

NEIL SARETSKY, M.D.
5468 LA SIERRA DR, SUITE 100
DALLAS, TX 75231

DATE: _____ SOCIAL SECURITY #: _____
LAST NAME: _____ FIRST NAME: _____ MI: _____
HOME ADDRESS: _____ CITY: _____ ST: _____ ZIP CODE: _____
NUMBER TO BE CONTACTED _____ EMAIL: _____
BIRTHDATE: ___/___/___ AGE: _____ SEX: _____ MARITAL STATUS: _____
EMPLOYER: _____ OCCUPATION: _____
WORK ADDRESS: _____ CITY: _____ ST: _____ ZIP _____
WORK TELEPHONE: _____ CELL PHONE: _____
STUDENT: Y / N FULL TIME: _____ PART TIME: _____ SCHOOL NAME: _____
NAME OF SPOUSE/GUARDIAN: _____ PHONE # _____
SPOUSE/GUARDIAN DATE OF BIRTH: _____ SS#: _____
SPOUSE/GUARDIAN EMPLOYER: _____ PHONE#: _____

EMERGENCY NOTIFICATION:(NOT LIVING WITH YOU)

NAME: _____ TELEPHONE: _____
HOME ADDRESS: _____ CITY: _____ ST: _____ ZIP _____
WHO REFERRED YOU TO OUR OFFICE?
NAME: _____ TELEPHONE: _____
ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

REASON FOR TODAY'S CONSULTATION: _____

IRREVOCABLE ASSIGNMENT OF BENEFITS AND TREATMENT:

I, _____, REQUEST THAT PAYMENTS OF AUTHORIZED INSURANCE BENEFITS, INCLUDING MEDICARE, OTHER GOVERNMENT SPONSORED PROGRAMS, PRIVATE INSURANCE AND OTHER HEALTH PLANS BE MADE TO NEIL H. SARETSKY, M.D. FOR SERVICES RENDERED TO ME. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID FOR BY SAID INSURANCE. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE ANY INFORMATION NEEDED TO BE DETERMINE THESE BENEFITS FOR RELATED SERVICES.

SIGNED: _____ DATE: _____

Patient Name: _____ HT: _____ WT: _____

Are you Allergic to any medications? If so please list :

Yes _____ No _____

Do you smoke? How many packs per day? _____

Yes _____ No _____

Have you or any member of your family ever reacted badly being put to sleep for surgery ?

Yes _____ No _____

Anesthesia reaction?

Yes _____ No _____

Have you ever received a blood transfusion or blood products?

Yes _____ No _____

Have you ever taken steroid medications or cortisone?

Yes _____ No _____

Do you have high blood pressure or any heart disorders?
If yes please explain:

Yes _____ No _____

Do you have shortness of breath or respiratory problems?

Yes _____ No _____

Do you have a family history of diabetes?

Yes _____ No _____

Do you bleed and or bruise easily from cuts, surgery, or tooth extractions?

Yes _____ No _____

Do you have any kind of skin disease, hives, eczema, or rash?
If yes please explain:

Yes _____ No _____

Do you form large scars or keloids?

Yes _____ No _____

Please provide the name and phone number of your family physician or
doctor you are currently under the care of:

Previous operations or procedures:

Do you have or have you had any significant emotional problems?

Yes _____ No _____

If yes, please explain:

Do you have children? If so, how many and what are their ages?

List any medications or herbal remedies you are currently taking:

Medical conditions that you have that are not listed above:

Dr. Neil Saretsky, M.D.
5468 La Sierra Dr
Dallas, TX 75231
214-368-4970

I _____ give permission to Dr. Neil Saretsky's staff to discuss my medical history with the following person(s).

With HIPPA regulations we are only allowed to speak with the patient only, unless otherwise indicated. Should you go forward with surgery, and you are unable to come to the phone whom may we speak with.

1. _____

2. _____

3. _____

Signature: _____

Witness: _____
(office staff only)

HIPPA Notice of Privacy Practices

Neil H. Saretsky, M.D.
5468 La Sierra
Dallas, TX 75231
214-368-4970

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 that relates to your past, present or future physical or mental health or condition and related health services.

1. 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 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 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 specific restriction requested and to whom you want the restriction to apply.

Your physicians is not required to agree to a restriction that you may request. If physicians 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 HIPPA Compliance Officer in person or by phone at our Main Phone Number.

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

Print Name: _____ Signature: _____ Date: _____