David Chansolme, M.D. | **Personal Information** | **Please complete all information*

Name ______________________ (First / Middle / Last)   __/__/__ **DOB**   ____ **Age**   **M F** **Sex**

Address ______________________ (Street Address / City, State / Zip)   ___-___-___ **Social Security #**

Home Phone ( ) -   Cell Phone ( ) -   Employer Phone ( ) -

Patient Employer ______________________   Job Title ______________________

Employer's Address ______________________ (Street Address / City, State / Zip)

Are you claiming this as an on-the-job injury? ☐Yes ☐No   Date: __________

Was the problem caused by an accident? ☐Yes ☐No   Date: __________

How did the accident occur? ______________________

Were you referred to our office? ☐Yes ☐No   By whom: __________

Who should we contact in case of an emergency? ______________________

______________________ (Address / City, State / Zip)   Phone ( ) -

Worker's Compensation Information

Worker's Compensation Insurance Carrier ______________   Claim # __________   Phone ( ) -

Address ______________________ (Address / City / State / Zip)

Person to Contact (Adjuster) ______________   Verified by: ______________

Do you have an attorney? ☐Yes ☐No   Whom: __________

Have you informed your employer about this problem? ☐Yes ☐No

If yes, are you receiving compensation for this problem? ☐Yes ☐No

Have you been treated by any other doctor for this problem? ☐Yes ☐No   If yes, list below.

Doctor	City	Date last seen

Required Authorizations

**Please take a moment to complete all of the following required consents*

1) **Consent for Treatment:** I hereby consent to an examination and/or treatment as may be deemed necessary by Dr. Chansolme.

Signed (patient or parent of minor) ______________________

2) **Benefits to Physician:** I hereby authorize payments directly to Dr. Chansolme of the surgical and/or medical benefits. I understand that I am responsible for any portion of my bill not covered by my worker compensation carrier in the event my claim is denied.

Signed (patient or parent of minor) ______________________

3) **Release of Information:** I hereby authorize release of information necessary for filing my insurance claim or pursuing payment reviews.

Signed (patient or parent of minor) ______________________

4) **I authorize** practice/billing company to contact me about my bill regarding medical services provided.

May we contact you by: **phone? yes** ☐ **no** ☐   **cell phone? yes** ☐ **no** ☐   **work phone? yes** ☐ **no** ☐   **mail? yes** ☐ **no** ☐

5) **I have received** a Notice of Privacy Practices from the office of Dr. Chansolme.

Signed ______________________   **Date** __________

6) **I have signed** the patient consent for use and disclosure of protected health information from the office of Dr. Chansolme.

Signed ______________________   **Date** __________

You may speak with the following person/s about my bill regarding medical services provided:

Name ______________   **Relationship** ______________   **Phone** ( ) -

You may not speak with the following person/s about my bill regarding medical services provided:

Name ______________   **Relationship** ______________

HEALTH HISTORY FORM

Confidential - subject to HIPAA regulations

Today's date:___/___/___

Patient name:____ Age:_______ DOB:___/___/_____

Why are you visiting the physician today?____

____

____

History of Chronic Illness:

___ Diabetes
___ High blood pressure
___ HIV/AIDS
___ Anemia
___ Emphysema or COPD (lung disease)
___ Congestive heart failure
___ Heart Attacks
___ Hepatitis (type_____)
___ High Cholesterol
___ Chronic kidney disease
___ Chronic liver disease
___ Bleeding disorders
___ Cancer (type:________________________________)

Did you take or are you currently on chemotherapy?_Yes _ No If so, when was your last therapy?____________

___ Multiple sclerosis
___ Vascular disease
___ Stroke
___ Thyroid disease
___ Tuberculosis
___ Headaches
___ Chemical dependency
___ Depression
___ Psychiatric disorder
___ Prostate problems
___ Deficient immune system (type:__________________)

___ Rheumatoid Arthritis
___ Lupus
___ Paralysis
___ Other__________________
___ Other__________________
___ Other__________________
___ Other__________________
___ Other__________________
___ Other__________________
___ Other__________________
___ Other__________________
___ Other__________________

Have you ever been hospitalized?

Why?	When?	Where?

Have you ever had surgery?

Type of surgery:	When?	Where?

Do you have any medication allergies?

__ No known drug allergies

Medication:	Type of reaction:

Are you on any medications currently?

Medication:	Dosage:	Number of doses per day:

Do you use tobacco?

__Yes __No

__Cigarettes - # packs per day ______________

__Other tobacco product

__type ________________________________

Do you drink alcohol?

__Yes __No

number of drinks per day________________

number of times per week you drink____________

Do you use any street drugs?

___ marijuana

___ cocaine

___ meth

___ other____________________________

____

How often do you use drugs?

____

What is your profession?

____

____

Do you own any pets?

____

____

____

____

__ indoors or __ outdoors

Have you ever travelled outside the U.S.?

Where?	When?

Do you have any of the following symptoms?

- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Loss of consciousness
- ☐ Vision changes
- ☐ Hearing changes
- ☐ Loss of balance
- ☐ Headaches
- ☐ Neck stiffness
- ☐ Loss of Sleep
- ☐ Weight loss
- ☐ Generalized numbness

Respiratory

- ☐ Shortness of breath
- ☐ Cough
- ☐ Productive sputum
- ☐ Coughing blood
- ☐ Sore throat
- ☐ Mouth ulcers
- ☐ Thrush

Cardiovascular

- ☐ Chest pain
- ☐ Poor circulation
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Rapid heart beat
- ☐ Swelling of legs/ankles
- ☐ Varicose veins
- ☐ Pacemaker
- ☐ Angioplasty
- ☐ Enlarged heart

Gastrointestinal

- ☐ Poor appetite
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Excessive gas
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Vomiting
- ☐ Rectal bleeding
- ☐ Excess fluid in belly
- ☐ Difficulty swallowing
- ☐ Ulcer disease
- ☐ Abdominal pain

Eyes, Ear, Nose, Throat

- ☐ Blurry vision
- ☐ Floaters
- ☐ Double vision
- ☐ Seasonal allergies
- ☐ Nasal stuffiness
- ☐ Sinus congestion
- ☐ Nosebleeds
- ☐ Ringing in ears
- ☐ Ear discharge
- ☐ Ear pain
- ☐ Hoarseness
- ☐ Persistent cough
- ☐ Thyroid swelling
- ☐ Neck masses

Skin

- ☐ Boils
- ☐ Abscesses
- ☐ Spider bites
- ☐ Scars
- ☐ Non-healing wounds
- ☐ Easy bruising
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ New moles
- ☐ Lumps
- ☐ Open sores

Orthopedics

- ☐ Joint pain
  - ☐ legs/feet
  - ☐ arms/hands
  - ☐ back/neck
  - ☐ knees
- ☐ Numbness
  - ☐ legs/feet
  - ☐ arms/hands
  - ☐ back/neck
  - ☐ knees
- ☐ Weakness
  - ☐ legs/feet
  - ☐ arms/hands
  - ☐ back/neck
  - ☐ knees
- ☐ Fractures
- ☐ Joint replacement

Women only

- ☐ Breast lump
- ☐ Nipple discharge
- ☐ Breast enlargement/reduction surgery
- ☐ Vaginal discharge
- ☐ Painful intercourse
- ☐ Menstrual pain
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Have you had children?
- ☐ Have you had a mammogram?

Men only

- ☐ Penis discharge
- ☐ Lump in testicles
- ☐ Sore on penis
- ☐ Erection difficulties

Men and Women

Is there a history of:

- ☐ Chlamydia
- ☐ Clap
- ☐ Genital warts
- ☐ Herpes
- ☐ Syphilis
- ☐ Gonorrhea
- ☐ Genital ulcers
- ☐ Scabies or Crabs
- ☐ Trichomonas
- ☐ Yeast infections
- ☐ Other sexually transmitted disease __________

Any other issues we need to know?

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Patient Consent for Use and Disclosure of Protected Health Information

With my consent, David H. Chansolme, M.D. may use and disclose **protected health information** about me to carry out **treatment, payment and healthcare operations**. Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Chansolme reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Privacy Officer at:

______________________________	David H. Chansolme, M.D., Inc.
Name of Privacy Officer	Practice
______________________________	______________________________
Address	City, State, Zip

Telephone

With my consent, David H. Chansolme, M.D. may call my home or another designated location and leave a message (on voice mail, answering machine or in person) in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory and other results.

Mail

With my consent, David H. Chansolme, M.D. may mail to my home or another designated location any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminder cards, correspondence and billing statements.

Email

With my consent, David H. Chansolme, M.D. may e-mail to my home or another designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards, correspondence and billing statements.

I have the right to request that David H. Chansolme, M.D. restrict the use or disclosure of my protected health information to carry out treatment, payment and healthcare operations. (Please request form.)

I understand that the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I consent to the use and disclosure of my protected health information to carry out treatment, payment and healthcare operations by David H. Chansolme, M.D..

I may revoke my consent in writing except to the extent that the practice has already made disclosures based upon my prior consent. If I do not sign this consent, David H. Chansolme, M.D. may decline to provide treatment to me.

______________________	______________________	____________
Print Patient's Name	Signature of Patient **or Legal Guardian*	Date

Attention Privacy Officer:
***If a patient wishes to limit how he or she is contacted by our practice or the release of information, please refer the patient to the form titled Request for Limitations and Restrictions of PHI.**

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Infectious Diseases Consultants of Oklahoma City

David Chansolme, MD, PC

You have come to the office of an infectious diseases physician because you have symptoms or a diagnosis where specialized care may be required. We have created this information sheet to acquaint you with our standard policies. We suggest that you keep your copy of this sheet to refer to in the future.

Office hours . . .

Our office is open Monday through Friday from 8:30 am until 4:30 pm, excluding holidays. We close for lunch between noon and 1:00 pm. The phones are answered during regular business hours. If you have an urgent problem requiring attention after hours, please call the office phone and you will be forwarded to the answering service. ***In the event of a medical emergency, please go to the Emergency Room!*** **Prescription refills are not considered an emergency**.

Appointments . . .

We make every attempt to schedule patients at the earliest possible opening. Should you need to cancel or reschedule, please give us at least 24 hours notice so that we can move another patient into the open time slot. **Many of our patients have complex diagnostic problems, and although we try to stay on schedule, a patient's condition may require additional time--and that creates delays in our schedule**. We cannot accommodate walk-ins; patients are seen by appointment only.

Prescription refills . . .

A physician review of a patient's chart prior to refilling or amending a prescription is required. For this reason, we ask our patients to request their refills at least 72 hours in advance of the need. We ask that you contact your pharmacy with your request, and allow the pharmacist to contact our office. Please check with the pharmacy directs to see if your refill has been approved—and remember to allow 72 hours! If you called on Friday or a holiday, you may check with your pharmacy on the next business day after 4 pm. **No refill requests will be accepted after office hours or on weekends**.

Payment policy . . .

Payment is due and payable at the time of service unless:

1) You are insured with Medicare. The deductible and copay is due at the time of service.
2) You are insured with a managed care plan with which our office participates. The amount due at the time of service will depend of the specifics of your plan. Copayments and deductibles are due at the time of service.

Hospitals . . .

Dr. Chansolme has staff privileges at a number of hospitals in the metro area but works primarily at Integris Southwest Medical Center. Any admissions will be to Integris Southwest Medical Center. If your plan requires admission to a different hospital, please alert our staff so that we can accommodate this need.

Disability policies . . .

Disability policies are private policies owned by the patient. Forms will require a charge of **$30 to $50 per form** to be completed, and **without exception** the **money must be prepaid** at the time the form is left with our office. We require 10 days to complete the form. Patients may come by to retrieve their form, or they may provide our office with a stamped, self-addressed envelope and it will be forwarded as indicated.

Diagnostic tests, x-ray and lab results . . .

If Dr. Chansolme orders a test, results will usually be available within 10 working days. Because of the volume of testing we perform, it is not possible to telephone all patients with their results. However, if you would like to know the results of your tests, please call our office and we will be happy to assist with the information. If the test was ordered or performed by another physician, you should contact that office for your results. Even if we obtained preauthorization for the procedure, you will still need to contact the office that originally ordered or performed the test for results.

Signature ______________________ Date ______________________

Notice Of Privacy Practices

As required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your **individually identifiable health information (IIHI)**.
Please review this notice carefully.

A. Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your **individually identifiable health information (IIHI)**. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Our obligations concerning the use and disclosure of your IIHI
- Your privacy rights in your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this notice, please contact our privacy officer. The name and contact information of our privacy officer can be obtained from the receptionist at our office.

C. We may use and disclose your individually identifiable health information (IIHI) in the following ways:

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

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D. Use and disclosure of your IIHI in certain special circumstances

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

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E. Your rights regarding your IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to our privacy officer specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to our privacy officer. Your request must describe in a clear and concise fashion:
(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to our privacy officer in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our privacy officer. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) not accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operation purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to our privacy officer. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact our privacy officer.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services at 200 Independence Avenue, SW. Washington, D.C. 20201. To file a complaint with our practice, contact our privacy officer. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact our privacy officer.

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