Eastern Iowa Neuropathy and Pain Clinic

WELCOME

PATIENT INFORMATION

Date _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

PATIENT CONDITION

Reason for Visit _____

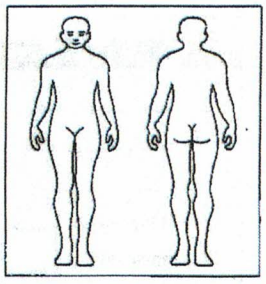
When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other



How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray _____ Urine Test _____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Other _____		
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No			
Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
						Rheumatoid Arthritis	☐ Yes	☐ No			

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

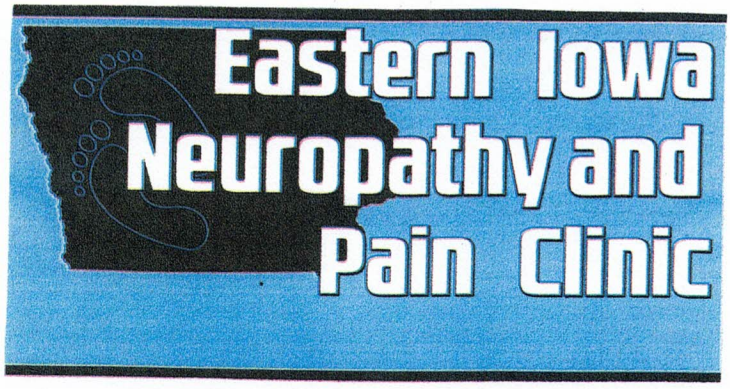
HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name_____		
Pharmacy Phone (____) _____		



Dr. Jacob Pudenz
14 Main St
Newhall, IA 52315
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HIPAA Statement

Eastern Iowa Neuropathy and Pain Clinic will identify and evaluate the likelihood and consequences of threats to the security of Protected Health Information and implement reasonable and appropriate measures to safeguard the confidentiality, availability, and integrity of that information. PCC will adopt and implement HIPAA security practices outlined in the approved HIPAA Security Procedures.

Eastern Iowa Neuropathy and Pain Clinic will safeguard information in a manner consistent with applicable requirements of federal, state and local law and regulations, including the final rule governing the security of health information systems enacted by the Department of Health and Human Services as required by HIPAA.

Used and Disclosures of Your PHI

The following sections describe different ways that we may use and disclose your PHI. For each section of uses or disclosures, there will be a description give. Not every use or disclosure will be listed.

Treatment

We may disclose your PHI to another healthcare provider, transport company, community agency, family member or other third party to provide and / or coordinate health care services and treatments.

Payment

We may use and/ or disclose your PHI to bill and obtain payment for treatment and/ or services you receive at Eastern Iowa Neuropathy and Pain Clinic.

Appointment Reminders

We may contact you to remind you that you have an appointment at our clinic.

Individuals Involved in Your Care or Payment

Unless there is a specific request made to and agreed to by the Privacy Officer at you location, we may disclose PHI to a person who is involved in your health care or helps pay for your care, such as a family member or friend to facilitate that person's involvement in caring for you in payment for your care.

Disaster Relief Efforts

We may disclose your PHI to an entity assisting in a disaster relief effort so your family can be notified about your condition, status and location.

As Required by law

We will disclose health information about you when required to do so by federal or state law.

Public Health Purposes

We may use or disclose your PHI when we are required to do so by law, for public health reasons, including, but not limited to: Reporting certain communicable diseases to health officials, reporting child abuse or neglect, reporting elder abuse, neglect, or exploitation.

Lawsuits and Other Legal Actions

We may disclose PHI in response to judicial proceedings and law enforcement inquiries as permitted by law. We may also disclose PHI in response to a subpoena, discovery request, warrant, summons, or other lawful process.

Worker's Compensation

We may disclose PHI as necessary for workers' compensation or similar programs that provide benefits for work-related injuries or illness, as authorized by law.

Other Used of PHI

Other uses and disclosures of PHI not covered by this notice or that laws, what apply to us will be made only with your written authorization.

Your Rights
Access to your PHI

You have the right to access, inspect, and/ or receive paper and/ or copies of the PHI that we maintain about you, with limited exceptions, Eastern Iowa Neuropathy and Pain Clinic provides to an individual, upon written request, access within 30 calendar days of the day the Clinic receives a request, to inspect and/ or their PHI. If you request paper copies, we will charge you our standard copy fee for each page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a reasonable cost-based fee for providing your PHI in that format. If you prefer, we will prepare a summary or an explanation of your PHI for a fee. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies.

Restrictions to your Records

You have the right to request that we place additional restrictions on our use or disclosure of your PHI for treatment, payment, and healthcare operations purposes. Depending on the circumstances of your request we may or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions, except in emergency treatment scenarios.

Amendments to Your Records

You have the right to request that we amend your PHI. Such requests must be made in writing and must explain why the information should be amended. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing and signed by you or your representative, and must state the reasons for the amendment' correction request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. Please note that even if we accept your request, we may not delete any information already documented in your health records.

Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies.

Changes to this Notice

We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any changes we make to our privacy practices and/ or this Notice may be applicable to PHI created or received by us prior to the date of the change.

Additional Information

Complaints

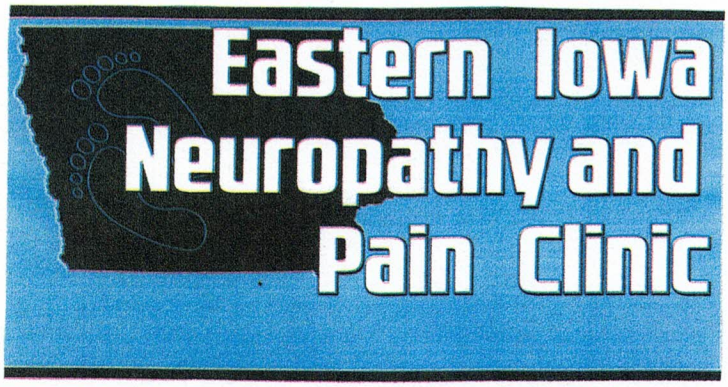
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decisions we may make regarding the use, disclosure, or access to your health information you may make a formal complaint in writing to us. You may also submit a written complaint to the U.S. Department of Health and Human Services in Washington D.C. All complaints must be made in writing and in no way will affect the quality of care you receive at our clinic.

Breach Notification

We are required to notify you in writing of any breach of your secured PHI as soon as possible, but in any event, no later than 60 days after we discover it.

Paper Copy of this Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you received this notice electronically, you are still entitled to a paper copy.



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Authorization and Assignment

In consideration of your undertaking care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any attorney, or adjuster in order to process any claim for reimbursement if charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney, out of any proceeds of any settlement of my case.
3. Charges will not be billed through any insurances, therefore you will be responsible for ALL charges.
4. In addition to the above, I hereby waive the statue of limitations on collection and recovery in the State of Iowa.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization and Assignment will be in continual effect until revoked by both parties.

Patient Consent & Signature

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Heath Care Privacy Notice, Facility terms & conditions, credit policies, & Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

_____ DATE

_____ SIGNATURE OF PATIENT/GUARDIAN