John A. Nassar, M.D., P.C.

HIPAA and Notice of Privacy Practices

Your Rights: The following is a statement of your rights with respect to your protected health information.
You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
You have a right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. **You have the right to request to receive confidential communications from us by alternate means or at an alternative location. You have the right to obtain a paper copy of this notice from us.** Upon request, even if you have agreed to accept this notice alternatively (i.e. electronically), you may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. **Complaints:** you may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaints. We will not retaliate against you for filing a complaint. This notice was published and became effective on or before April 14, 2003. We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only an acknowledgement that you have received this Notice of our Privacy Practices:

Signature ____ Date_______________

Printed Name: ____

John A. Nassar, M.D., P.C.

Patient Name: Age: Today's Date:

How did you find out about Dr. Nassar/who referred you?

Why are you here today?

How long have you had this problem? Which side is involved? ☐ right ☐ left

What is your main problem?

☐ pain ☐ grinding ☐ weakness ☐ increased warmth
☐ deformity ☐ popping ☐ limp ☐ collapsing arch
☐ instability ☐ stiffness ☐ ulcer/sore ☐ numbness/tingling
☐ catching ☐ swelling ☐ redness ☐ open wound

What type of pain are you having?

☐ sharp ☐ aching ☐ throbbing ☐ burning ☐ tearing

How did it start? ☐ gradually ☐ suddenly

What could have caused this? ☐ injury ☐ accident ☐ activity ☐ unknown

Have you had the same or similar problem in the past? ☐ no ☐ yes

How severe is the pain/problem? ☐ mild ☐ moderate ☐ severe

The pain/problem is:

☐ present during activity ☐ present at rest ☐ present at night
☐ worse when starting up after rest

The pain/problem is: ☐ constant ☐ intermittent

The pain/problem is:

☐ not changing ☐ gradually getting worse ☐ rapidly getting worse
☐ gradually getting better ☐ rapidly getting better

What makes your pain/problem worse?

☐ standing ☐ walking ☐ running ☐ jumping ☐ stairs
☐ uneven ground ☐ hard surfaces ☐ dress shoes ☐ any shoes ☐ barefoot

What makes your problem better?

☐ rest ☐ elevation ☐ ice ☐ heat ☐ stretching
☐ removing shoe ☐ rubbing foot ☐ comfortable shoes ☐ avoiding aggravating activities

What types of treatments have you had?	Does this help?		
☐ anti-inflammatory medication	☐ no	☐ a little	☐ a lot
☐ pain medication	☐ no	☐ a little	☐ a lot
☐ compressive wrap	☐ no	☐ a little	☐ a lot
☐ brace	☐ no	☐ a little	☐ a lot
☐ physical therapy	☐ no	☐ a little	☐ a lot
☐ cortisone shot	☐ no	☐ a little	☐ a lot
☐ shoe insert	☐ no	☐ a little	☐ a lot
☐ custom orthotics	☐ no	☐ a little	☐ a lot
☐ cast	☐ no	☐ a little	☐ a lot
☐ cane/crutches/walker	☐ no	☐ a little	☐ a lot

 Reviewed by:______________

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Patient Name:	Today's Date:

Who is your Primary Care Physician?	☐none
Date last seen?	

Height:	Weight:

List all your **MEDICAL** problems: currently being treated?

	currently being treated?	
1.	☐yes	☐no
2.	☐yes	☐no
3.	☐yes	☐no
4.	☐yes	☐no
5.	☐yes	☐no

List all your past **SURGERIES**: Year Complications?

	Year	Complications?	
1.		☐yes	☐no
2.		☐yes	☐no
3.		☐yes	☐no
4.		☐yes	☐no
5.		☐yes	☐no

List all your current **MEDICATIONS**: dose/frequency? how long taking?

	dose/frequency?	how long taking?
1.		
2.		
3.		
4.		
5.		

List all your past **ALLERGIES** to medications: reaction

	reaction
1.	
2.	
3.	

Have you experienced **ANY PROBLEMS** with the following?

General health	☐current	☐previously	Circulation	☐current	☐previously
Eyes	☐current	☐previously	Stroke	☐current	☐previously
Ear, Nose, Throat	☐current	☐previously	Seizures	☐current	☐previously
Heart Attack	☐current	☐previously	Diabetes	☐current	☐previously
Irregular heart beat	☐current	☐previously	Thyroid	☐current	☐previously
High blood pressure	☐current	☐previously	Infection	☐current	☐previously
Lungs	☐current	☐previously	Cancer	☐current	☐previously
Pneumonia	☐current	☐previously	Anemia	☐current	☐previously
Shortness of breath	☐current	☐previously	Blood Clots	☐current	☐previously
Stomach Ulcers	☐current	☐previously	Easy bleeding	☐current	☐previously
Acid Reflux	☐current	☐previously	Hepatitis	☐current	☐previously
Osteoarthritis	☐current	☐previously	HIV	☐current	☐previously
Rheumatoid Arthritis	☐current	☐previously	Drug abuse	☐current	☐previously
Gout	☐current	☐previously	Alcohol abuse	☐current	☐previously
Emotional problems	☐current	☐previously	Liver	☐current	☐previously
Pyschiatric disorders	☐current	☐previously	Kidneys	☐current	☐previously
Artificial bone/joints	☐current	☐previously	Urinary Tract	☐current	☐previously
Bone Infection	☐current	☐previously	Bowels	☐current	☐previously

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Patient Name:	Today's Date:

Surgical Risk Factors:

Have you experienced any of the following? Please Explain any yes answers:

Blood clot in your legs or lungs	☐no	☐yes	
Problems with excessive bleeding	☐no	☐yes	
Latex allergy	☐no	☐yes	
Sleep Apnea	☐no	☐yes	Do you use a CPAP? ☐no ☐yes
Problems with anesthesia	☐no	☐yes	
MRSA Infection	☐no	☐yes	

Women only:

Are you pregnant?	☐no	☐yes
Have you reached menopause?	☐no	☐yes

FamilyHistory:

Family History of: ☐ Anesthesia Problems ☐ Abnormal Blood Clots ☐ Abnormal Bleeding

	Major Medical Problems	Age of Death	Cause of Death
Father			
Mother			
Siblings			
Children			

Social History:

Occupation:					
Work Status:	☐full time	☐part time	☐disabled		
Marital Status:	☐single	☐married	☐divorced	☐separated	☐widowed
Do you have children?	☐no	☐yes	How many?		
Do you live alone?	☐no	☐yes			

Do you exercise? no yes

How often? daily weekly rarely never

What type of exercise?

Do you smoke? ☐no ☐yes

How many packs per day?		For how many years?		
Previously smoked	packs per day, for	years.		
Quit smoking?	☐this year	☐1 year ago	☐5 years ago	☐>10 years ago

Do you drink alcoholic beverages?	☐no	☐yes		
How often?	☐daily	☐weekly	☐monthly	☐rarely
How many drinks?	☐1	☐1-3	☐3-6	☐>6

Do you have a history of any alcohol, substance, or drug abuse?

☐no ☐yes ☐current ☐previous

My signature below indicates that I have provided an accurate and complete medical history:

Signature ______________________________ **Date**______________

Printed Name ______________________________

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