

PATIENT EVALUATION AND HISTORY

Patient Full Name: _____ DATE of visit: _____

CHIEF COMPLAINT: DESCRIBE THE PROBLEM FOR WHICH YOU ARE BEING SEEN TODAY:

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PLEASE LIST YOUR MEDICATIONS:

PLEASE LIST YOUR MEDICAL AND FOOD ALLERGIES:

		Are you allergic to LATEX? <input type="checkbox"/> YES <input type="checkbox"/> NO

LIST ANY HERBAL SUPPLEMENTS OR OVER-THE-COUNTER MEDICATIONS:

LIST ANY PAST SURGERIES AND THE DATE OF OCCURRENCE:

LIST ANY MAJOR ILLNESSES OR HOSPITALIZATIONS AND THE DATE OF OCCURRENCE:

FAMILY MEDICAL HISTORY

DO YOU OR ANY CLOSE RELATIVE HAVE?	PERSONAL	FAMILY	RELATIONSHIP
DIABETES	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
HIGH BLOOD PRESSURE	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
HEART TROUBLE	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
CANCER	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
STROKE	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
CONVULSIONS	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
ARTHRITIS/GOUT	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
BLEEDING PROBLEMS	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
RECURRING INFECTIONS	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
VENEREAL DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
HEREDITARY DEFECTS	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
LIVER PROBLEMS / HEPATITIS	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
SLEEP APNEA	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
PROBLEMS WITH ANESTHESIA	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	

Comments if yes

SOCIAL HISTORY

DO YOU...			
SMOKE	<input type="checkbox"/> YES <input type="checkbox"/> NO	packs/day: _____ Quit date: _____	SUNBATHE OR TAN <input type="checkbox"/> YES <input type="checkbox"/> NO
DRINK ALCOHOL	<input type="checkbox"/> YES <input type="checkbox"/> NO	drinks/day: _____	WEIGHT CHANGE <input type="checkbox"/> YES <input type="checkbox"/> NO
USE DRUGS	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	EXERCISE REGULARLY <input type="checkbox"/> YES <input type="checkbox"/> NO
EAT FATTY FOODS	<input type="checkbox"/> YES <input type="checkbox"/> NO		GET ENOUGH SLEEP <input type="checkbox"/> YES <input type="checkbox"/> NO
DRINK COFFEE	<input type="checkbox"/> YES <input type="checkbox"/> NO	cups/day: _____	DO BREAST SELF-EXAM <input type="checkbox"/> YES <input type="checkbox"/> NO

PERSONAL HISTORY

DO YOU HAVE or EVER HAD in the last 3 months...	YES	NO
<input type="checkbox"/> CONSTITUTIONAL SYMPTOMS		
Poor general health lately	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> EYES		
Eye disease or injury	<input type="checkbox"/>	<input type="checkbox"/>
Wear glasses/contact lenses	<input type="checkbox"/>	<input type="checkbox"/>
Blurred or double vision	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>

ACTIVITY	YES	NO
Can you walk one (1) block?	<input type="checkbox"/>	<input type="checkbox"/>
Can you climb a flight of stairs?	<input type="checkbox"/>	<input type="checkbox"/>
If no, explain:		

DO YOU HAVE or EVER HAD in the past 3 months... **YES** **NO**

<input type="checkbox"/> HEARS/NOSE/MOUTH/THROAT		
Hearing loss or ringing	<input type="checkbox"/>	<input type="checkbox"/>
Earaches or drainage	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat or voice change	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> CARDIOVASCULAR		
Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain or angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>
Palpitation	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath with walking (1 BLOCK)	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath with climbing flight or stairs	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath lying down	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve problems	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> RESPIRATORY		
Chronic or frequent coughs	<input type="checkbox"/>	<input type="checkbox"/>
Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Asthma or wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Any lung problems	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> GASTROINTESTINAL		
Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>
Change in bowel movements	<input type="checkbox"/>	<input type="checkbox"/>
Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Frequent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Painful bowel movements	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Rectal bleeding or blood in the stool	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Peptic ulcer (stomach or Duodenal)	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> GENITOURINARY		
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
Burning or painful urination	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Change in force of stream when urinating	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
Any Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>
<Female>		
irregular periods		
Last menstrual period		
# Of Pregnancies		
<input type="checkbox"/> MUSCULOSKELETAL		
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Joint stiffness or swelling	<input type="checkbox"/>	<input type="checkbox"/>
Weakness of muscles or joints	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> INTEGUMENTARY (SKIN, BREAST)		
Change in skin color	<input type="checkbox"/>	<input type="checkbox"/>
Rash or itching	<input type="checkbox"/>	<input type="checkbox"/>
Breast lump	<input type="checkbox"/>	<input type="checkbox"/>
Breast discharge	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>

DO YOU HAVE or EVER HAD in the last 3 months... **YES** **NO**

<input type="checkbox"/> NEUROLOGICAL		
Frequent or recurring headaches	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions or seizures	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Head injury	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> PSYCHIATRIC		
Memory loss or confusion	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> ENDOCRINE		
Glandular or hormone problem	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes		
insulin-dependent	<input type="checkbox"/>	<input type="checkbox"/>
non-insulin dependent	<input type="checkbox"/>	<input type="checkbox"/>
Excessive thirst or urination	<input type="checkbox"/>	<input type="checkbox"/>
Heat or cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> HEMATOLOGIC/LYMPHATIC		
Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>
Bruising tendency	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Past transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged glands	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> ALLERGIC/IMMUNOLOGIC		
HIV	<input type="checkbox"/>	<input type="checkbox"/>
Low white blood count	<input type="checkbox"/>	<input type="checkbox"/>

HEIGHT _____ **WEIGHT** _____

LIST ALLERGIES NOT MENTIONED ELSEWHERE:

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING IMPLANTS?

Pacemaker	<input type="checkbox"/> YES <input type="checkbox"/> NO	Breast	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cochlear	<input type="checkbox"/> YES <input type="checkbox"/> NO	Port a Cath	<input type="checkbox"/> YES <input type="checkbox"/> NO
Total Joint	<input type="checkbox"/> YES <input type="checkbox"/> NO	Shunt	<input type="checkbox"/> YES <input type="checkbox"/> NO
Brain Aneurysm Clip	<input type="checkbox"/> YES <input type="checkbox"/> NO	ACID (automatic cardiac internal defibrillator)	<input type="checkbox"/> YES <input type="checkbox"/> NO

DO YOU HAVE OR EXPERIENCE?

Varicose Veins	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sleep Apnea	<input type="checkbox"/> YES <input type="checkbox"/> NO
Leg swelling	<input type="checkbox"/> YES <input type="checkbox"/> NO	c-pap	<input type="checkbox"/> YES <input type="checkbox"/> NO
Leg Pain	<input type="checkbox"/> YES <input type="checkbox"/> NO	Dizziness	<input type="checkbox"/> YES <input type="checkbox"/> NO

Reviewed, and authenticated by:

- James Mhyre, MD
- Michael Towbin, MD
- Marion Johnson, MD
- Kelly Clinch, MD
- John Ebisu, MD
- Harry Kahn, MD
- Katherine Batts, PA-C

Date Reviewed:

Date Re-Reviewed:

HIPAA NOTICE OF PRIVACY PRACTICES

Effective date: April 14, 2003

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this Notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the Notice that is currently in effect.

How we may use and disclose health information about you:

- For treatment
- For payment
- For health care operations
- For appointment reminders
- As required by Law
- To avert a serious threat to health and safety
- As required by the Military or Veterans and Workers Compensation
- Public Health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Protective Services for the President and others
- Security Officials for Inmates

Your rights regarding Health Information about you:

- Right to Inspect and copy
- Right to Amend
- Right to an Accounting of Disclosures
- Right to Request Restrictions
- Right to Request Confidential Communications
- Right to a Paper copy of this Notice (*full Notice is available upon request*)

Changes to this Notice:

We reserve the right to change this Notice. We will post a copy of the current notice in our facility with the current effective date on the first page.

Complaints:

If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location where you were treated to file a complaint.

Acknowledgement of Receipt of this Notice:

We will request that you sign a separate form acknowledging you have received a copy of this notice. This acknowledgement will become part of your records.

NOTICE OF PRIVACY PRACTICES — ACKNOWLEDGEMENT

Patient:

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

Check one:

- By my signature below I acknowledge receipt of the Notice of Privacy Practices.**
- By my signature below I acknowledge that I have declined to accept the complete Notice of Privacy Practices and instead asked to receive only the Short Form Notice of Privacy Practices. I have been made aware that the complete Notice of Privacy Practices is available to me at any time, if I request a copy, is available and on display in the waiting room, and is available on the Proliance Surgeons web site at address: www.proliancesurgeons.com.**

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

parent legal guardian
 personal representative
Relationship (parent, legal guardian, personal representative)

This area for staff notes (if any):

This form will be retained in your medical record.

Last Update: December 20, 2005

12333 NE 130th Lane, Suite 420 Kirkland, WA 98034 phone: 425.899.5500 fax: 425.899.5523

Authorization for Proliance Surgeons, Inc., P.S. to Use or Disclose My Health Care Information

Patient name: _____ Date of birth: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

- All health care information in my medical record
 Health care information in my medical record relating to the following treatment or condition:

- Health care information in my medical record for the date(s): _____
 Other (e.g., X rays, bills), specify date(s): _____

You may disclose this health care information to: (check here if none)

1. Name (or title) and organization: _____
 Relationship to the patient: self parent child spouse legal guardian personal representative
 Address: _____ City: _____ State: _____ Zip: _____

2. Name (or title) and organization: _____
 Relationship to the patient: parent child spouse legal guardian personal representative
 Address: _____ City: _____ State: _____ Zip: _____

Reason(s) for this authorization (check all that apply):

- at my request other (specify): _____

This authorization ends: *(If disclosure is to a financial institution or employer of the patient for purposes other than payment, then as to those disclosures this authorization expires 90 days after signed, unless renewed.)*

- on (date): _____
 when the following event occurs: at end of treatment

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Proliance Surgeons, Inc., P.S. based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the practice. Or
- Write a letter to the practice.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date Time

Printed name if signed on behalf of the patient

Relationship
(parent, legal guardian, personal representative)

Last Update: 08/28/09

EVERGREEN SURGICAL CLINIC

Financial Policy

EVERGREEN SURGICAL CLINIC is committed to providing the highest level of quality medical care and personal service to our patients. We feel it is the patient or the guardians' responsibility to meet their financial obligations. As we see patients from many different insurance plans, it is impossible for us to know all the covered benefits, co-pays and deductibles for each plan. In addition, your insurance company will not guarantee payment to us. While it is our intention to assist, it is still your responsibility to ensure that all services rendered are paid in full. In order to clarify EVERGREEN SURGICAL CLINICS' Financial Policy, our requirements are listed below:

Appointments

As a courtesy, 24 hours notice is expected if you need to cancel or reschedule your appointment. Missed appointments may be assessed a fee.

Financial Responsibility

You, the patient (or the patient's guarantor), are ultimately responsible for all charges associated with your care regardless of insurance coverage. Co-payments and Deductibles are a contract responsibility between the patient and their insurance. These amounts are non-negotiable.

Patients Without Insurance Coverage

Payment at the time of service is required. We offer a 5% discount on office visits and a 20% discount on surgical procedures if paid in full at time of service. Before being seen, we require a deposit of 150.00 for all new patients. If necessary, short-term payment plans are available, but must be requested prior to the services being performed.

Participating Insurances

We participate with a variety of insurance plans. It is your responsibility to:

- Verify with your insurance that we are a contracted provider
- Bring your insurance card and picture ID to every visit
- Be prepared to pay your co-pay before each visit (cash, check , Discover, American Express, Visa or Mastercard)
- Bring any required referral for treatment prior to or at the time of your visit

Auto Accidents

As a courtesy to all our patients, if you have all of the necessary information, we will bill the third party insurance one time for you. Please note that we will not hold for third party payment longer than 90 days.

Workers Compensation Claims

If your visit is for a work related injury, we will need you to fill out the necessary paperwork for the State of Washington Labor & Industries or provide us with your claim information. If your employer is self insured with another carrier please bring the appropriate paperwork and/or billing information. Please be advised that our office is required by law to report all work related injuries.

Pre-Surgery/Pre-payment

Your insurance carrier will be contacted to verify benefits and eligibility prior to surgery. We will also assist you in estimating your costs. Pre-payment of deductibles may be required.

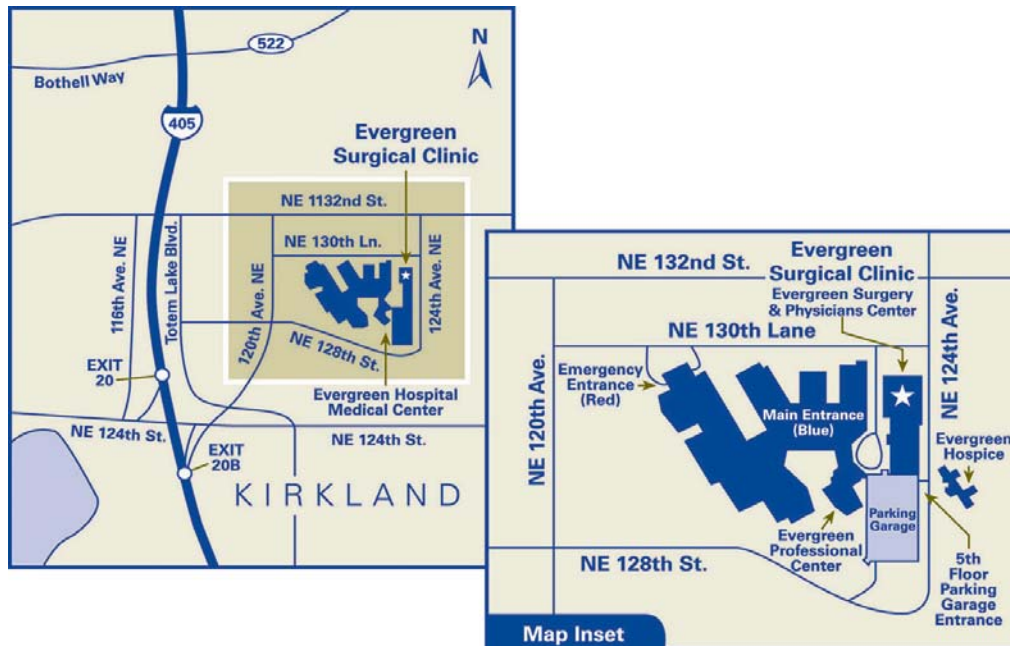
Additional Charges

- For checks returned for Non Sufficient Funds, a \$35 fee will be charged to your account.
- A service fee of \$10.25 will be charged monthly on all balances not paid in full after 45 days
If payment arrangements have been made and the arrangements are being honored -this fee may be waived, depending on the terms of the arrangement. Service fees will resume if payments are not met according to the agreement.

Collection Accounts

If your account is sent to collections, you will need to contact our collection agency. We may require that you pre-pay visits after having a bad debt account with us even if you have paid the amount owing with the collection agency.

12333 NE 130th Lane, Suite 420 Kirkland, WA 98034 phone: 425.899.5500 fax: 425.899.5523



Directions

Southbound I-405:

Merge onto I-405 (South).
 At I-405 Exit 20, turn off onto Ramp N.E. 124th Street.
 Turn LEFT (East) onto NE 124th Street.
 Turn LEFT (North) onto Totem Lake Blvd.
 Turn RIGHT (North) onto 120th Ave. N.E.
 Turn RIGHT (East) onto N.E. 130th Lane

Northbound I-405:

Merge onto I-405 (North).
 At I-405 Exit 20B, turn off onto Ramp.
 Keep RIGHT to stay on Ramp toward Totem Lake Blvd.
 Keep STRAIGHT onto 120th Ave. N.E.
 Turn RIGHT (East) onto N.E. 130th Lane.

Parking

Option A:

Follow the "Blue Entrance" sign for Evergreen Hospital Medical Center to the parking garage.
 Take the parking garage "TAN" elevator to level A.
 Follow the covered walkway to the right towards "Evergreen Surgery & Physicians Center" main entrance.
 Take the elevator to the 4th floor to **Evergreen Surgical Clinic, suite 420.**

Option B:

Follow the "Blue Entrance" sign for Evergreen Hospital Medical Center to the parking garage.
 Park on "level D" in the parking garage. Go in the tan colored door marked Evergreen Surgery & Physician Center "Access to Floors 1-4 Only."
 Go to the end of the hall and turn left and follow signs to **Evergreen Surgical Clinic, suite 420.**