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:(no dashes)	Gender: ☐ M ☐ F	Marital Status: (please check one) ☐ Single ☐ Married ☐ Divorced ☐Separated ☐ Widowed
Preferred Language: ☐English ☐Spanish ☐Other:____________ Translator Needed? ☐ YES ☐ NO	Ethnicity: ☐Hispanic ☐ Non-Hispanic ☐ Decline	Race: (check 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:
Patient's Employer:	Patient's 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 check one) ☐ Medicare ☐ Public Aid ☐ United Health Care ☐ Wellmark/BCBS

☐ Other: ____

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

Address:

____

City, State & Zip:

____

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
____	____________________	______________________________
____	____________________	______________________________
____	____________________	______________________________
____	____________________	______________________________

Menstrual / Menopause History
Last period occurred (approximate date) _____________________ Cycle and days of menses ______________________
Menopause occurred at what age ___________________

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 check 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 (check 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 check 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

Whether signing as the patient, or patient agent, I agree that in consideration of the services to be rendered, I hereby individually obligate myself to pay the account in accordance with the regular rates and terms, even in the event that my insurance company denies payment. I shall also be responsible for any office co-pay owned at the time of service. I understand that I am financially responsible for any charges as determined by my insurance carrier. I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, Iowa Cancer Specialists, P.C. may disclose portions of my financial and medical records to the person or entity which is or may be liable for all or any portion of the payment(s) to Iowa Cancer Specialists. I the undersigned, agree to the following terms. I agree to be personally responsible for all charges. In the event it becomes necessary for Iowa Cancer Specialists, P.C. to incur collection costs or institute suit to collect any amount due under this agreement, the undersigned agrees to pay collection fees and expenses, including reasonable attorneys' fees and court cost plus all legal fees if incurred for collection and submits to jurisdiction and venue in Scott County, IA.

I hereby certify that the information given by me in applying for payment by insurance is correct. I understand that by signing this form, I authorize direct payment for medical services to be made to Iowa Cancer Specialists, P.C.

I understand that as a courtesy, Iowa Cancer Specialists, P.C. will file any and all insurance for charges incurred. Any balance owed after all insurance payments have been received will be due 30 days after the first statement, and become the responsibility of the party below.

I understand that patient balances not paid within 30 days of the first statement may accrue additional charges.I understand that a $30.00 charge will be assessed on all returned checks, including but not limited to checks returned by insufficient funds.

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 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.

The doctor will accept the charge and determination of Medicare or the other insurance as the full charge and the coinsurance and deductible are based upon the charge determination of Medicare or the other insurance company.

Signature: ____ Date: ____________________

Print name: ____

Iowa Cancer Specialists, P.C.

HIPPA Form

Consent for Release and Use of Confidential Information, and Receipt of Notice of Privacy Practices Form

I, ____(Name of Patient or Authorized Representative) hereby give consent to Iowa Cancer Specialists 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. The Notice of Privacy Practices provides detailed information about how the practice may be used and disclose my confidential information.

I understand that the physician has reserved the right to change his privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available to me or made available to me at my request.

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

Name	Relationship	Phone Number

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

____

____

____

I authorize Iowa Cancer Specialist to leave messages on my home or cell phone for general messages or in appointment scheduling changes. YES NO

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

____ (Signature of Patient / or 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.