CARE 4 YOUR HEART
CARDIOVASCULAR DISEASE TREATMENT & PREVENTION
KATHLEEN J. DRINAN, DO, FACC

PATIENT INFORMATION FORM

In order to best serve you, please provide us with the following information:

Patient Information (Please Print) Today's Date:

Patient First Name: Middle: Patient Last Name:

Date of Birth:

Street Address:

City, State, Zip:

Home Phone: Daytime/Cell Phone:

Social Security Number: Sex: Male Female

Marital Status: Single Married Divorced Separated Widowed

Race: Caucasian African American Asian Hispanic Native American Pacific Islander Other

Preferred Language: English Other Any Communication Needs?

Email Address:

I do not have email but give permission to send my medical information to the following email address:

_____Relationship:_____

(Your email address is confidential and will not be shared by Kathleen Drinan, DO, FACC)

May we leave test results on your answering machine? Yes No

May we relay information to anyone answering your home phone? Yes No

Local Pharmacy: Name: Street:

*City:*_____

*Mail Order Pharmacy:*_____

How did you hear about Dr. Drinan?

_____

*Primary Care Physician:*_____

*Phone:*_____

*Emergency Contact Name and Phone Number:*_____

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Primary Insurance Information
Insurance Name: ID#
Insured's Employer: Group#

Secondary Insurance Information
Insurance Name: ID#
Insured's Employer: Group#

Additional Insurance Coverage (if applicable)
Insurance Name:
Insured's Employer:

Person Responsible for Payment *(if other than Patient):*
Assignment of Benefits:

I certify that the above information is accurate. I hereby authorize my medical benefits to be paid directly to Kathleen Drinan DO, FACC and allow the release of medical information necessary to process insurance claims.

Patient Signature: ***Date:***

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Medical History

Name: Date
Date of Birth: Sex: Primary Care Physician:
Chief Complaint (Reason for visit):

Have you had any of the following?

Recent hospitalization: When: Hospital:
Recent lab tests: When: Lab:
Cardiac tests: Type: When: Where:
Peripheral vascular ultrasound tests: Type: When: Where:

Risk Factors
High blood pressure: Yes No
Smoke: Yes No
If yes or former smoker: Number of years Packs/day Year Quit
High Cholesterol: Yes No
Diabetes: Yes No
Exercise regularly: Yes No
Family history of early heart disease (60 years or less): Yes No
Weight (20 lb over ideal): Yes No

Past Medical History
Heart attack: Yes No
Angioplasty/stent: Yes No
Congestive heart failure: Yes No
Stroke/mini stroke: Yes No
Lung problems: Yes No
Blood clots in legs or lungs: Yes No
Hypothyroid/Hyperthyroid: Yes No
Stomach problems (ulcer, hiatal hernia, gastric reflux): Yes No
Liver problems: Yes No
Kidney, bladder, prostate problems: Yes No
Rheumatic/Scarlet Fever: Yes No
Carotid artery blockage: Yes No
Eye problems (cataracts, glaucoma, macular degeneration, blind): Yes No
Arthritis: Yes No

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Sleep disorder (sleep apnea): Yes No
Use CPAP or BiPAP machine: Yes No
Psychiatric problems (anxiety, depression): Yes No
Other:
Surgeries (List procedure and year):

Family History of Heart Disease (i.e., heart attack, angioplasty, bypass surgery):
Father : Yes Alive/deceased
Mother: Yes Alive/deceased
Brother(s): Yes Alive/deceased
Sister(s): Yes Alive/deceased
Grandfather/Grandmother (Paternal): Yes Alive/deceased
Grandfather/Grandmother (Maternal): Yes Alive/deceased
Family history of abdominal aortic aneurysm: Yes Who

Social History
Caffeine intake (cups per day of caffeinated coffee, tea, and cola):
Alcohol: Never Rarely Socially Daily
Number of drinks per day/week: Number of years:
Regular exercise: Yes No
If yes: Type of exercise Times per week:
Diet: Balanced Low fat low cholesterol Low salt
Marital status: Married Single Widowed Divorced
Occupation:

Allergies (List Medication and reaction; include food and seasonal allergies
Are you aware of any sensitivity to latex products, i.e., Band-Aids, medical gloves, balloons, etc.?
Medications (List of all prescription, nonprescription medications, and nutritional supplements)

Name of Drug	**Dose**	**Times per Day**

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Review of Systems (Place an "X" by the items that you presently have)

General:	Fatigue		
	Recent weight loss:		
	Recent weight gain		
Eye:	Blurred vision	Double vision	Blind
Ear/Nose/Throat:	Hearing loss		
	Ringing in ears		
	Nosebleeds		
Respiratory:	Shortness of breath		
	Cough		
	Hard to breathe lying flat		
	Cough up blood		
	Snore		
Gastrointestinal:	Blood in stool		
	Black, tarry stools		
	Heartburn		
	Abdominal swelling		
	Abdominal pain		
Kidney/Bladder:	Blood in urine		
	Frequent urination at night		
Musculoskeletal:	Arthritic pain		
	Calf pain with walking		
	Low back pain		
Skin:	Leg swelling		
	Rash		
Neurologic:	Transient blurred vision		
	Weakness on one side		
	Slurred speech		
	Numbness		
	Dizziness		
	Fainting spells		
Hematology:	Bruise easily		
	Bleeding problems		

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Financial Policy

Thank you for entrusting Kathleen Drinan DO, FACC with your cardiovascular needs. We strive to provide excellence in all aspects of patient care. In order to better serve our valued patients, we would like to familiarize you with our financial policy.

PPO Plans

Please verify with your insurance plan that Dr. Kathleen Drinan is contracted with your plan. This will help to ensure your services will be paid by your plan at their highest rate. We are required under our contract with the plan to collect any co-payments, deductibles or co-insurance. Most plans have a co-payment, which you are expected to pay at the time of service. We will bill you for any deductible or co-insurance amount.

HMO/POS Plans

A referral is required before any service is rendered. If you do not obtain a referral, you may either: 1.) Sign an unauthorized waiver stating that you are responsible for payment, or 2.) Reschedule the appointment until you receive the referral from your primary care physician. The HMO Plans will not pay for your services unless you obtain a referral.

We are required under contract with these plans to collect any co-payment, co-insurance and deductible amounts. Co-payment is expected at the time of service. You will be billed for co-insurance and deductible amounts.

Self-Pay

Unless you are a member of one of our contracted plans, Medicare, or Medicaid, please be prepared to pay for services at the time of service. We accept cash, check, Visa, MasterCard, Discovery and American Express.

Missed Appointments

A $50.00 fee will be billed to the patient for a missed appointment if the office is not notified of need to cancel or reschedule.

If you have any questions regarding our policy or your account, please contact our Patient Financial Services office at 630-522-1100.

Our office is open Monday-Friday from 8:30 am to 5:00 pm.

I have read and fully understand the above statements regarding payment policies and agree that I am responsible for any fees incurred on account for services rendered.

Patient/Legal Guardian:_____ **Date:**_____

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HIPPA NOTICE ACKNOWLEDGEMENT
(Provider)

Purpose: This form is used to document an individual's acknowledgement of receipt of our Privacy Practices Notice or our good faith, but unsuccessful effort to obtain that acknowledgement. We are not obliged to attempt to obtain this acknowledgement in an emergency treatment situation.

SECTION A: Individual receiving Privacy Practices Notice

Name:_____

Address:_____

Telephone:_____ **E-mail:**_____

Date of Birth:_____

TO THE INDIVIDUAL: Please complete the following acknowledgement.

I acknowledge that I received the Privacy Practices Notice of Kathleen Drinan, DO, FACC

Signature:_____ **Date:**_____

If this acknowledgement is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name:_____

Relationship to Individual:_____

SECTION B: Good faith effort to obtain acknowledgement (complete only if individual refuses written acknowledgement of receipt of Privacy Practices Notices on this form or otherwise).

Individual refused or was unable to sign an acknowledgement that the individual received our Privacy Practices Notice. Describe your good faith effort to obtain the individual's signed acknowledgement and the reason you were unsuccessful:

_____

Individual received the joint Privacy Practices Notice applicable to our organization from another participant in our organized health care management. We are therefore not required to deliver a Notice or obtain an acknowledgement. Attach a copy of the acknowledgement, or the documentation of the unsuccessful good faith effort to obtain acknowledgement, from the participant who furnished the joint Notice.

Individual received our Privacy Practices Notice in connection to an emergency situation. We are not required to obtain an acknowledgement.

SIGNATURE

I ATTEST THAT THE ABOVE INFORMATION IS CORRECT

Signature:_____Date:_____

Print Name:_____

Title:_____

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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.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintain the privacy of your **protected health information (PHI).** In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law (the Health Insurance Portability and Accountability Act of 1996 or HIPPA) 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 PHI. 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 PHI
- Your privacy rights concerning your PHI
- Our obligation concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI 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 office 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 ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Privacy Officer 16515 S.106th Ct., Orland Park, IL 60467 Phone: (708)226-0506

C. Uses and Disclosures of Health Information

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or health care providers who are involved in taking care of you now or in the future.
We may also use health information about you to call you or send a letter to remind you about an appointment, to follow up with diagnostic test results, or to provide you with information about other treatment and care that could benefit your health.
For payment: We may use and disclose medical information about you so that the treatment and services you receive at the hospital may be billed and payment may be collected from you, an insurance company or a third party.
For healthcare operations: Our practice may use and disclose your PHI 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 PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. Every effort will be made to insure anonymity.

D. Other Disclosures

Business Associates: We will share your PHI and third party associates that perform various activities for the clinic. Whenever any arrangement between our clinic and a business associate involves the use of disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.
Communication with others involved with your care: Our health professionals may, in the event you are incapacitated or in an emergency circumstance, using their judgment, disclose to a family member, or other relative, close personal friend or any other person you identify, health information directly relevant to that person's involvement in your care or payment related to your care.
Research: Under certain circumstances, we may use and disclose health information about you from your medical record for research purposes. All research projects, however, are subject to a special approval process designed to protect the privacy of your health information.
Required by law: Our office may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such disclosures.
Public Health Risks: Our practice may disclose your PHI 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 or withdrawn, needs repairs or replacement.
 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 require or are authorized by law to disclose this information
 Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

Health Oversight Activities: Our practice may disclose your PHI 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.
Legal Proceedings: We may disclose your PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal, in certain conditions in response to a subpoena, discovery request or other lawful purpose.
Law Enforcement: We may release PHI 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 office
 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, identify or location of the perpetrator)

Deceased Patients: Our practice may release PHI 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.
Organ and Tissue Donation: Our practice may release your PHI 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.
Research: our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI 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 written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your PHI is being used only for the research and (iii) the researcher will not remove any of your PHI from our practice; or (c) the PHI sought by the researcher only relates to decedents and the researcher agrees 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 PHI of the decedents.
Serious Threats to Health or Safety: Our practice may use and disclose your PHI 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 or lessen the threat.

Military: Our practice may disclose your PHI if you are a member of the US Armed Forces, a veteran, or a member of foreign military forces for activities deemed necessary by appropriate military command authorities, including the Department of Veterans Affairs for the purpose of your eligibility for or entitlement to certain benefits provided by law.

National Security: Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
Inmates: Our practice may disclose your PHI 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 health, safety and security of the institutions, and its officers and employees and/or (c) to protect your health and safety or the health and safety of other individuals.
Workers' Compensation: Our practice may release your PHI for workers' compensation and similar programs to the extent necessary to comply with applicable laws.
Required uses and Disclosures: Under the law, we must make disclosures to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirement of Section 164.500 et. seq.
We will **not** use information in your records for marketing purposes. Other uses and disclosures from your medical record will be made only with your written authorization or approval.
E. YOUR RIGHTS REGARDING YOUR PHI
You have the following rights regarding the PHI 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, please use the contact information below to make an appointment to complete the form. 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 PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment of 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 PHI, you must make your request in writing using the contact information below. 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 PHI that may be used to make decisions about you, including patient medical records and billing records. However, you may not obtain psychotherapy notes or information compiled in reasonable anticipation of a civil, criminal or administrative action or proceeding. You must submit your request in writing using the contact information below in order to inspect and/or obtain a copy of your PHI. 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 our practice. To request an amendment, your request and reason for the request must be made in writing using the contact information below. You must provide us with a reason that supports your request for an 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: 9a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) was 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 PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor shares 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 using the contact information below. All requests for an accounting of disclosures must state a time period, which may not be longer than six (6) years from the date the accounting of disclosures is requested 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.
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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 by contacting us utilizing the contact information below.
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. You will not be retaliated against for filing a complaint. To file a complaint with our practice, use the contact information below.
8. Right to Provide and 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 PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: We are required to retain records of your care.

Contact Information:

Privacy Officer 16515 S. 106th Ct., Orland Park, IL 60462 Phone: (708)226-0506
Fax: (708)460-6795