



## **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.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the *Notice of Privacy Practices* currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this *Notice*, please contact the Privacy Officer at this practice.

### **WHO WILL FOLLOW THIS NOTICE**

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this *Notice*. All subsidiaries, business associates, sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this *Notice*. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

### **HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU**

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

#### **FOR TREATMENT**

We may use your medical information about you to provide you with medical treatment of services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence medications we prescribe for the treatment process.

#### **FOR PAYMENT**

We may use and disclose medical information so the treatment and services you receive from us may be billed and payment may be collected from you, your insurance company a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

#### **FOR HEALTH CARE OPERATIONS**

We may use and disclose your medical information for health care operations to assure that you receive quality care. Example: We may use medical information to evaluate our treatment and services and further the performance of our staff in caring for you.

## OTHER USES AND DISCLOSURES THAT CAN BE MADE WITHOUT CONSENT OR AUTHORIZATION

- ❖ As required during an investigation by law enforcement agencies
- ❖ To avert a serious threat to public health or safety
- ❖ As required by military command authorities for their medical records
- ❖ To workers' compensation or similar programs for processing of claims
- ❖ In response to a legal proceeding
- ❖ To a coroner or medical examiner for identification of a body
- ❖ If an inmate, to the correctional institution or law enforcement official
- ❖ As required by the US Food and Drug Administration (FDA)
- ❖ Other healthcare providers' treatment activities
- ❖ Other covered entities' and providers' payment activities
- ❖ Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- ❖ Uses and disclosures required by law
- ❖ Uses and disclosures in domestic violence or neglect situations
- ❖ Health oversight activities
- ❖ Other public health activities
- ❖ We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

## USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are required to retain our records of the care we have provided you.

## YOUR INDIVIDUAL RIGHTS REGARDING YOUR MEDICAL INFORMATION

**Complaints.** If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

**Right to Request Restrictions :** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment of health care operations or to someone who is involved in your care or the payment of your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit a request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

**Right to Request Confidential Communications:** You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request and will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

**Right to Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, You must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not a part of the information which you would be permitted to inspect or copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have a right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal. Statements of disagreements and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

**Right to an Accounting of Non-Standard Disclosures:** You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional list, we reserve the right to charge you for the cost of providing the list.

**Right to a Paper Copy of This Notice:** You have the right to a paper copy of this *Notice* at any time. To obtain a paper copy of the current *Notice*, please request one and it shall be given to you.

## CHANGES TO THIS NOTICE

We reserve the right to change this *Notice*. We reserve the right to make the revised or changed *Notice* effective for medical information we already have about you and any information we receive in the future. We will post a copy of the current *Notice*, with the effective date in the upper left corner of the first page.



## NOTICE OF PRIVACY PRACTICE

HIPPA (Health Insurance Portability and Accountability Act) regulations require us to provide to you, the patient or personal representative, a copy of our *Notice of Privacy Practice*. Please sign this form as a acknowledging receipt of this brochure.

In addition, this notice will serve as acknowledgment and authorization for your records to be used in the scope of this office, including but not limited to, use by the St. Joseph Hospital Bariatric Care Center multidisciplinary team and data collection members.

Please list how we may contact you and still provide the privacy and security you require as we protect your health and personal information.

### Please check

- \_\_\_\_\_ Please list telephone number(s) at which a message may be left.  
Home \_\_\_\_\_  
Work \_\_\_\_\_  
Cell \_\_\_\_\_
- \_\_\_\_\_ Telephone and message to another person.  
Phone \_\_\_\_\_ Name \_\_\_\_\_
- \_\_\_\_\_ Mail.
- \_\_\_\_\_ Designated caregiver, legal guardian or relative.  
\_\_\_\_\_ (Please specify)
- \_\_\_\_\_ Yes. I would like to be visited by the Volunteer Ambassadors during my hospital stay.

Print Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



## PATIENT HISTORY

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Chief Complaint (please state your problem in your own words)

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List Present of Past Medical Problem (s)

(i.e., heart disease, high blood pressure, diabetes, kidney or liver disease, other)

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List Previous Hospitalizations (dates and reasons)

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List Previous Surgical Procedures

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List Medications (please specify dosage, how many times per day, and what form, i.e. capsules, tablets or liquid)

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List Drug Allergies

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Have you had any problems with General Anesthesia or Previous Operation?  Yes  No

Please explain \_\_\_\_\_

Have you had Previous Transfusions?  Yes  No If yes, estimate how many \_\_\_\_\_

Do you smoke?  Yes  No If yes, how many packs per day \_\_\_\_\_

If none, have you ever smoked \_\_\_\_\_ If yes, when did you quit? \_\_\_\_\_

Alcohol \_\_\_\_\_ ounces per month (i.e. 1 oz =1 can of beer or 8 oz glass of wine or 1 shot of hard liquor)

Have you ever been treated for Drug Abuse or Alcoholism?  Yes  No

If yes, how long ago \_\_\_\_\_

Do you have any problems with bleeding? (i.e., bruise easily, recurrent nosebleeds, heavy menstrual flow, etc.)

Yes  No If yes, please describe \_\_\_\_\_

Do you take aspirin?  Yes  No

If yes, when is the last time you took aspirin? \_\_\_\_\_

Do you take Birth Control Pills?  Yes  No Type of Dosage \_\_\_\_\_

### Do you take one/more of the following

	Yes	No
Aspirin		
Motrin		
Ibuprofen		
Dicofenac		
Advil		
Alleve		

### Have you ever had the following:

	Yes	No
Rheumatic Fever		
High Blood Pressure		
Shortness of Breath		
Asthma, Emphysema, Previous lung disease		
Diabetes		
Fainting or Blackout Spells		
Dentures, Bridges, Capped Teeth		
Cold or Flu in last two months		
Recent Headache or Blurred Vision		
Back Pain, Spine Trouble, Sciatica		
Kidney Trouble		
Do you wear a Hearing Aid?		

What diseases run in your family? (List disease, which relative, and their current status)

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**Please indicate if you have had one/more of the listed exams**

	Date	Facility	Ordering MD
Ultrasonound/Sonogram			
CAT/CT Scan			
MRI			
HIDA Scan			
Nuclear Medicine			
Other Diagnostic Exam			

Date and place of most recent Chest X-Ray \_\_\_\_\_

Date of most Electrocardiogram or EKG \_\_\_\_\_

Date of most recent labs \_\_\_\_\_ Ordering Physician \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

## PATIENT PARTNERSHIP PLAN

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your best possible health requires a “partnership” between you and your doctor. As our “partner in health,” we ask you to help us in the following ways:

### Schedule Visits With My Doctor For Routine Physical Exams And Other Recommended Screenings:

I understand that my doctor will explain to me, which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc). These health screenings are tests that can help detect life-threatening diseases and conditions. If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule a regular visit with my doctor to complete my physical exam and to discuss these health screenings.

### Keep Follow-up Appointments and Reschedule Missed Appointments:

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him/her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order test, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and do not reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

### Call The Office When I Do Not Hear The Results Of Labs And Other Test:

I understand that my physician’s goal is to report my laboratory and test results to me as soon as possible. However, if I do not hear from my physician’s office within the time specified, I will call the office for my test results.

### Inform My Doctor If I Decide Not To Follow His Or Her Recommended Treatment Plan:

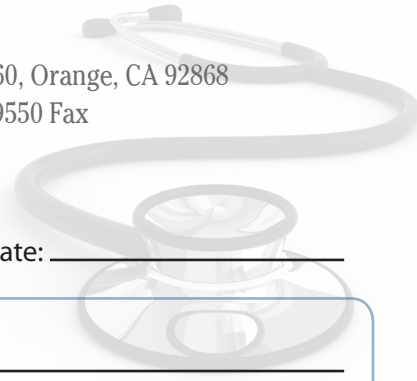
I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and test, or even asking me to return to the office within a certain period. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Patient Signature \_\_\_\_\_ Print Patient’s Name \_\_\_\_\_ Date \_\_\_\_\_

Sami B. Hammaji, M.D., F.A.C.S., F.R.C.S.(C) \_\_\_\_\_





## PATIENT REGISTRATION FORM

Date: \_\_\_\_\_

### Patient Information

Patient Name \_\_\_\_\_ Social Security# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Daytime Phone (Hm or Wk) \_\_\_\_\_ Evening Phone (Hm or Wk) \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Ethnicity \_\_\_\_\_ Gender  Male  Female  
Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
Family Doctor/PCP \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Employment Information

Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

### Insurance Information

Insurance Carrier \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_  
Claims Mailing Address \_\_\_\_\_ Phone \_\_\_\_\_  
Name of Primary Insured \_\_\_\_\_ Social Security# \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer \_\_\_\_\_ Business Phone \_\_\_\_\_  
Secondary Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_ Group# \_\_\_\_\_  
Claims Mailing Address \_\_\_\_\_ Phone \_\_\_\_\_  
Name of Primary Insured \_\_\_\_\_ Phone \_\_\_\_\_

I hereby authorize payment directly to SAMI B. HAMAMJI of the medical and/ or surgical benefits otherwise payable to me for the services, but not to exceed the charges as stated. I also understand that I am financially responsible to the physician for all the charges not covered by this authorization.

Signature \_\_\_\_\_ Date \_\_\_\_\_



**PATIENT HISTORY QUESTIONNAIRE**

PATIENT: Please print in black ink. If more space is needed, attach additional sheet.

Last Name: \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Stated Height: \_\_\_\_\_ Stated Weight: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Primary Language: \_\_\_\_\_ Telephone #: \_\_\_\_\_ Work #: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Cardiologist: \_\_\_\_\_

ALLERGIES AND ALLERY REACTIONS		LIST PREVIOUS CARDIAC/MEDICAL PROCEDURES			
Name of Medication	Reaction	Procedure	Year	Complications	Anesthesia Type
				Yes/No	
				Yes/No	
				Yes/No	
				Yes/No	
				Yes/No	

MEDICATIONS *Include medication for pain, herbs, diet pills, food supplements			LIST PREVIOUS SURGERIES			
Name of Medication	Dose/How Often	Reason	Procedure	Year	Complications	Anesthesia Type
					Yes/No	
					Yes/No	
					Yes/No	
					Yes/No	
					Yes/No	
					Yes/No	
					Yes/No	

Chief complaint: (please state your problem in your own works): \_\_\_\_\_

Please circle YES or No for the following questions: \_\_\_\_\_

Have you used Aspirin or Aspirin-containing medications in the last 14 days?  Yes  No

Do you use Blood Thinners, i.e. Coumadin, Aspirin or Ibuprofen?  Yes  No

Medication Name: \_\_\_\_\_

Patient Name (PLEASE PRINT) \_\_\_\_\_

Are you more than 50 lbs. above your desired weight?  Yes  No

Have you used diet pills in the last two (2) weeks:  Yes  No

Medication Name: \_\_\_\_\_

Have you taken Steroids or Cortisone within the last 3 months?  Yes  No

If yes, medication name: \_\_\_\_\_

How long? \_\_\_\_\_

Do you take antibiotics before dental work?  Yes  No

Have you ever smoked? \_\_\_\_\_

If you quit smoking, when: \_\_\_\_\_

Do you drink alcohol more than 4 days per week?  Yes  No

How much: \_\_\_\_\_ Kind: \_\_\_\_\_

Do you use recreational drugs?  Yes  No

Type: \_\_\_\_\_

Do you use oxygen to perform daily activities?  Yes  No

Have you, or your immediate family, had unusual reactions, problems or complications associated with anesthesia.  Yes  No

If yes, describe: \_\_\_\_\_

Do you exercise?  Yes  No

If yes, how often: \_\_\_\_\_ How long? \_\_\_\_\_

Type of exercise: \_\_\_\_\_

Is your level of activity related to health limitations?  Yes  No

If yes explain: \_\_\_\_\_

Do you wear contact lenses?  Yes  No

Do you have caps, bridges, dentures or loose teeth?  Yes  No

If yes, explain: \_\_\_\_\_

Does your immediate family have a history of heart disease?  Yes  No

- Age of onset:  Father  
 Mother  
 Sibling

**Medical History: Please check YES or No for the following questions:**

Heart attack  Yes  No Swelling feet/ankles  Yes  No Dialysis  Yes  No

Coronary Artery Disease  Yes  No Asthma  Yes  No Cancer/Malignancy:  Yes  No

Angina, Chest Pain  Yes  No COPD (lung disease)  Yes  No Location: \_\_\_\_\_

Abnormal ECG  Yes  No Sleep Apnea  Yes  No Radiation Therapy  Yes  No

Patient Name (PLEASE PRINT) \_\_\_\_\_

Irregular heart rhythm	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker:	<input type="checkbox"/> Yes <input type="checkbox"/> No	History of Blood Clots:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Transfusion:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Model: _____		Lung/Leg _____		Date: _____	
Implanted Defibrillator	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congestive Heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Back Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiomyopathy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heartburn	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hyperthyroidism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers/GERD	<input type="checkbox"/> Yes <input type="checkbox"/> No
Poor Circulation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypothyroidism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in Urine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Please list any other medical conditions that are not listed above: \_\_\_\_\_

Please list previous Hospitalizations: (dates and reasons): \_\_\_\_\_

Family History: Please list past or present medical problem (i.e., heart disease, high blood pressure, diabetes, kidney or liver disease, family history, other) \_\_\_\_\_

Please check YES or No for the following questions:

Have you had blood drawn in the past 6 month?  Yes  No If yes, location: \_\_\_\_\_

Have you had an EKG done in the past 12 months?  Yes  No If yes, location: \_\_\_\_\_

Have you had a Chest X-Ray done in the past 12 months?  Yes  No If yes, location: \_\_\_\_\_

If Female, is there a possibility of being pregnant?  Yes  No

When did your last menstrual period begin? \_\_\_\_\_

Have you had a recent medical evaluation by your Internist, Cardiologist or Family Practitioner?  Yes  No

If yes, Doctor's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for providing this important information.

Patient/Parent/Guardian \_\_\_\_\_

If other than patient, Indicate relationship \_\_\_\_\_ Date \_\_\_\_\_

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714-541-5959 Tele, 714-835-9550 Fax

