Patient Information Form   Date: ________________

Patient Name: ___________________________ Primary Doctor: ________________

Address: ________________________________ Doctor Phone:_________________

City: _____________ St. ____ Zip ____________ Pharm. Phone:________________

Phone: _________________________________ Employer Name:_______________

Cell:___________________________________ Employer Phone:_______________

Email:__________________________________ Employment Status:____________

Date of Birth: ___________________________ Student Status: ________________

Patient SSN: ___________________________ Marriage Status: _______________

Primary Insurance: __________________________ Insured DOB: __________________

Insured's Name: _______________________________ Employer Phone: ________________

Insured Employer: ______________________________ Group Number: _________________

Ins. ID Number: ________________________________ Insured SSN: ___________________

Relationship to Patient: __________________________

Secondary Ins:____________________________ Insured DOB:______________________

Insured's Name:_______________________________ Employer Phone:__________________

Insured Employer:______________________________ Group Number:__________________

Ins. ID Number:________________________________ Insured SSN:____________________

Relationship to Patient:__________________________

Insurance Notification/Waiver

Dr.Hart's office will be happy to file a claim with your insurance company. If you're insurance requires a referral, it is up to the insured to provide this to the office. If you're insurance changes, it is up to you to notify the office. Once a claim has been filed and the insurance determines the services to be cosmetic or not medically necessary, you will be responsible for all charges.   Initial: _____________

____ Date: ________________________

Patient Signature (or parent if under 18 years of age)

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What brings you to the doctor? ____

____

How long have you had this problem? ____

Are you having any problems associated with this condition?____________________________________

Allergies	Types of Reactions				
	Hives	Rash	Swelling	Breathing	Other
Latex or Contact Dermatitis					
Medications? Please List:					
Foods? Please List:					
Other? Please List:					

Do you smoke/use tobacco? ______________________________ If Quit, When? _________________________

If Yes: ______________packs per day _____________________# of years.

Do you drink alcohol? ____________________________________ If yes: _______________# of drinks per week.

Are you chemically dependent?_______________ Have you had addiction problems in the past? ____________

Do you use drugs recreationally? __________________________If yes: _________________ # of times per year

Do you consume caffeine? ___________ If yes, how much per day? _____________________________________

Are you currently pregnant? _____________________________ If yes, How far along:______________________

Have you had any significant weight loss or gain in the past year? _______ Loss or Gain? ___________________

If so, what was the reason? ____

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Current Medications				
NAME	Dose	Frequency	Reason for taking?	Date started taking?

Are you presently experiencing pain? ___________ If Yes, Location? ___________________________________

How long does it last?____

Describe the pain: SHARP, DULL, CONSTANT, ETC.? ____

Does it occur at a particular time?____

Is the pain related to activities, meals, exercise, etc.?____

Does anything seem to help the pain: REST, MEDICATIONS, ETC.? _____________________________________

Intensity: ☺ 😐 ☹

Little to No Pain 1 2 3 4 5 6 7 8 9 10 Very Painful

Previous Hospitalization/Surgeries/Medical Problems		
Surgery/Procedure	Date	Location of Operation

Have you had any recent MRI's, EKG's, X-Rays, Blood Tests, Fluid Analysis, ETC.? _________________________

If Yes, Please list the date, reason, ordering physician, and results: _______________________________

____

Have you ever had any adverse reaction to: Sedation/Analgesia, Local, Regional, or General Anesthesia?_____

If so, describe your reaction: ____

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Past Medical History

	Patient		Date of Occurance	Family		Relationship
Aids/HIV	Yes	No		Yes	No	
Anemia	Yes	No		Yes	No	
Anesthesia Problems	Yes	No		Yes	No	
Ano-Rectal Problems	Yes	No		Yes	No	
Arthritis	Yes	No		Yes	No	
Asthma	Yes	No		Yes	No	
Bladder Problems	Yes	No		Yes	No	
Blood Disorder	Yes	No		Yes	No	
Breast Cancer	Yes	No		Yes	No	
Bronchitis	Yes	No		Yes	No	
Cancer (general)	Yes	No		Yes	No	
Colitis	Yes	No		Yes	No	
Colon Cancer	Yes	No		Yes	No	
Congenital Heart	Yes	No		Yes	No	
Crohns Disease	Yes	No		Yes	No	
Diabetes	Yes	No		Yes	No	
Diverticulitis/Polyps	Yes	No		Yes	No	
Ear/Nose/Throat problem	Yes	No		Yes	No	
Epilepsy	Yes	No		Yes	No	
Goiter	Yes	No		Yes	No	
Hay Fever	Yes	No		Yes	No	
Headaches/Migraine	Yes	No		Yes	No	
Hearing Loss	Yes	No		Yes	No	
Heart Attack	Yes	No		Yes	No	
Heart Disease	Yes	No		Yes	No	
Hepatitis	Yes	No		Yes	No	
High Blood Pressure	Yes	No		Yes	No	
Hypertension	Yes	No		Yes	No	
Inflammatory Problems	Yes	No		Yes	No	
Irritable bowel	Yes	No		Yes	No	
Jaundice	Yes	No		Yes	No	
Kidney Disease	Yes	No		Yes	No	
Leukemia	Yes	No		Yes	No	
Nervous Breakdowns	Yes	No		Yes	No	
Neurological Problems	Yes	No		Yes	No	
Pneumonia	Yes	No		Yes	No	
Psychiatric History	Yes	No		Yes	No	
Rectal Bleeding	Yes	No		Yes	No	
Respiratory Disease	Yes	No		Yes	No	
Rheumatic Heart	Yes	No		Yes	No	
Seizures	Yes	No		Yes	No	
Sleep Apnea	Yes	No		Yes	No	
Stomach Ulcers	Yes	No		Yes	No	
Stroke/TIA	Yes	No		Yes	No	
Tonsilitis	Yes	No		Yes	No	
Tuberculosis	Yes	No		Yes	No	
Vision Difficulties	Yes	No		Yes	No	
Other:	Yes	No		Yes	No	

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HIPPA

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.

UNDERSTANDING YOUR HEALTH RECORD

A record is made each time you are treated at our office or related facility. Your injuries, evaluation, test results, diagnosis, treatment, and plan of care are recorded. This information is most often referred to as your "health or medical record," and serves as a basis for planning your care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will help you to ensure its accuracy, and enable you to relate to who, what, where, and why others may be allowed access to your health information. This effort is being made to assist you in making an informed decision before authorizing the disclosure of medical records to others.

UNDERSTANDING YOUR HEALTH INFORMATION RIGHTS

Your health record is the physical property of the doctor's office, but the content is about you and therefor belongs to you. You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments to be made to your health record. Your rights include being able to review or obtain a paper copy of your health information, and be given account of all disclosures. You may also request communication of your health information be made by alternative means or to alternative locations. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.

OUR RESPONSIBILITIES

This office is required to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. This office is required to abide by the terms of this notice and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate your health information by alternative means or to alternate locations. This office reserves the right to change its practices and effect new provisions that enhance the privacy standards of all patient health information. In the event that changes are made, this office will notify you at the current address provided by you on your medical file. Other than for reasons described in this notice, this office agrees not to use or disclose your health information without your authorization.

YOUR HEALTH INFORMATION WILL BE USED FOR TREATMENT, PAYMENT, & HEALTHCARE OPERATIONS.

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TREATMENT- Information obtained by your doctor, nurse, or medical staff/associate in this office will be recorded in your medical record and used to determine the course of treatment. This consists of your doctor/staff recording his/her own expectations and those of others involved in providing your care. The sharing of your health information may progress to others involved in your care, such as physicians.

PAYMENT- Your healthcare information will be used in order to receive payment for services rendered by this office. A bill may be sent to you or a third party payer with accompanying documentation that identifies you, your diagnosis, procedures performed, and supplies used.

HEALTHCARE OPERATIONS- The medical staff in this office will use your health information to assess the care you received and the outcome of your case compared to others like it.

UNDERSTANDING OUR OFFICE POLICY FOR SPECIFIC DISCLOSURES

Business Associates- Some or all of your health information may be subject to disclosure through contracts for services to assist this office in providing health care. To protect your health information, we require our business associates to follow the same standards held by this office through terms detailed in a written agreement.

Notification- Your health record may be used to notify or assist family members, personal representatives, or other persons responsible for your care to enhance well-being or your whereabouts.

Communications With Family- Using best judgment, a family member, or close personal friend (identified by you), may be given information relevant to your case and/or recovery.

Worker's Compensation- This office will release information to the extent authorized by law in matters of worker's compensation.

Public Health- This office is required by law to disclose health information to public health and/or legal authorities charged with tracking reposts of birth and morbidity. This office is further required by law to repot communicable disease, injury, or disability.

Law Enforcement- **(1)** Your health information will be disclosed for law enforcement purposes as required under state law or in response to a valid subpoena. **(2)** Provisions of federal law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys in the event that a staff member or business associate of this office believes in good faith that there has been unlawful conduct or violations of professional or office standards that may endanger one or more patients, workers, or the general public.

NOTICE OF PRIVACY PRACTICES AVAILABILITY

All individuals receiving care will be asked to acknowledge receipts of the terms described in this notice by signing below. By signing this document, you are agreeing that you have read and fully understood this entire form and that all medical history questions have been answered appropriately and accurately to the best of your knowledge.

X____ Date ______________

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INTRODUCTION TO THE PHYSICIAN-PATIENT ARBITRATION AGREEMENT

In an effort to provide some explanation regarding the arbitration agreement you are being asked to sign, the following is provided in order to make you more aware of the terms of this agreement.

What is the Physician-Patient Arbitration Agreement?

This is an agreement between you and your doctor to resolve disputes without going to court. You should read this carefully before deciding whether to sign or not sign this agreement.

What claims are covered?

All present or future claims, of **$5,000** or more, of any kind between you and your family and your doctor for which you might sue your doctor are covered, except for claims your doctor may have against you for payment of fees for medical services rendered. Those medical fees and damage claims under **$5,000** may be recovered in associate court or small claims court.

What is Arbitration?

Arbitration is an alternative way of resolving disputes. Instead of taking your disagreement through the long and sometimes expensive process of litigation, you and your doctor agree in advance to submit any disputes through arbitration. After a hearing, which is usually less formal than a court proceeding, the arbitrator(s) make(s) the decision. Although the procedures are different, generally the same laws and same measure of damages applied in court proceedings apply in arbitration.

Who chooses the arbitration?

You and your doctor each agree to appoint an arbitrator and those arbitrators appoint a third arbitrator; and, if you and your doctor do not make the selection, either you or your doctor may apply to the state circuit court to have the court name or appoint an arbitrator to hear the arbitration proceeding. Missouri law, Chapter 435 of the Revised Statutes of Missouri, also provides for the court to appoint an arbitrator if you and your doctor cannot agree on identifying the third arbitrator.

Who is bound by this agreement?

If you choose to sign the arbitration agreement, you will be agreeing to bind yourself and anyone who could bring suit in connection with treatment or services provided to you by your doctor. If you sign on behalf of a family member or some other person for whom you have responsibility, you will bind that person as well as anyone who could sue in connection with treatment or services provided to that person by your doctor. Likewise, the doctor or anyone suing on behalf of the doctor, is bound by the agreement. If the doctor is temporarily absent from practice and refers you to a substitute physician who has agreed in advance to be bound by the terms of this agreement, then any disputes between you and the substitute physician, or vice versa, will also be subject to arbitration.

Any other person with an interest in the dispute will be permitted to participate in the arbitration proceeding so that the entire matter will be arbitrated at one time.

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May I be represented by an attorney of my choice?

Yes. Any party to arbitration may be represented by an attorney of his or her choice, at his or her own expense. The arbitrators will hear the facts and decide the case whether or not the parties are represented by lawyers.

What does arbitration cost?

In general, the arbitration process is less expensive than court actions. The arbitrators fees are to be shared equally by the parties. The amount of those fees will demand upon the complexity and length of the case.

If either party does not like the arbitration result, could there still be a jury trial in court?

Generally, the answer is "No". The whole purpose of arbitration is to avoid the expense, delay and inconvenience of going to court. Arbitration awards may be appealed to a court under very limited circumstances.

Do I really have a choice?

Yes. You are not required to sign this agreement. If you do sign the agreement and change your mind, you can cancel the agreement by giving written notice to your doctor within thirty (30) days after the date you signed the agreement. If you do not cancel the agreement within the thirty (30) day period, then you and the doctor will be bound by the agreement for the course of your treatment by the doctor.

What if I have other questions?

If you have any questions about this agreement, we would urge you to contact your personal attorney. You are also free to speak with the doctor about any questions you may have or any parts of the agreement which you wish to change in any way.

____

Patient Initial

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PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: The parties to this agreement are the Physician (including any medical group to which Physician belongs), and the Patient. It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered or omitted to be rendered by the Physician to the Patient were unnecessary or unauthorized or were improperly, negligently or incompletely rendered or omitted, will be determined by submission to arbitration and not by a lawsuit or resort to court process except as state law provides for judicial review of arbitration proceedings. The parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration as the appropriate forum to resolve a dispute.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the Physician including any spouse or heirs of the Patient and any children, whether born or unborn, at the time of occurrence giving rise to any claim in the case of any pregnant mother. The term "Patient" herein shall include both the mother and the mother's expected child or children.

All Claims for monetary damages of five thousand dollars ($5,000) or more against the Physician and the Physician's partners, associates, association, corporation or partnership, or other entity, and the employees, agents, and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the Physician to collect any fee from the Patient shall not waive the right to compel arbitration of any medical malpractice claim. However, following the assertion of any claim against the Physician, any fee dispute, whether or not the subject of any exiting court action shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty (30) days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within sixty (60) days thereafter. Each party to the arbitration shall pay fifty percent (50%) of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. In the event the arbitrators do not select the neutral arbitrator within the sixty (60) day period, either party may request the state circuit court, located in the county in which the Patient or Physician resides, to appoint a neutral arbitrator and the court's selection shall be final and binding on the parties. The arbitrator shall apply the laws of the State of Missouri, including the statute of limitations and limitation on damages applicable to medical malpractice cases.

A decision by the majority of arbitrators hearing the case shall be the final decision of the arbitrators in the arbitration.

Notwithstanding, the neutral arbitrator may choose to assess more than fifty percent (50%) of his or her fees up to one hundred percent (100%) against Physician but as to the fees of the neutral arbitrator, Patient shall in no event be responsible for more than fifty percent (50%) of such fees.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

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The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such and additional person or entity shall be stayed pending arbitration.

It is understood and acknowledged by the Patient that he/she is not required to use the undersigned Physician and that there are numerous other physicians in the immediate area who are qualified to provide the same services. In the event Patient requests, Physician will supply the names of other physicians the Physician believes competent to supply medical care to Patient.

The arbitration proceeding shall be conducted in accordance with the provisions of Chapter 435 RSMo., as such may be amended from time to time.

Article 4: General Provisions: All claims based upon the same incident transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof if received, the claim, if asserted in a civil action, would be barred by the applicable state statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by Patient upon written notice delivered to the Physician within thirty (30) days of the Patient's signature date, and if not revoked within that time frame, it will govern all claims regarding medical services involving Patient and Physician.

Article 6: Retroactive Effect: If Patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) Patient should initial below.

Agreement is effective as of the date of first medical service. ________________

Patient Initials

Prior to signing this document, Patient may confer with Physician in order to request any change or modification to the provisions of this document. Patient is encouraged to notify Physician of any provision Patient disagrees with and Patient/Physician may amend any provision which both agree to change.

If any provision of this Physician-Patient Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

THIS CONTRACT CONTAINS A BINDING ARBITRATION PROVISION WHICH AMY BE INFORCED BY THE PARTIES.

____ **DATE:** _________________________

PATIENT SIGNATURE

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