Northern Iowa Cardiovascular & Thoracic Surgery Clinic, P.C.
REGISTRATION FORM

(PLEASE PRINT)
Today's Date:________________________

Patient Information: ____ Validated ID _____ Photo ID Refused _____ No Photo ID Available

Last Name:____________________ First Name: _____________________ Middle Initial:___________
Nickname: _________________ Birthdate: ________________ Age:___ Social Security#:___________
Please Circle:
Marital Status: _____Single _____ Married _____ Divorced _____ Legally Separated _____ Widowed
Primary Language: ______ English ______ Spanish ______Bosnian ______ Other
Ethnicity Values: _____ Hispanic _____Non Hispanic _____ Latino _____Non Latino ______ Declined
Race: ____ African American ____ Hispanic ____ Caucasian ____Other _____ Declined
Address: ________________________ PO Box: __________ City:________________ State: ________
Zip Code: _____________ Home Phone: ___________________ Cell Phone: _____________________
Email Address: ____

Referred By:_______________________________ Family Doctor: ______________________________

Emergency Contact Name:___________________ Relationship:__________ Phone: ___________________

Student Information: ____Not a Student ____ Yes, if yes: ___Full time ___ Part time
College Name (if attending) ____

Employment Information: _____Full Time ______ Part Time _____Retired _____Not Employed
Occupation: ________________ Employer: _______________________ Employer Phone: _______________

Spouse's Name:_________________________Spouse's Employer: _________________________________

Who will be responsible for your account? _____Self _____Spouse ______Father _____Mother _____Other
If not self, please complete: Name____________________ SS#_______________ Phone: ________________
Address: ________________________ City:_____________________ State:_______ Zip Code:__________

HEALTH INSURANCE:

Primary Insurance
Insurance Comp. Name:________________ Group#:___________ Policy#_________________________
Policy Holder:_________________ Policy Holders Birthdate____________Policy Holder SS#______________
Insured Employer: ____________________________ Relationship to Patient: ___________________________

Secondary Insurance
Insurance Comp. Name: ________________ Group#___________ Policy#_________________________
Policy Holder:_________________ Policy Holders Birthdate ___________ Policy Holder SS#______________
Insured Employer: ____________________________ Relationship to Patient: ___________________________

For Patient's under the age of 18:
Father's Name:____________________________ Mother's Name:______________________________
Address:__________________ Phone:__________ Address:__________________ Phone:__________
Employer: ________________________________ Employer:__________________________________

If this is a result of an accident or an injury, please answer:
Date of Injury:_______________ Brief Description of Injury:_________________________________

- I authorize you to give me reasonable and proper medical care by today's standards.
- I authorize Northern Iowa Cardiovascular & Thoracic Surgery Clinic, P.C. to release any medical information necessary to process my claim.
- I authorize payment of my medical benefits to Northern Iowa Cardiovascular & Thoracic Surgery Clinic, P.C.
- I understand that I am responsible for any balance due on my account.
- I authorize that a copy of this information to be as valid as the original.

Signature:____________________________ Date:________________________________

Northern Iowa Cardiovascular & Thoracic Surgery Clinic, P.C.

Patient Name: ____________________ **Date of Birth:** ______________

Authorization To Provide Treatment To Minors (Under Age 18)

I hereby grant NICTSC permission to treat my child or legal dependent whether they arrive accompanied or unaccompanied for any office visit. This authorization is valid indefinitely or until the minor reaches the age of 18. **Parent/Guardian Signature:**_____________________________

Consents: **Before you can be seen, please initial each item and sign below.**

Consent for Treatment:

I hereby give permission to NICTSC to provide treatment and submit charges for medical services to my insurance carrier(s)/Medicare. This consent includes all medical treatment, laboratory procedures and condition monitoring. I understand I have the right to decline services at any time. _____

Agreement to Pay/Insurance Acknowledgment:

I understand that I am financially responsible for any charges not covered by my insurance and co-pays, co-insurance and cosmetic services are due at the time of service. If you do not keep your appointment and fail to notify us, you may be charged up to $50. This will be the patients responsibility to pay, and it will not be billed to insurance. I authorize the release of any information necessary to my insurance company to determine insurance benefits, along with the payment of benefits directly to you. _____

Self-Pay/Cosmetic:

I understand that if I do not have health insurance or my health insurance is not accepted at NICTSC, I will be responsible to pay in full at the time of visit. This may result in overpayment or underpayment in which case a refund or additional bill will be issued. I understand that any cosmetic service is not covered by insurance and is due in full at the time of service. _____

Release of Information:

I authorize the release of medical information for continuing health care services to or from my referring or consulting physicians. I authorize the release of information to process insurance claims, insurance applications, pre-authorizations and prescriptions. I authorize a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or to NICTSC. _____

Verbal Communication Authorization

NICTSC must have your specific authorization to share any of your Protected Health Information (PHI) with a spouse, family member or other individual or to leave a message regarding your health care. This authorization **does not** affect how we leave messages regarding the reminder of, or the rescheduling of, an appointment. **The type of information disclosed:** Any medical, diagnostic, and/or account information. This form **does not** authorize the disclosure of any of your **written** health information.

Verbal communication regarding my treatment can be shared with: (please print)

Name: ____________________ Phone:__________________ Relationship:_________

Name: ____________________ Phone:__________________ Relationship:_________

Phone number where a detailed message regarding my health information may be left:

Phone: _______________

Signature of Patient/Parent or Guardian: ______________________ Date: ________

If signed by authorized person, print name and relationship, and if applicable, provide a copy of the Power of Attorney.

This authorization may be revised, limited or revoked at any time by giving written notice to this office.

Northern Iowa Cardiovascular & Thoracic Surgery Clinic PC
Dr. E. Anthony Otoadese
146 West Dale St #202
Waterloo, IA 50703
Tel: 319-233-6211 Fax: 319-233-2164

NOTICE OF PRIVACY PRACTICES

In accordance with the Health Insurance Portability and Accountability Act of 1996, as of April 14, 2003 all health care providers are required to provide their patients with a "Notice of Privacy Practice' statement.

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.

The health provider named above is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

1. We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.
2. On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with the healthcare provider named above.
3. It is our policy to provide a substitute health care provider, authorized by the healthcare provider named above to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation.

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to us for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received.

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.

We may disclose your health information to coroners or medical examiners.

Organ Donation.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

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NOTICE OF PRIVACY PRACTICES

Marketing.

We may contact you for marketing purposes or fundraising purposes, as described below.

1. As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

2. It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Health Care provider sponsored fund-raising events.

Change of Ownership.

In the event that the health care provider named above is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

1. You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that the healthcare provider named above is not required to agree to the restriction that you requested.
2. You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
3. You have the right to inspect and copy your health information.
4. You have a right to request that the healthcare provider named above amend your protected health information. Please be advised, however, that the healthcare provider named above is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
5. You have a right to receive an accounting of disclosures of your protected health information made by the healthcare provider named above.
6. You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

1. The healthcare provider named above reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, the healthcare provider named above is required by law to comply with this Notice.
2. The healthcare provider named above is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please call the office number listed at the top of this page.

Complaints

Complaints about your Privacy rights, or how the healthcare provider named above has handled your health information should be directed to Practice Privacy Officer by calling this office at the number noted at the top of this page. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights, 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide the healthcare provider named above with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Name (print) ______________________________

Patient's Signature ______________________________ Date__________

Authorized Facility Signature ______________________________ Date__________

Northern Iowa Cardiovascular
Thoracic Surgery Clinic

Name______________________Birth Date___/___/___

Past Medical History

Yes	No	Asthma	Yes	No	Gallbladder
Yes	No	Lung disease	Yes	No	High blood pressure
Yes	No	Heart disease	Yes	No	Arthritis
Yes	No	Thyroid Problems	Yes	No	Liver disease/Hepatitis
Yes	No	Kidney Disease	Yes	No	Strokes or TIA
Yes	No	Colitis/Chron's/IBS	Yes	No	Colon Polyps
Yes	No	Cancer	Yes	No	Reflux/Hiatal Hernia
Yes	No	Tuberculosis	Yes	No	Elevated Cholesterol
Yes	No	Diabetes	Yes	No	Claudication
Yes	No	Dialysis	Yes	No	MRSA Infection
Yes	No	COPD/Emphysema	Yes	No	Pacemaker/Defibrillator

Last Menstrual Cycle_____

Previous Surgeries

Yes	No	Back	Yes	No	Tonsils
Yes	No	Appendix	Yes	No	Gallbladder
Yes	No	Hernia	Yes	No	Breast
Yes	No	Hysterectomy	Yes	No	Tubal Ligation
Yes	No	Angioplasty	Yes	No	D & C
Yes	No	Heart Surgery	Yes	No	Vascular Surgery
Yes	No	___________			

Review of Systems: Circle if you have any of these symptoms.

Skin: Itching Hives Rash Dryness Lesions Bruising Bleeding

Eyes: Vision changes Double vision Irritation Light Sensitivity

Ears: Hearing Aids Hearing Loss Pain Discharge Infections Ringing

Nose: Nosebleeds Discharge Infections Pain

Mouth/Throat: Cavities Dentures Bleeding Gums Sores/Lesions Sore Lesions Hoarsness

Neck: Pain Masses Goiter Thyroid

Turn Over →

Respiratory: Cough Shortness of Breath Hemoptysis Asthma
Emphysema Tuberculosis Pneumonia/Bronchitis

Cardiovascular: Chest Pain Palpitations Shortness of breath with sleeping
Shortness of breath with walking Swollen legs Cramps
Varicose Veins Color changes in legs

Gastrointestinal: Vomiting Constipation Diarrhea Heartburn
Blood in Stool Changes in Stool Difficulty Swallowing
Jaundice Liver Disease Gallbladder Disease

Genitourinary: Urine Frequency Pain Hematuria Incontinence
Urination Difficulty

Hematology/Lymphatic: Anemia Sickle Cell Disease
Hemophilia Swollen Glands Night Sweats Itching
Bleeding Disorder Hypercoagulable State
Enlarged Lymph Nodes

General: Fever Chills Loss of Appetitie Weight loss

Neurological: Headaches Dizziness Numbness TIA's
Falls Tremors CVA's Memory Loss
Problems with Gait/walking Weakness Paralysis

Psychiatric: Depression Anxiety Bipolar

Endocrine: Excessive Thirst Excessive Urine
Intolerance to Heat Intolerance to Cold Diabetes
Hot/Cold Flashes Weight Changes

Allergy/Immune: HIV/Aids Hepatitis B Hepatitis C
Hay Fever Persistent Infections

Musculoskeletal: Weakness Paralysis Stiffness Joint Pain
Swelling Arthritis Gout Pain

Please Provide List of Medications.

NICTSC
Varicose Vein Documentation Form
(Please be VERY Specific)

Name:_____________________

Date:______________________

Do you ever have to stop what you are doing due to leg discomfort?
Yes/No
What is it that you are doing when you have to stop?

____

Do your legs keep you from doing any activities of daily living such as house work, shopping, child care, employment?
Yes/No

If yes, what activities?

____

Do you ever have to get up from sitting for long periods of time to walk around due to leg discomfort?
Yes/No

If yes what activities?

____

Do your legs swell?
Yes/No

Do you use pain medication of any type to help with your leg discomfort?
Yes/No

If yes, what medication?

____

CARDIOVASCULAR AND THORACIC SURGERY
CEDAR VALLEY VEIN CLINIC

E. ANTHONY OTOADESE, M.D., Ph.D., F.A.C.S.
ALLYSON LANDPHAIR, ARNP

PERMISSION FOR USE OF PHOTOGRAPHS/SLIDES

I hereby give the providers of this office permission to use my photographs in the following manner(s), please check all that apply:

___ Web Site Photos for the Cedar Valley Vein Clinic.

___ In office to show "before/after" picture to yourself, or other patients.

___ New patient seminars to teach other patients about procedures.

___ Medical education/lectures to others.

___ Use in professional writing which may include textbooks, journals, newsletters.

___ Send photographs to your insurance company upon their request.

I Understand that there will be NO personal information attached to these photographs.

The specific restrictions on the use of my photographs include:

____

____

____

I understand that this consent may be revoked in writing at any time.

____________________ ____________________

Patient Signature Date