Richard N. Hess, MD, FACS, PC
7436 N La Cholla Blvd
Tucson, AZ 85741
520/297-3300
520/888-2698 FAX
info@richardhessmd.com

To Our Patients:

Thank you for downloading our patient registration and health history information. If you have access to a fax machine you may fax the information to us and that will help speed your registration process on the day of your visit. You may want to check with us prior to your appointment to make sure we have received the information if you do not plan on bringing the completed forms to your visit.

Also, please be sure to bring your insurance cards with you to your visit as we will need to scan them into our system.

If you need directions to our office, please check the location page of our website – www.richardhessmd.com.

We look forward to seeing you soon!

PATIENT INFORMATION DATE: ___________

Name (Last, First, Initial: ______________________________ Age: ________

Address: ______________________________

City: ______________ State: ______________ Zip: ______________
E-Mail Address: ______________________________
Home Phone Number: ______________ Work Number: ______________
What number would you like us to use to contact you? ______________________________

Patient Status: ☐ 1-Married ☐ 2-Single ☐ 3-Other
☐ 4-Separated ☐ 5-Divorced ☐ 6-Widowed

Birthdate: ______________ Sex: ________ Social Security #: ______________

Emergency Contact: ______________________ Emergency Phone: ______________

Referred by: ______________________ Primary Care Doctor: ______________________
Address: ______________________ Address: ______________________
Employment Status: ☐ 1-Employed FT ☐ 2-Employed PT ☐ 3-Retired
☐ 4-Not Employed ☐ 5-Student FT ☐ 6-Student PT

Employer's Name: ______________________ Phone #: ______________

Address: ______________________________

GUARANTOR INFORMATION/SECONDARY ADDRESS (Person responsible for payment of charge if not the patient)

Name: ______________________________ Phone #: ______________

Address: ______________________________ SS #: ______________

INSURANCE INFORMATION:

PRIMARY INSURANCE: ______________________________

Address: ______________________________ Phone #: ______________

Policyholder's Name: ______________________ Employer: ______________

Policyholder's Birthdate: ______________________ Policyholder's Sex: ______________

Policy Number: ______________________ Group Number: ______________

SECONDARY INSURANCE: ______________________________

Address: ______________________________ Phone #: ______________

Policyholder's Name: ______________________ Employer: ______________

Policyholder's Birthdate: ______________________ Policyholder's Sex: ______________

Policy Number: ______________________ Group Number: ______________

ASSIGNMENT OF BENEFITS, FINANCIAL RESPONSIBILITY, AND RELEASE OF INFORMATION

I hereby assign my insurance benefits to be paid directly to RICHARD N. HESS, MD, FACS, PC. I am financially responsible for non-covered services. I understand and agree that if I do not pay my account in a timely fashion and collection steps become necessary, I will be responsible for all collection costs including, but not limited to, attorney fees and court costs. I also authorize the Office of RICHARD N. HESS, MD, FACS, PC to release any information required to process this claim.

PATIENT/PARENT/GUARDIAN'S SIGNATURE: ______________________DATE: ___________

Patient Name ***Date of Birth*** ***Today's Date***

Do you have any medication allergies? If so, which medications and what is the reaction? ____

____

Immunization: Date of last tetanus booster:

Family History

__ Skin cancer Type:	__ Bleeding tendencies	__ High blood pressure
__ Cancer Type:	__ Heart disease	__ Other

Past Medical History – Please check any ***past*** illness: or Diagnosis

__ Abnormal lab results Describe:	__ Heart disease __ Hepatitis
__ Anemia	__ High blood pressure
__ Arthritis	__ HIV positive
__ Asthma	__ Kidney disease
__ Bleeding Tendencies	__ Lung disease
__ Blood Clots	__ Mental Illness/Depression
__ Cancer	__ Stroke
__ Diabetes	__ Thrombophlebitis
__ Drug addictions	__ Other

Past Surgical/ History:

Type of surgery	Year
______________________________	__________
______________________________	__________
______________________________	__________
______________________________	__________

Social History:

Do you smoke? Yes No Quantity Have you ever?

Alcohol Consumption: None Occasional Moderate Heavy Quantity:

Current Medications:	***Dosage***	***Purpose***:
__________________	_________	________________
__________________	_________	________________
__________________	_________	________________
__________________	_________	________________

Please list vitamins or supplements:

Please list weight loss medications:

Patient Name: _________________________

Richard N Hess MD FACS PC
Welcome to our practice!!!

Patient Name: Date:
Date of Birth:

To assist us with your care please complete the following health information:

What is your height?____________ What is your weight ?___________

REVIEW OF SYSTEMS – Please check any ***current*** symptoms:

General
__ Fever
__ Recent weight loss __ Lbs

__ Recent weight gain __ Lbs
__ Other

Skin
__ Rash
__ Other

HEENT
__ Wears glasses/ contacts
__ Hearing loss RT LT
__ Other

Respiratory
__Oxygen at home
__ Hx of asthma
__ Chronic lung disease
__ Other

Breast
__ Breast mass
__ Breast pain
__ Breast swelling
__ Other

Cardiovascular
__ Hx of heart attack
__ Hx of heart failure
__ Pacemaker
__ Chest pain current
__ Other

Gastrointestinal
__ Abdominal pain
__ Abdominal mass
__ Other

Musculoskeletal
__ Joint pain/stiffness
__ Muscle pain/stiffness
__ Swelling of extremities
__Other

Neurological
__ Headaches
__ Hx of stroke
__ Hx of tremor
__ Numbness
Location
__ Memory loss

Psychiatric
__ Depression
__ Panic attacks
__ Frequent crying
__ Other

Endocrine
__ Heat intolerance
__ Cold intolerance
__ Other

Hematology
__ Excessive bleeding
__ Abnormal bleeding
__ Blood clots
__ Anemia
__ Easy Bruising

Patient Name: ___________________________

RICHARD N. HESS, MD, FACS, PC

FINANCE POLICIES

The following is an explanation of our financial policies and expectations. Please take a few moments to read these policies as it will describe your responsibilities for the handling of your account. We ask that you pay the patient responsibility portion of your charges at the time service is rendered. Please ask for assistance if you have questions.

Medicare
We accept Medicare assignment. This means we accept what Medicare has determined to be allowable for services rendered. Medicare will pay 80% of the allowed charges and you will be responsible for 20% plus any annual deductible not met. As a courtesy if secondary insurance is provided, we will bill your secondary carrier one time. If we have not received payment after 30 days the account may be converted to patient responsibility.

HMO/PPO Plans (that we are contracted with)
Your co-payment and deductible are due prior to services being rendered. If your plan requires a written referral from your primary care physician, it is your responsibility to obtain a valid referral prior to your scheduled appointment.

Other Insurance Plans Including Health Savings Accounts/Medical Savings Accounts
As a courtesy to you we file insurance claims. We may require a payment of 50% of the estimated charges prior to some procedures and/or services. The remaining payment is due at 45 days if the insurance company has not made payment. When services rendered are expected to be less than $500.00 we may require payment prior to services being rendered.

Third Party /Attorney Requested Visits
We do not accept liens as payment. You are responsible for payment of your account at the time of service.

Workman's Compensation
You are responsible for notifying your employer of your injury and for providing us with the billing information. If your claim is denied for any reason, you are responsible for payment.

Self-Pay/Cosmetic
If you are paying for your account without utilizing a form of insurance, we ask that you pay for your office visits and procedures at the time of service. Fees for cosmetic surgery are to be paid seven days prior to surgery.

I certify that I have read and fully understand the financial policies of Richard N. Hess, MD, FACS, PC. I realize that I am responsible for my charges and that any collection or attorney's fees will be charged to me in the event my account is not paid in full as described in the terms and conditions described above. I also understand there is a $25.00 charge on each returned check.

Patient Signature: ______________________________ Date: ______________

Richard N. Hess, MD, FACS, PC

I acknowledge that I have had the opportunity to review and request a copy for my records this office's Notice of Privacy Practices.

______________________________	____________________
Patient or legally authorized signature	*Date*
______________________________	____________________
Printed name	*Relationship (if not patient)*

CONGRATULATIONS!!! YOU HAVE NOW COMPLETED OUR PAPERWORK.

ATTACHED IS A COPY OF OUR NOTICE OF PRIVACY PRACTICES FOR YOUR REVIEW. PLEASE LET US KNOW IF YOU WOULD LIKE A COPY.

— For your records

Richard N. Hess, MD, FACS, PC

Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY

This office is required by federal regulation, known as the HIPAA Privacy Rule, to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices. This office will not use or disclose your health information except as described in this Notice.

This office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operation. Protected health information is the information we create and obtain in providing our services to you. The health information about you is documented in a medical record and on a computer. Such information may include documenting your symptoms, medical history, examination and test results, diagnoses, treatment and applying for future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for treatment purposes are:

- A medical assistant obtains treatment information about you and records it in a health record.
- During the course of your treatment, Dr. Hess determines he will need to consult with another specialist in the area. He will share the information with such specialist and obtain his/her input.

Example of use of your health information for payment purposes:

- We submit requests for payment to your health insurance company(s). The health insurance company (or other business associate helping us obtain payment) requests health information from us regarding medical care given. We will provide information to them about you and the care given, which may include copies or excerpts of your medical record which are necessary for payment of your account. For example, a bill sent to your health insurance company may include information that identifies your diagnosis and the procedures and supplies used.

Example of use of your health information for health care operations:

- We obtain services from our insurers or other business associates (an individual or entity under contract with us to perform or assist us in a function or activity that necessitates the use or disclosure of health information) such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical transcription, medical review, legal services and insurance. We will share health information about you with our insurers or other business associates as necessary to obtain these services. We require our insurers and other business associates to protect the confidentiality of your health information.

Your Health Information Rights

The health and billing records we maintain are the physical property of Richard N, Hess, MD, FACS, PC. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office – we are not required to grant the request but will comply with any request granted;
- Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
- Request that you be allowed to inspect and receive a copy of your medical record and billing record – you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your medical record be amended to correct incomplete or incorrect information by delivering a written request, including a reason to support it, to our office. (We are not required to make such amendments);

For your Records

- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include uses and disclosures of information for treatment, payment or health care operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; or to family members or friends or uses relevant to that person's involvement in your care or in payment for such care; or uses or disclosures to notify family or others responsible for you care of your location, condition, or your death; we may charge a cost-based fee for more that one accounting in a 12-month period;
- Request that confidential communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact Tina Olsen, Office Manager, Richard N. Hess, MD, FACS, PC, 520/297-3300, 7436 N. La Cholla, Tucson, AZ 85741, in person or in writing, during normal business hours. She will provide you with assistance on the steps to take to exercise your rights.

You have the right to review this Notice before signing the acknowledgement authorizing use and disclosure of your protected health information for treatment, payment and healthcare operations purposes.

Our Responsibilities

This office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practice and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, want to report a problem regarding the handling of your information, or if you believe your privacy rights have been violated and wish to file a written complaint with our office, please contact Tina Olsen, Office Manager, 520/297-3300, 7436 N. La Cholla, Tucson, AZ 85741. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services.

- We cannot, and will not, require you to waive your rights under the Privacy Rule including the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

For your Records

Other Disclosures and Uses We Can Make Without Your Written Authorization

Notification of Family/Friends

- Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family/Friends

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Disaster Relief

- We may use and disclose your health information to assist in disaster relief efforts.

Employers

- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute an authorization for the release of that information to your employer.

Deceased Persons

- We may disclose your health information to funeral directors, medical examiners, or coroners consistent with applicable law to allow them to carry out their duties. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary for them to carry out their duties.

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Appointment Reminders, Marketing and Treatment Alternatives

- We may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you. We may also encourage you to purchase a product or service when we see you. We will not disclose your health information without your written authorization.

Food and Drug Administration

- We may disclose to the FDA your health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers' Compensation

- If you are seeking compensation through Workers' Compensation, we may disclose your health information to the extent necessary to comply with laws relating to Workers' Compensation.

Public Health

- As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person why may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse, Neglect and Domestic Violence

- We may disclose your health information to public authorities as allowed by law to report abuse, neglect, or domestic violence.

Sign in Sheet

- We may use and disclose your health information by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Inmates

- If you are an inmate of a correctional institution or under the custody of a law enforcement officer, we may disclose to the institution or law enforcement official health information necessary for your health and the health and safety of other individuals.

For your Records

Law Enforcement

- We may disclose your health information for law enforcement purposes as required by law, such as when required by a court order; for identification of a victim of a crime if certain protective requirements are met; to report a crime on our premises; to report crime in emergencies; and other appropriate situations by law.

Health Oversight

- We may disclose your health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

- We may disclose your health information in the course of any judicial or administrative proceeding as allowed or required by law or as directed by a proper court order or in response to a subpoena, with your authorization, discovery request or other lawful process if certain specific requirements are met.

Serious Threat

- To avert a serious threat to health or safety, we may disclose your health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions

- We may disclose your health information for specialized government functions as authorized by law such as to armed forces personnel, for national security purposes, or to public assistance program personnel.

Other Uses

- Other uses and disclosures of your health information besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided in this Notice.

Research

- We may disclose your information 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 protected health information.

I acknowledge that I have been presented with a copy of the office's Notice of Privacy Practices

______________________________	______________________________
Patient or legally authorized signature	Date
______________________________	______________________________
Printed name	Relationship if not patient

Effective 4/14/03