charged a reasonable fee for copying.)
- Request communications of your health information by alternative means or at alternative locations.

OVER →

- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

We do not have to honor your request for restrictions on activities that are otherwise allowable under law.

If we deny you request, you will receive notification of our denial along with a written basis for our denial. Any request for restrictions on use of disclosure must be made in writing. We will notify you within 30 days of our decision. We may request an additional 30 days to consider your request.

Our responsibilities:

We are required to:

- Maintain the privacy of your health information.
- Provide you with a Notice of Privacy Practices that describes our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of Dr. Kurt C. Garren M.D. Inc. regarding our Notice of Privacy Practices.
- Notify you if we will not agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices at any times and to make any new provisions effective for all the protected health information we maintain. Prior to making any significant changes in our privacy practices, we will change our Notice of Privacy Practices if any of our information practices change.

The office of Dr. Kurt C. Garren will not use or disclose your health information without your authorization, except as described in this notice.

As a condition of treatment (except for emergency treatment) your are required to sign a consent form for use and disclosure of Protected Health Information for purposed of payment, treatment and healthcare operations. We use information about you for treatment, to obtain payment, and to evaluate the quality of care you receive. In certain instances we may use or disclose your information that is not for payment, treatment or healthcare operations when required or authorized by law.

Complaints: If you believe your privacy rights have been violated you can file a complaint with the office of Dr. Kurt C. Garren . You may either send a written complaint to 400 Medical Park Drive, Suite 103, Dover, OH 44622 or you may call the office at 330.343.9600 during normal business hours. You may also file a complaint with the Secretary of U.S. Department of Health and Human Services in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

Acknowledgment of Receipt of Notice:

Please sign below to acknowledge that you received a copy of this Notice of Privacy Practices.

X _____ **X** _____ **Date** _____
Please Sign Name **Please Print Name**