Susannah Friemel, M.D.
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Davenport, IA 52807
563-345-HEAL(4325)
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To help us learn more about you and your healthcare needs, please complete this form prior to visit.

PATIENT INFORMATION

Patient's Name Last:	First:	Middle:
Maiden Name:	Date of Birth:	Age:
Address:	Phone:	Email:
City, State & Zip:	What you like to be called:	
Social Security Number:	Gender: M F	Marital Status: (please circle one) Singe Married Divorced Separated Widowed
Preferred Language: (please circle one) English Spanish Other:_____ Translator needed? YES NO	Ethnicity: (please circle one) Hispanic Non-Hispanic Decline	Race: (please circle all that apply) White Black/African American Asian American Indian Alaskan Other:_____
Primary Care Provider:	Preferred Pharmacy:	Preferred Pharmacy Location:
Emergency Contact:	Relationship to You:	Phone:
Employer:	Occupation:	

INSURANCE INFORMATION

Please provide a copy of all insurance cards to front desk. **If you bring your insurance card with you, you do not need to fill out this section.**

(Please circle one) Medicare Public Aid United Health Care Wellmark/BCBS

Other: _____

Policy #:	Group #:	
Policy holder:	DOB: / /	Phone:
Address:		

PATIENT HISTORY

Please list all ALLERGIES (food, drug, environmental) _____ No known allergies

_____ _____

_____ _____

_____ _____

Please list all medications you are currently taking, including over the counter and herbal supplements.
You can attach your medication list if available. _____ No medications

Medication	Dosage	Times/day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Tobacco use: Never Minimal Yes, currently ____packs/day for ____years
Previous use: Quit date_____ ____packs/day for ____years Other: (cigars, chew, etc.) _____

Are you interested in smoking cessation? Yes No

Iowa Cancer Specialists offers both individual and group smoking cessation classes. Are you interested in learning more about this opportunity? Yes No

Alcohol (please circle one): Never Rarely Less than 10 /week More than 10 /week

Illicit drug use (please circle one): No Yes What type? _____

I am concerned about my use of alcohol or drugs (please circle one): Yes No

Do you have any Implantable Devices? If so, please list them

Device _____ **Device ID**_____ **UDI** _____

Device _____ **Device ID**_____ **UDI**_____

What else would you like for us to know about you?

_____

_____

_____

PATIENT MEDICAL HISTORY

Please ***circle*** all that pertain to *your personal history:*

Anxiety Depression Seizures Headaches/Migraines Arthritis Osteoporosis

Anemia Abnormal Bleeding/Blood disorder Stroke DVT Thyroid problems Irregular heat beat

High blood pressure Heart disease Diabetes Asthma COPD Kidney disease Liver disease

Cancer (please specify what type of cancer and approximate date of diagnosis)

_____

_____

_____

Past surgical history/major illness or hospitalization (please include approximate date)

_____

_____

_____

_____

Preventive care (please list approximate date of most recent procedure)

Colonoscopy _____ Normal/Abnormal (circle one)

Prostate exam _____ Normal/Abnormal

Mammogram _____ Normal/Abnormal

Pap test _____ Normal/Abnormal

If you circled abnormal for any of the tests listed above, please provide information on where we may obtain results for our records.

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

Please ***circle*** all that pertain to *your family members:*

High blood pressure Heart disease Stroke Bleeding disorders Diabetes Osteoporosis

Cancer (type)	Family member	Age at diagnosis	Living?
_____	_____	_____	**Yes No**
_____	_____	_____	**Yes No**
_____	_____	_____	**Yes No**
_____	_____	_____	**Yes No**

(For office staff only- patient meets NCCN guidelines for genetic testing Yes No)

At Iowa Cancer Specialists, we value you as our patient and offer a variety of services to provide a holistic approach to your care.

Please let us know if you are interested in any of the following resources listed below.

Smoking cessation _____

Individual lifestyle intervention/weight management _____

Group Wellness classes _____

Perimenopause/menopause symptoms _____

Palliative care counseling _____

We look forward to working with you to achieve your healthcare goals!

INSURANCE AND MEDICAL POLICY INFORMED CONSENT

I request that payment of authorized Medicare or other insurance company benefits be made on my behalf to Iowa Cancer Specialists, PC (ICS) for any services furnished to me by ICS. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If I have additional insurance policies, my signature authorizes releasing information to the insurers or agency shown. In Medicare or other insurance company assigned cases, the doctor will accept the charge and determination of Medicare or other insurance as the full charge and the co-insurance and the deductible are based upon the charge determination of Medicare or other insurance company(s).

I also understand that my signature authorizes ICS to perform medical testing and/or treatment which may include, but are not limited to, blood tests, bone marrow, lumbar puncture, and/or chemotherapy, if necessary.

Signature: _____ Date: _____

Print name: _____

IOWA CANCER SPECIALISTS, PC

HIPAA Form

Consent for Release and Use of Confidential Information,

and Receipt of Notice of Privacy Practices Form

I, _____ hereby give consent to Iowa Cancer Specialists

(Name of Patient or Authorized Representative)

(ICS) to use or disclose, for the purposes of carrying out treatment, payment, or health care operations,

all information contained in the patient record of _____.

(Patient Name)

I acknowledge receipt of the Physician's Notice of Privacy Practices which provides detailed information about how the practice may use and disclose my confidential information.

I understand that the Iowa Cancer Specialists has reserved the right to change the privacy practices that are described in the Notice.

I also understand that a copy of any Revised Notice will be provided to me upon my request.

I authorize the release of information to be given to the following persons:

Name	Relationship	Phone Number

I request the following restrictions for the use and disclosure of my health information:

_____

_____

I authorize ICS to leave messages on my home phone or cell phone for general messages or for appointment scheduling changes. YES NO

I authorize ICS to contact me at my place of employment if unable to reach me at my phone number. YES NO

_____ _____

(Signature of Patient / Authorized Representative) Date Signed

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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 are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

Ways in Which We May Use and Disclose Your Protected Health Information

The following paragraphs describe different ways that we use and disclose your protected health information.
Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally, we may disclose your health information to other physicians we have requested to be involved in your care.
Payment. We will use and disclose your protected health information to obtain payment for the health care services we provide you, if required by your insurance company.
Heath Care Operations. We will use and disclose your protected health information to support the practice. For example, we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you.

Other Ways We May Use and Disclose Your Protected Information

Appointment Reminders. We will use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment. We will leave a message on your answering machine if you are not home unless you specify otherwise.
Treatment Alternatives. We will use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to you.
Others Involved In Your Care. We will use and disclose your protected health information to a family member, a relative, a close friend, or any other person whom you identify as involved in your medical care or payment of care.
Research. We will use and disclose your protected health information to researchers, only by informed consent, provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
As Required by Law. We will use and disclose your protected health information when required to by federal, state, or local law. You will be notified of any such disclosures.
To Avert a Serious Threat to Public Health or Safety. We will use and disclose your protected health information to a public health authority that is permitted to collect or receive information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.
Worker's Compensation. We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.
Inmates. We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others, or for the safety and security of the correctional institution.

Your Health Information Rights

Although your health record is the physical property of the health care provider or facility that compiled it, the information belongs to you. You have the right to:
A Paper Copy of this Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking that one be mailed to you.

Inspect and Copy. You have the right to inspect and copy the protected health information that we maintain about you for as long as we maintain that information. This includes medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We many charge a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. If you wish to inspect or copy your medical information, you must submit your request in writing to our office. You may mail in your request or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our office.

Request Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our office, stating exactly what information is incomplete or inaccurate and your reasoning that supports your request. We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if: 1) the information was not created by us, or the person who created it is no longer available to make the amendment; 2) the information is not part of the record which you are permitted to inspect and copy; 3) the information is not part of the chart kept by this practice, or 4) if it is the opinion of the health care provider that the information is accurate and complete.

Request Restrictions. You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operation. For example, you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to our office. We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. However, if we do agree, we will comply with your request unless that information is needed for emergency treatment.

An Accounting of Disclosures. You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulations) nor for a period of time greater that six years (our legal obligation to retain information.) Your first request for a list of disclosures within a 12-month period will be free of charge. If you request an additional list within 12 months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before costs are incurred.

Request Confidential Information. You have the right to request how we communicate with you to preserve your privacy. For example, you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

Filing a Complaint

If you believe we have violated your medical information privacy rights, you have the right to file a complain with our practice manager or directly to the Secretary of Health & Human Services. To file a complaint with our manager, you must make it in writing within 30 days of the suspected violation and send it to Iowa Cancer Specialists, P.C., Attn: Privacy Officer. You should know that your medical care will not be compromised in any way for filing a complaint.

Uses or Disclosures Not Covered

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

For More Information

If you have questions or would like additional information, you many contact our Privacy Officer at (563) 345-4325.