PRINT AND BRING WITH YOU

ROBERT WAYNE, M.D., F.A.C.S.
2265 Exchange Street
Astoria, OR 97103
Phone: 503-325-9597
Fax: 503-338-4076

In order to expedite your first visit, please look over and complete the forms included with this letter before you arrive. Bringing these completed forms in for your appointment will decrease your waiting time and allow us to create your medical chart. If you have any questions about any of these forms, please feel free to call Connie at 503-338-4075, ext. 5729 or Adrianne at ext 5786.

Please remember to bring these items to your first visit:

* A list of medications and vitamins you are currently taking
* Insurance card and copayment if one is required
* If no insurance, a deposit of $75 is required. We accept cash, check, Visa or Mastercard. If you are unable to bring this deposit, financial Arrangements can be made prior to your appointment.
* Photo I.D. (driver's license)

Thank you and we are looking forward to helping you to better health.

Sincerely,

Robert Wayne, MD and his staff

** Log on to: **www.robertwaynemd.com** for more information.

Dr. Robert Wayne Health History

Patient Name _____ **Today's Date**_____

Date of Birth _____ **Age** _____ **Reason for visit** _____

Primary Doctor _____ **Referring Doctor** _____

Please list your Pharmacy _____

Allergies: Please list any allergies you may have including Latex, tape or metal or IVP Dye

Medication Name	Type or Reaction

Do you have problems with Anesthesia? No ☐ **Yes** ☐ describe: _____

Medications: Please list any medications you are taking on a regular basis including over the counter medications, vitamins, minerals and supplements.

Medication Name	Strength	Frequency	Reason for Taking

Social History:

Tobacco Use: No ☐ Yes ☐ Current packs per day _____ Quit Date _____

Caffiene Use: No ☐ Yes ☐ Type and Frequency _____

Alcohol Use: No ☐ Yes ☐ Type and Frequency _____

Drug Use: No ☐ Yes ☐ Type and Frequency _____

Fractures: Please list any fractures below:

Type of Fracture	Location of Fracture

LAST COLONOSCOPY DATE _____

Dr. Robert Wayne Health History

Conditions: Check (√) conditions you currently have or have had in the past

☐ Aids	☐ Chemical Dependency	☐ High Cholesterol	☐ Prostate Problem
☐ Alcoholism	☐ Chicken Pox	☐ HIV Positive	☐ Psychiatric Care
☐ Anemia	☐ Diabetes type_____	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anorexia/Bulimia	☐ Emphysema	☐ Liver Disease	☐ Scarlet Fever
☐ Anxiety	☐ Epilepsy/Seizures	☐ Major Infection type:	☐ STD's
☐ Appendicitis	☐ Gastritis	_____	☐ Stomach Ulcer
☐ Arthritis	☐ Glaucoma	☐ Measles	☐ Stroke
☐ Asthma	☐ Goiter	☐ Migraine Headaches	☐ Suicide Attempt
☐ Bleeding disorder	☐ Gonorrhea	☐ Miscarriage	☐ Thyroid Problems
☐ Breast Lump	☐ Gout	☐ MRSA	☐ Tonsillitis
☐ Bronchitis	☐ Heart Attack	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Bursitis	☐ Heart Disease	☐ Mumps	☐ Typhoid Fever
☐ Cancer type _____	☐ Hepatitis	☐ Pacemaker	☐ Ulcers
☐ Cataracts	☐ Hernia	☐ Pneumonia	☐ Vaginal Infections
	☐ High Blood Pressure	☐ Polio	☐ Other: _____

Surgeries/Hospitalizations: Please list surgeries or hospitalizations including pregnancies you've had below:

Year	Procedure/Reason for being Hospitalized	Outcome or Complications if any

Family History:	Deceased		If Yes, Age	If No, Health History		
	Yes	No	And from What:	Good	Fair	Poor
Father:						
Mother:						

Please check (√) any conditions that your blood relatives may have below:

	Father:	Mother:	Brother:	Sister:
Arthritis				
Asthma				
COPD				
Bleeding problems				
Diabetes type 1				
Diabetes type 2				
Heart Disease				
High Blood Pressure				
Osteoporosis				
Kidney Disease				
Stroke				
Cancer Please list type:				
Other condition Please list:				

Patient Name _____ **Date of Birth** _____

DR. ROBERT WAYNE

PATIENT INFORMATION REGISTRATION FORM **Date:**

PATIENT INFORMATION

Last Name	First Name	Middle Name
Birth/Maiden Name	Gender ☐ MALE ☐ FEMALE	Social Security Number
Maritial Status ☐ Married ☐ Single ☐ Widowed		Date of Birth
Race ☐ African American ☐ Alaska Native ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native Hawaiian ☐ Pacific Islander ☐ Other _____		Ethnic group: ☐ Hispanic-E1 ☐ Non-Hispanic-E2 ☐ Unknown-E9
Primary Language	Religion	Primary Provider
Address	City/State/Zip	
Home Phone	Cell Phone	Work Phone
E-mail Address	Referring Doctor (if different from Primary)	
Preferred Contact Method ☐ Home Phone ☐ Cell Phone ☐ Work Phone		
Preferred Reminder Method ☐ Home Phone ☐ Cell Phone ☐ Work Phone		
Driver's License Number	Driver's License Expiration Date	State

EMPLOYMENT INFORMATION

Employer Name and Address	Position
Is this a Workmen's Comp claim? yes/no	If yes, Claim Number
Insurance handling claim	
Adjustor's Name	Adjustor's Contact Number

SPOUSE/PARENT/GUARDIAN INFORMATION

Spouse's Name	Social Security Number	Date of Birth
Guarantor Name (if patient is a minor)	Relationship to Patient	Date of Birth

INSURANCE INFORMATION

Primary Insurance

Name of Policy Holder	Policy Holder Date of Birth
Policy Number	Group Number
Active Date	Relationship to Patient

Secondary Insurance

Name of Policy Holder	Policy Holder Date of Birth
Policy Number	Group Number
Active Date	Relationship to Patient

IN CASE OF EMERGENCY

Name	Phone Number
Address	Relationship to patient

ROBERT WAYNE, M.D., F.A.C.S.

GENERAL SURGEON

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

SIGNATURE:____

DATE:__________________

♦♦

<u>MEDICARE PATIENTS</u>: I request payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Robert Wayne for any services furnished to me by Dr. Wayne. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claims forms or electronically submitted claims, my signature authorizes releasing of the information to the insured or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

<u>ASSIGNMENT OF BENEFITS & PAYMENT AUTHORIZATION:</u> I authorize payment directly to Dr. Robert Wayne of all benefits otherwise payable by any insurance policy/policies and I hereby irrevocably assign such benefits to Dr. Wayne in an amount not to exceed the charges for the services rendered. I authorize the release of any medical information needed to determine these benefits. I agree to be financially responsible for charges denied by insurance. If my indebtedness for such charges is placed with an attorney or agency for collection, I agree to pay Dr. Wayne reasonable attorney's fees and collection expenses.

_____________________________________ ____________

PATIENT'S SIGNATURE- RESPONSIBLE PARTY DATE

*Please note: Your signature is required by law to allow us to bill your insurance.

HIPAA Notice of Privacy Practices

Robert Wayne, M.D., F.A.C.S.
2265 Exchange Street
Astoria, OR 97103

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____

PRINT AND BRING WITH YOU