Jefferson Surgical CLINIC

Thank you for choosing Jefferson Surgical Clinic for your health care needs.

Dr. Molly Rutherford's office is located at 1234 Franklin Road, S.W., Roanoke, VA. Directions and a map are enclosed. We offer handicapped parking at 1229 3rd Street, S.W., at our Vascular Building. All other parking is across from our main Walnut Avenue entrance.

We are enclosing several forms for you to complete prior to your appointment. **Please bring these completed forms at the time of your appointment and give them to the receptionist when you sign in.** Please arrive 15 minutes prior to your appointment time so we can review your documents and gather additional information if necessary. If you have not completed your paperwork, you will need to arrive 30 minutes prior to your appointment.

Your form packet includes:

- Patient Information and Acknowledgement of Receipt of Privacy Notice/Consent
- Consent and Authorization
- Request for Release of Medical Records
- Patient Medical History
- Current Medications and Allergies
- Notice of Privacy Policy

In addition to these completed forms, please bring your current insurance cards and your driver's license or valid picture ID. If your insurance requires a referral from your primary care physician, it is your responsibility to obtain that referral prior to arriving for your appointment. Any copayment required by your insurance company will be collected when you sign in.

If possible, please bring your records from your previous cardiology office. We have enclosed a release authorization for you to use in obtaining your past records.

Please call our office at 540.283.6077 or 540.283.6000 should you have questions prior to your appointment.

Jefferson Surgical
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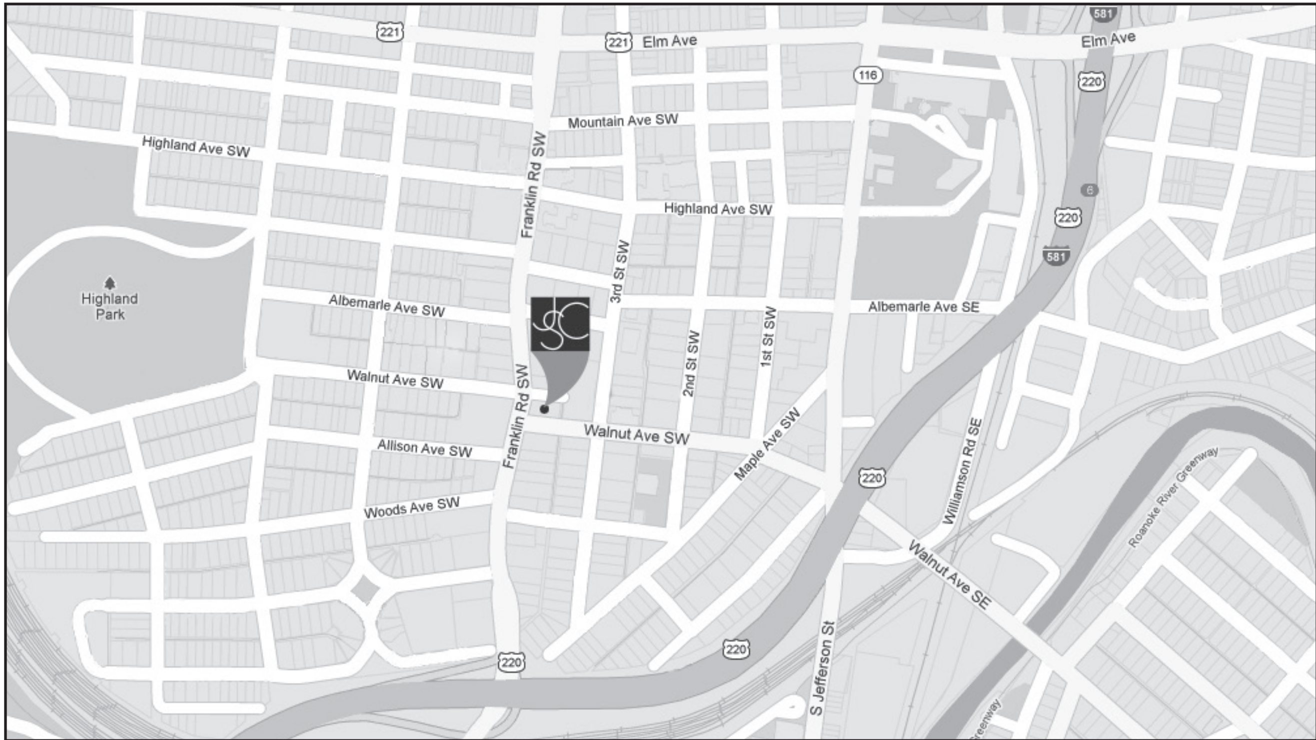
**Main Office**
**1234 Franklin Road**
**Roanoke, VA 24016**
**540.283.6000**




## From I-81:

- Merge onto I-581 South/US 220 South via Exit 143 toward Airport/Roanoke
- Take the VA-24/Elm Avenue exit (Exit 6)
- Take the ramp toward Downtown
- Merge onto Elm Avenue Southeast
- Turn left onto US-220 Franklin Road Southwest
- Turn left onto Walnut Avenue
- Turn right into the first parking lot on your right
- Jefferson Surgical Clinic is at the corner of Franklin Road and Walnut Avenue

## From US 220 North/I-581 North:

- Take the Franklin Road Southwest exit
- Turn right at the first traffic light onto Walnut Avenue
- Turn right into the Jefferson Surgical Clinic parking lot
- Jefferson Surgical Clinic is at the corner of Franklin Road and Walnut Avenue

# PATIENT INFORMATION

PLEASE PRINT AND COMPLETE ALL INFORMATION

Patient Name: ____________________
Last First Middle Maiden

Address: ____________________
Street or P.O. City State ZIP

Home Phone: __________ Work Phone: __________ Cell Phone: __________

SS#: __________ DOB: __________ Sex: ____ Marital Status: __________

Race: __________ Hispanic: __Yes __No Language: __________

Employer: __________ Retired: __Yes __No

Patient E-Mail: __________ Pharmacy: __________

Family Physician: __________ Referred By Physician: __________

**Spouse or Parent/Guardian (if minor)**

Name: __________ DOB: __________ SS#: __________

Employer: __________

**Emergency Contact:** __________ Relationship: __________ Phone: __________

# ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE/CONSENT

I have been presented with a copy of this practice's NOTICE OF PRIVACY POLICIES, detailing how my information may be used and disclosed as permitted under federal and state law.

I hereby authorize Jefferson Surgical Clinic, Inc. to release any and all information pertaining to my health care, test results, procedures, billing and/or accounting, appointment needs or any other information contained in my records to the following person(s) or agency:

___ Spouse — Name: __________

___ Parents — Name: __________

___ Other — (Please Specify): __________

___ No One

I further authorize any Jefferson Surgical Clinic, Inc. representative to contact me in one or more of the following ways:

By phone: ___at home ___at work ___cell

By leaving a message: ___at home ___at work ___cell

Other: ___postal mail ___e-mail ___text

I understand that Jefferson Surgical Clinic, Inc. may release any information to those persons whom I have designated. They may receive this information without a separate consent or prior notification. I also understand that this relates to ALL the above mentioned information. IF I WISH TO MAKE ANY CHANGES TO THE STATUS OF THIS FORM, I MUST DO SO IN WRITING.

**Patient Signature:** __________ Date: __________

If not signed by the patient, please indicate relationship to the patient (e.g., spouse, parent)

Relationship: __________ Witness: __________

Jefferson Surgical
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Name: ________________________ DOB: ______________ Today's Date______________

## CONSENT AND AUTHORIZATION

1. **Consent to Treatment:** I, the undersigned, do consent to the physicians of Jefferson Surgical Clinic, Inc. to administer any and all treatments deemed necessary for diagnostic or treatment purposes while in their care. This consent is given for a period of one year, ending one year from the date signed below.

2. **Consent to HIV Testing:** In case a health care worker of this Clinic, during your care, is punctured by a needle or is directly exposed to fluids that may transmit the HIV virus, in accordance with Section 32.1-45.1 of the Virginia Code, you will be deemed to have consented to the Clinic's right to draw blood for testing for the HIV virus and the release of such test results to the Clinic and the worker who suffered the exposure. All positive test results will be disclosed to the Department of Health. Other persons to whom the results may be disclosed include health care providers involved in your care or treatment, emergency medical services personnel, others who have access to the record for quality assurance, your parent(s) if you are a minor, or your spouse.

3. **Consent for Virginia Jurisdiction:** The relationship between the undersigned Patient and Jefferson Surgical Clinic shall be in accordance with and governed by the laws of the Commonwealth of Virginia in effect as of the date of this Registration. The Patient hereby consents to the personal jurisdiction of any state or federal courts located within the Commonwealth of Virginia.

4. **Authorization of Benefits:** I authorize the release of any medical information necessary to process my insurance claims for services rendered by Jefferson Surgical Clinic, and request payment to be made directly to Jefferson Surgical Clinic. I accept responsibility for all charges incurred at Jefferson Surgical Clinic.

5. **Consent to Medical Photography:** I consent for medical photographs to be made of me or my child (or person for whom I am legally responsible). By consenting to these medical photographs, I understand that I will not receive payment from any party for them. I understand the photograph(s) may be used in my medical record and for purposes of medical teaching.

6. **Authorization to Release PHI for participation in Electronic Prescription Database:** I authorize the use or disclosure of my individual Protected Health Information (PHI) as described below, with the understanding that this authorization is voluntary and may be revoked at any time by notifying JSC, in writing, except to the extent it has already taken action in reliance on this Authorization. This authorization covers individual prescription (present and future) PHI and prescription history disclosed by the physicians and other employees of Jefferson Surgical Clinic, P.C. (JSC) as well as to employees and agents of Sure Script and SRSsoft. The purpose of this disclosure of PHI is to permit JSC to provide prescription and prescription history information to a national electronic clearing house of such information to facilitate accessibility to and exchange of such information among my various health care providers and third-party pharmacy program payors for purposes of my treatment, reimbursement for prescriptions, and for any related purpose. If the organization authorized to receive the PHI is not a health plan, health care clearing house or healthcare provider covered by federal privacy regulations, the released PHI may no longer be protected from further use or disclosure by federal privacy regulations and may be subject to redisclosure by the recipient(s). I understand that I may see and receive a copy of the information described above if I request it in writing, I have the right to a copy of this consent, I have a right to refuse to sign this consent, and acknowledge that this consent will expire on termination of my status as a patient of Jefferson Surgical Clinic, P.C.

**I have read and understand the consent information above. I understand any changes to the above consents must be made in person or in writing.**

**Patient Name (please print):** ________________________________

**Patient Signature:** ________________________ **Date:** ______________

**As the patient's ____Parent ____Legal Guardian or ____Power of Attorney, I am authorized to sign on behalf of the above named patient.**

**Authorized Signature:** ________________________ **Date:** ______________

# REQUEST FOR RELEASE OF MEDICAL RECORDS

______________________________ request release of my medical records from:
(Last) (First) (Middle) (Maiden)

Facility: ______________________________

Telephone Number: ____________________ Fax Number: ____________________

From (date) ____________ to (date) ____________ Medical Records Number: ____________

Please check type of information to be released:

| | | |
|---|---|---|
| __ Entire Medical Record | __ Pathology Report | __ Progress Notes |
| __ History and Physical Exam | __ X-Ray Reports | __ Itemized Bill |
| __ Laboratory Test Results/Reports | __ Other Diagnostic Test | __ ____________________ |
| __ Operative Report | ____________________ | __ ____________________ |

Please send medical records no later than ____________________ to:

**Jefferson Surgical Clinic**
**1234 Franklin Road, SW**
**Roanoke, VA 24016**

**Phone 540.345.1561** **Fax** ____________________

Signature ______________________________ Date ____________

Printed Name ______________________________

Relationship if not Patient ______________________________

Patient's Date of Birth ____________________ Social Security # ____________________

Patient's Address ______________________________

Patient's Telephone Number ______________________________

**FOR FACILITY USE ONLY**

Identity of Requestor verified via: __ Photo ID __ Matching Signature __ Other, specify ____________

Verified by ______________________________

Jefferson Surgical CLINIC

Name: ______________________ DOB: ______________ Today's Date______________

# PATIENT MEDICAL HISTORY
VASCULAR/CARDIOLOGY

Family Physician: ______________________
Referring Physician: ______________________
Pharmacy: ______________________

Height: ____________ Weight: ____________

Endocrinologist (Diabetes): ______________________
Podiatrist (Feet): ______________________
Nephrologist (Kidney): ______________________
Cardiologist (Heart): ______________________
Pulmonologist (Lungs): ______________________

**FOR OFFICE USE ONLY**

Reason for Visit (Chief Complaint) ______________________________________

History of Present Illness ______________________________________

______________________________________

______________________________________

Past Medical History ______________________________________

______________________________________

______________________________________

## MEDICAL CONDITIONS

Check ✔ conditions you currently have or have had in the past.

__ Alcoholism
__ Anemia
__ Aneurysm
__ Aortic stenosis
__ Appendicitis
__ Arthritis
__ Asthma
__ Atrial fibrillation
__ Bleeding disorder
__ Blood clots
__ Blood transfusion
__ Breast lump
__ Bronchitis
__ Cancer
Type: ____________
__ Cataracts
__ Chest pain

__ Congestive heart failure
__ Crohn's Disease
__ Dementia
__ Depression/anxiety
__ Diabetes
__ Dialysis/end-stage renal disease
__ Diverticulitis
__ Emphysema/COPD
__ Epilepsy/seizure disorder
__ GERD/acid reflux
__ Glaucoma
__ Goiter
__ Gout
__ Heart attack
__ Heart disease/ heart blockages

__ Hepatitis
__ Hernia
__ Herpes
__ High blood pressure
__ High cholesterol
__ HIV positive
__ Irritable bowel syndrome
__ IV contrast or iodine allergy
__ Kidney failure
__ Kidney stones
__ Liver disease
__ Migraine headaches
__ Mitral valve prolapse
__ Mitral valve regurgitation
__ Multiple sclerosis
__ Osteoarthritis
__ Pacemaker/Defibrillator

__ Peripheral vascular disease
__ Pneumonia
__ Prostate problem
__ Psychiatric care
__ Pulmonary embolism
__ Pulmonary hypertension
__ Rheumatic fever
__ Sleep apnea/CPAP
__ Stomach ulcers
__ Stroke/TIA
__ Thyroid problems
__ Tuberculosis
__ Ulcerative colitis
__ Varicose veins

CONTINUED ON NEXT PAGE

Jefferson Surgical
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Name: ______________________ DOB: ______________ Today's Date______________

## PATIENT MEDICAL HISTORY (continued)
VASCULAR/CARDIOLOGY

| Year | OPERATIONS | Physician |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |
| | | |

| Year | HOSPITALIZATIONS | Physician |
| --- | --- | --- |
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## REVIEW OF SYSTEMS

__ Right- or __ Left-Handed __ Glasses __ Dentures __ Hearing Aids

Check ✔ conditions you currently have.

**General**
- __ Chills
- __ Fever
- __ Sleep loss/problems
- __ Weight gain
- __ Weight loss
- __ Night sweats
- __ Fatigue

**Muscle/Joint/Bone**
Aches/pain/weakness/ numbness
- __ Arms __ Back
- __ Feet __ Hands
- __ Hips __ Legs
- __ Neck __ Shoulders
- __ Knees

**Genitourinary**
- __ Blood in urine
- __ Frequent urination
- __ Lack of bladder control
- __ Painful urination
- __ Impotence

**Gastrointestinal**
- __ Poor appetite
- __ Bloating
- __ Bowel changes
- __ Constipation
- __ Diarrhea
- __ Excessive hunger
- __ Excessive thirst
- __ Gas
- __ Hemorrhoids
- __ Indigestion
- __ Nausea
- __ Rectal bleeding
- __ Stomach pain
- __ Vomiting
- __ Vomiting blood
- __ Yellow jaundice

**Neurological**
- __ Headache __ Numbness
- __ Weakness __ Seizures
- __ Dizziness __ Memory loss
- __ Balance problems

**Cardiovascular/Pulmonary**
- __ Chest pain/pressure
- __ Breathing problems
- __ Irregular heartbeat
- __ Heart murmur
- __ Poor circulation
- __ Swelling of ankles
- __ Varicose veins
- __ Blood clots (DVT or PE)
- __ Bleeding problems
- __ Coughing up blood
- __ Shortness of breath
- __ Wheezing __ Snoring
- __ Fainting/blackouts/pass out
- __ Leg swelling
- __ Leg pain with walking
- __ Wounds/ulcers on feet/legs

**Skin**
- __ Easy bruising __ Rash
- __ Hives __ Scars
- __ Itching __ Ulcers
- __ Change in moles
- __ Sore that won't heal

**Eye/Ear/Nose/Throat**
- __ Bleeding gums
- __ Blurred vision
- __ Change in vision
- __ Double vision
- __ Earache
- __ Ear discharge
- __ Loss of hearing
- __ Ringing ears
- __ Hay fever
- __ Nosebleeds
- __ Persistent cough
- __ Hoarseness
- __ Sinus problems
- __ Difficulty swallowing
- __ Painful swallowing

CONTINUED ON NEXT PAGE

Jefferson Surgical
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Name: ______________________ DOB: ______________ Today's Date______________

# PATIENT MEDICAL HISTORY (continued)

VASCULAR/CARDIOLOGY

| FAMILY HISTORY | | | | | | |
|---|---|---|---|---|---|---|
| | **Father** | **Mother** | **Sibling** | **Child** | **Other** | **Unknown** |
| Arthritis | | | | | | |
| Aortic Aneurysm | | | | | | |
| Blood clots/bleeding disorder | | | | | | |
| Cancer (List type of cancer.) | | | | | | |
| Diabetes | | | | | | |
| Heart disease | | | | | | |
| High blood pressure | | | | | | |
| High cholesterol | | | | | | |
| Kidney disease | | | | | | |
| Stroke | | | | | | |
| Peripheral vascular disease | | | | | | |
| Varicose veins | | | | | | |
| | | | | | | |
| Current age | | | | | | |
| Age of death | | | | | | |
| Cause of death | | | | | | |

| SOCIAL HISTORY |
|---|
| Marital Status: __ Married __ Divorced __ Single __ Widowed<br>Children: ______________________ |
| Habits? __ Tobacco __ Alcohol __ Drugs |
| Current Occupation: ______________________ Retired: __Y __ N |
| Living situation: __ Home __ Nursing Home __ Assisted Living __ Other:______________ |

Name: ______________________ DOB: ____________ Today's Date____________

## CURRENT MEDICATIONS

**List all medications you are currently taking and their dosage and frequency.**
**Please also list herbal and OTC medications.**

| Name of Medication | Dose | Frequency | Date Started | Prescribed By |
|---|---|---|---|---|
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## ALLERGIES

| Allergic To | Type of Reaction |
|---|---|
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Attach additional paper if needed.

585168 08-17 Rutherford

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# NOTICE OF PRIVACY POLICY

This notice, effective April 1, 2003, describes how information about you may be used and disclosed and how you can get access to this information. The physicians and staff of Jefferson Surgical Clinic are committed to treating and using your protected health information responsibly. This Notice of Privacy Policy describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice of Privacy Practices covers all departments within our practice, and any physicians, providers, and staff who treat you at any of our locations.

Each time you visit the physician, a record of your visit is made. These records contain personal information and medical information and are used for your direct care and treatment. It's also used to produce an accurate bill for the services you receive, helps improve the care we give and strengthens the operations of our organization.

**Your Health Information Rights**
Although your medical record is the physical property of Jefferson Surgical Clinic, the information in it belongs to you. You have the following rights with respect to your health information:

You can inspect and get a copy of your health information that may be used to make decisions about your care, subject to a few limited exceptions. You may request copies of your health information, in writing, from medical records personnel at Jefferson Surgical Clinic. We may charge a fee for the costs of copying, mailing or other supplies associated with your request.

If you feel the health information 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 by, or for, our practice. Your request must be made in writing and include the reason for your request. We may deny your request if you ask us to amend information that was not created by us. We may also deny your request to amend information if we believe the information to be accurate and complete.

You may request a restriction or limitation on the health information we use or disclose about you for treatment, payment or our operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. We are not required to agree to your request. In your request, you must tell us:

- What information you want to limit.
- Whether you want to limit our use, disclosure or both.
- Who you want to receive your medical information.

You can request an accounting of your health information disclosures, except for those needed to carry out treatment, payment or our operations. Other exceptions include, but are not limited to:

- For national security and intelligence.
- Use by law enforcement officials or correctional institutions.

Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003.

The first list you request within a 12-month period will be free.

You can revoke your authorization to use or disclose health information, unless disclosure has already occurred.

You can request communications of your health information by alternative means, at alternative locations or in a confidential manner. For example, you can ask that we contact you only at work or by mail. We will accommodate all reasonable requests.

You can request a paper copy of this notice even if you have agreed to receive the notice electronically.

**Our Responsibilities**
Jefferson Surgical Clinic is required by law and is committed to:

- Maintain the privacy of your health information.
- Provide you with this notice of our legal duties and privacy practices with respect to health information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction and, in most cases, allow you to request a review of our decision.

We reserve the right to change our privacy practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will amend this notice and post a copy of the revised notice.

This notice will contain on the first page the effective date. In addition, the first time you register at our practice for health care services as patient, we will offer you a copy of the current notice in effect.

**For More Information or to Report a Problem**
If you have questions and would like additional information, you may contact Karen Tuttle, Jefferson Surgical Clinic's Privacy Officer, at 540-345-1561. If you believe your privacy rights have been violated, you can file a complaint with Jefferson Surgical Clinic's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201

Jefferson Surgical CLINIC

# NOTICE OF PRIVACY POLICY

**Permitted Uses and Disclosures Which Do Not Require Your Written Consent or Authorization**

We will use your health information for treatment, which means the provision, coordination or management of the health care services we provide. For example, information obtained by a nurse, physician or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his/her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will use your health information for payment, an activity necessary for us to receive reimbursement for the services we provide to you. For example: a bill may be sent to you, an insurance company or other payer. The information on, or accompanying, the bill may include information that identities you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health care operations, such as quality assessments, evaluating practitioner performance, cost management and general administrative activities. For example: members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide, and provide training to our staff.

Some services are provided in our practice through contracts with business associates, We may disclose your health information to our business associates so they can perform the job we've asked them to do. Our contracts require business associates to appropriately protect the privacy and security of your health information.

We may disclose health information relevant to your care or payment for your care to a family member, other relatives, a close personal friend or any other person you identify.

During the initial visit, we may ask you to identify those whom you would like to receive information about you.

We may use or disclose health information to notify or assist in notifying a family member, personal representative, or another person responsible for your care about your location and general condition.

We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the practice. In leaving a message on an answering machine, we will only leave our name and the appointment's time and date.

We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use sign-in sheets in certain locations to check you into the practice. We also may call your name in the waiting area. If you do not wish to sign the sign-in sheet or have your name called, please tell the receptionist and we will make adjustments to meet your request.

We may also disclose health information as permitted or required by law, such as in the following circumstances:

- to the extent required by worker's compensation or other similar programs.
- to a health oversight agency for audits, investigations and inspections
- to public health or legal authorities charged with maintaining health records and preventing or controlling disease, injury or disability.
- to the FDA relative to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs or replacement.
- to researchers when their 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. We will always ask for your specific authorization if the researcher will have access to your name, address or other information that reveals who you are or will be involved in your care at one of our facilities.
- to research, public health and health care operations in a limited, non-identifiable, data set.
- to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant. Organs will only be procured with written authorization.
- to a coroner or medical examiner and to funeral directors as necessary to carry out their duties.
- to a law enforcement official or in response to a court order, subpoena, warrant, summons or similar process.
- to authorized federal officials for intelligence, counterintelligence and other national security activities.
- if you are a member of the armed forces, as required by military command authorities.
- to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct investigations.
- If you are an inmate of a correctional institution, to the institution or agents for your health and the health and safety of other individuals.
- A Group Health Plan may disclose protected health information to a plan sponsor.

Other uses and disclosures of medical information not covered by this notice, required for emergency treatment or permitted by the laws that apply to us will be made only with your written authorization. If you authorize disclosure, you may revoke that, in writing, at any time.

If you revoke your authorization, we will not use or disclose your medical information for the reasons covered by your prior written authorization. Please understand we are unable to take back disclosures we already made with your prior authorization, and that we are required to retain our records of the care that we provide to you.