CARDIAC SURGERY ASSOCIATES, S.C.

PATIENT'S PERSONAL HISTORY

NAME: _____ **DATE:** _____

Referring Physician: _____

Primary Care Physician: _____ **Cardiologist:** _____

Reason for Today's Consultation/Visit: _____

PRESENT ILLNESS

Location of the problem: Chest Arm Leg Abdomen Back
Other: _____
Rate the pain on a Scale of 0 to 10 (0= None, 5= Moderate, 10= Worst) 1 2 3 4 5 6 7 8 9 10
Describe the problem? Dull to Sharp _____ Very sharp _____ Sharp then leaves _____ Constant_____
Other: _____
When did you notice the problem? Today ____ Days ago ____ Weeks ago ____ Months ago _____
How long does the problem last? 30 minutes _____ 1 Hour _____ Its always there _____
What makes the pain better? Moving around _____ Standing Up _____ Lying _____
Other: _____
What makes the pain worse? Moving around _____ Standing Up _____ Lying _____
Other: _____
Does anything else occur at the same time? YES ____ NO _____
Rash Nausea Headache Fever
Describe: _____
Does the problem interfere with your normal daily activity? YES _____ NO _____
Explain: _____

HEIGHT _____	WEIGHT _____ lbs

PAST MEDICAL HISTORY:

High Blood Pressure	N _____	Y _____
Diabetes	N _____	Y _____
High Cholesterol	N _____	Y _____
Rheumatic fever as child	N _____	Y _____

Other _____
Other _____

PAST SURGICAL HISTORY:

Coronary Bypass	N _____	Y _____	Year _____
Heart Valve Surgery	N _____	Y _____	Year _____
Pacemaker/Defibrillator	N _____	Y _____	Year _____
Stents/Angioplasty	N _____	Y _____	Year _____

Other _____
Other _____

Please List Drug Allergies Below:

Drug Name: _____ Type of reaction: _____
Severity: Very Mild Mild Moderate Severe
Onset: Childhood Adulthood Unknown

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FAMILY HISTORY:

	Age	Sex	Medical Problems	If Deceased... Age at Death	If Deceased... Cause
Father					
Mother					
Brothers/Sisters					

Do you know of any blood relative who has or had: ***(Circle and give relationship)***

Stroke: _____ Cancer: _____ High Blood Pressure: _____

Diabetes: _____ Heart Disease: _____ High Cholesterol: _____

MEDICATIONS (prescription and non-prescription):

We highly recommend that you bring in all your pill bottles (including over the counter drugs) to the visit. Otherwise, please list the medications, strength, and number taken below.

	Medication Name	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Additional medications, please list on the back page.

Vitamins? N _____ Y _____ Please List _____

Herbs (e.g. teas/drinks)? N _____ Y _____ Please List _____

Oral Contraceptives? N _____ Y _____ Please List _____

SOCIAL HISTORY:

Occupation: _____

Where Employed? _____

[ ] Retired [ ] Disabled

Tobacco Use:	Amount _____	How Long? _____	Yr. Discontinued _____
Alcohol Use:	Type _____	Quantity _____	Frequency _____
Illicit Drug Use:	Type _____	Quantity _____	Frequency _____
Coffee Use:	Amount _____	How Long? _____	Frequency _____
Tea Use:	Amount _____	How Long? _____	Frequency _____
Soft Drinks:	Amount _____	How Long? _____	Frequency _____

Exercise Regularly? What kind? _____ How often? _____

Flu Shot? Yes No When Received: (Mo/Yr) _____

REVIEW OF SYSTEMS:

Constitutional

____ Fever
____ Chills
____ Significant Weight Change
____ Sleeping on More Than one Pillow

Cardiovascular/Respiratory

____ Chest Pain
____ High Blood Pressure
[ ] Controlled [ ] Uncontrolled
____ Varicose Veins
____ Swelling in Ankles/Feet
____ Wheezing
____ Cough
____ Shortness of Breath
[ ] With Exertion
[ ] Without Exertion

Skin (Integumentary)

____ Rash
____ Itch

Hematogical/ Endocrine

____ Thyroid Problem
____ Hot Flashes
____ Cold Intolerance
____ Diabetes
____ Blood Clotting Problems
____ Unexplained Bruising

Neurological/Psychological

____ Syncope
____ Dizziness
____ Numbness
____ Arm/Leg Weakness
____ Depression
____ Anxiety

Gastrointestinal

____ Abdominal Pain
____ Diarrhea/Constipation
____ Nausea/Vomiting
____ Heartburn

Musculoskeletal

____ Neck Pain
____ Back Pain
____ Leg/Hip Pain When Walking

Additional Comments/Concerns: _____

Physician Use Only

Physical Exam

General Appearance: (constitutional)	Normal appearance NAD
Eyes:	PERRLA sclera non icteric
ENT:	normal appearance no thyromegaly neck with FROM trachea midline
Hematologic/Lymphatic:	no palpable lymphadenopthy
Cardiovascular:	regular rhythm no murmur, gallops, rubs + palpable peripheral pulses no JVD no HJR no peripheral edema no cyanosis
Respiratory:	normal expansion normal palpation normal percussion normal auscultation
Abdominal/Gastrointestinal:	no tenderness or masses normal bowel sounds no organomegally
Musculoskeletal:	normal strength FROM no clubbing
Skin:	no rashes, lesions or ulcers
Neurologic:	alert and oriented normal gait no focal deficit

Assessment/Plan: _____

_____

_____

Total Time Spent: _____

_____ _____

physician signature date

CARDIAC SURGERY ASSOCIATES, S.C.

Cardiac Surgery Associates
2650 Warrenville Rd., Suite 280
Downers Grove, IL 60515
866-378-7900 630-324-7900

MEDICAL INFORMATION WAIVER

We will automatically send information regarding your medical condition, as well as recommendations for treatment to your referring doctor and medical doctors.

If we need to convey information to you regarding your treatment and medical care and if you are unavailable when we call, may we leave medical information on your answering machine or voicemail?

_____Yes _____No

It is our policy to share medial information with your children and spouse. Do you give permission to notify your children and/or spouse? Indicate below:

_____Yes _____No

Is there another person with whom you would like us to share medical information?

_____Yes _____No

Name: _____
Relationship: _____
Phone number: _____

I have been made aware of the Privacy Policy for this practice and have been offered a copy of such documents.

Print Name: _____
Signature: _____
Date: _____

CARDIAC SURGERY ASSOCIATES, S.C.

NEW PATIENT INFORMATION

Date of Visit_____

PATIENT NAME (PLEASE PRINT)	SS#	MARITAL STATUS SEX
STREET ADDRESS	CITY AND STATE	ZIP
BIRTHDATE AND AGE	HOME PHONE	MOBILE PHONE
EMAIL ADDRESS	WORK PHONE	OTHER NUMBER(S)
ETHNICITY	PREFERRED LANGUAGE	RACE
PATIENTS EMPLOYER	OCCUPATION	DURATION OF EMPLOYMENT
EMPLOYER'S STREET ADDRESS		
DRUG ALLERGIES AND INTERACTION		
SPOUSE OR PARENT NAME	SS#	BIRTHDATE
EMERGENCY CONTACT NAME	EMERGENCY CONTACT ADDRESS	PHONE
REFERRED BY	STREET ADDRESS, CITY, STATE	PHONE
PRIMARY/FAMILY MD	STREET ADDRESS, CITY, STATE	PHONE

PLEASE READ: PLEASE PROVIDE THE NECESSARY INSURANCE FORMS ANDCOPIES OF INSURANCE CARDS & PROOF OF ADDRESS TO HELP EXPEDITE INSURANCE CARRIET PAYMENTS.

PRIMARY INSURANCE	**SECONDARY INSURANCE**
NAME OF INSURANCE	NAME OF INSURANCE
STREET ADDRESS, CITY, STATE, ZIP CODE	STREET ADDRESS, CITY, STATE, ZIP CODE
PHONE NUMBER	PHONE NUMBER
POLICY #	POLICY #
GROUP #	GROUP #
NAME OF POLICY HOLDER AND DOB	NAME OF POLICY HOLDER AND DOB
POLICY HOLDER SS#	POLICY HOLDER SS#

PLEASE PROVIDE CARDS TO BE COPIED

INSURANCE AUTHORIZATION AND ASSIGNMENT/ HIPAA

Initial_____ I authorize the release to Medicare/other insurance company of such information as may be necessary of the completion of my insurance claims. I hereby authorize payment directly to Cardiac Surgery Associates, S.C of the expense benefits otherwise payable to me. If item 9 of the CMS-1500 Claim form is completed, my signature authorizes releasing of the information and payment to the insurer or agency shown. I understand that I am financially responsible for the charges made by them for services rendered. I have read this document in it entirety and I fully understand it.

Initial_____ I acknowledge that I have received a copy of the Cardiac Surgery Associates Notice of Privacy Practices

Signature_____Date_____

Cardiac Surgery Associates, S.C.

We reserve the right to change this notice and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. A copy of the current notice in effect will be available at CSA, S.C.

Effective Date: 10/01/2021

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can access this information. Please review it carefully.

Our Pledge Regarding Your Health Information

We understand that information about you and your health is personal. We are committed to protecting the privacy of this information. Each time we provide services, we create a record of the care and services you receive. We need this record to provide quality care to comply with certain legal requirements. This notice applies to all of the records of your care generated by us, or received by us from you or others

Our primary responsibility is to safeguard your personal health information. We must also make available this notice of our privacy practices, and we must follow the terms of the notice that is currently in effect. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights of access, amendment, control and other rights concerning the use and disclosure of your health information.

PLEASE NOTE: If you are the parent, legal guardian, or personal representative of the patient we are treating, the reference herein such as "your personal health information" Shall be understood to refer to the patient.

COMPLAINTS: If you believe your privacy right have been violated, you may file a complaint with any of our facilities. This complaint can be filed in writing to our privacy officer: John Barakat, Cardiac Surgery Associates, S.C., 2650 Warrenville Rd., Suite 280, Downers Grove, IL 60515. There will be no retaliation for filing a complaint. You can file a complaint with the Secretary of the Department of Health and Human Services.

How We May Use and Disclose Your Health Information

The following categories describe different ways that we may USE your health information within Cardiac Surgery Associates, S.C. and DISCLOSE your health information to persons and entities outside of Cardiac Surgery Associates, S.C. We have not listed every use or disclosure within the categories, but have given some examples for understanding.

Common Uses and Disclosures Allowed by Law

Treatment: We may use your health information to provide you treatment and services. We may disclose health information about you to others who are involved in your care.

Payment: We may use and disclose your health information so the treatment and services you receive at Cardiac Surgery Associates, S.C. may be billed to and payment collected from you, an insurance company of third party. We may also disclose health information to your insurance plan to obtain prior authorization for treatment and procedures.

Healthcare Operations: We may use and disclose your health information for healthcare operations and activities, such as quality assurance, administration, CSA, SC financial and business planning and development; customer service (including investigation of complaints); and certain marketing and fundraising. These uses and disclosures are necessary to operate our healthcare facility and make sure patients receive quality care.

Electronic Medical Records System: Cardiac Surgery Associates, S.C. participates in an Organized Health Care Arrangement ("OHCA") with Edward-Elmhurst Healthcare ("EEH") and other health care providers in Illinois not otherwise affiliated with Cardiac Surgery Associates, S.C. to better manage health care of shared patients and for purposes of risk management activities. To further those goals, Cardiac Surgery Associates, S.C., EEH, and the other OCHA members use a shared electronic health record platform that allows Cardiac Surgery Associates, S.C. and the other OHCA members to store, update, and use your health information. The shared electronic health record platform makes it easier for one of your health care providers to access all of your relevant health information, including records that were created by another of your health care providers and stored on the ahead electronic health record platform. For a list of health care providers that participate in the OHCA and utilize the shared electronic health record platform, please Sara Baig, System Director od Compliance and Privacy – Sara.Baig@EEHealth.org.

Business Associates: Some services may be provided to our organization through contracts with business associates, such as accountants, consultants, quality assurance reviewers, billing and transcription services. We may disclose your health information to your business associates so that they can perform the job we've ask them to do. We require our business associates to sign a contract that states they will appropriately safeguard your information.

Contacting You About Your Health: We may use and disclose health information to contact you, such as a reminder about an appointment or other treatment options at Cardiac Surgery Associates, S.C.

Marketing or Fundraising: We may contact you as part of marketing or fundraising efforts. We may, for instance, tell you about CSA, S.C. Health related products, services or activities that may be of interest.

Research that does not Involve your Treatment: When a research study does not involve any treatment, we may disclose your health information to researches when an institutional review board has established appropriate protocols to ensure that privacy of your health information, and has approved the research.

Individuals Involved in Your Care: We may disclose health information about you to a friend or family member who is involved in your care, unless you tell us in advance not to do so.

Other Laws: At times there may be federal, state or local laws that require us to use or disclose health information in other ways, and we will obey those laws. Additionally, when a state law about protecting your health information give you more protection than the federal laws, we will follow those.

Special Situations Which Do Not Require Your Authorization

The following disclosures of your health information are permitted by law without any oral or written permission from you:
Organ and Tissue Donation: If you are an organ donor, we may release health information to organizations that handle organ procurement or transplantation, as necessary to facilitate the donation.

Military and Veterans: IF you are a member of the armed forces, we may release health information about you are required by military command authorities.

Worker's Compensation: We may release health information about you for worker's compensation or similar programs if you have a work-related injury.

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Averting a Serious Threat to Health or Safety: We may use and disclose your health information when necessary to avert a serious threat to you or others. These disclosures would be made only to someone able to intervene.

Public Health Activities: We may disclose health information about you for public health activities including:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report child abuse or neglect
- To report reactions to medications, problems with products or other adverse events
- To notify people of recalls or products they may be using
- To notify a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition
- To notify the appropriate government authority if we believe a patient has been the victim of abuse (including child abuse), neglect or domestic violence
- To disaster relief agencies (such as the Red Cross) for notification as to your location and condition

Health Oversight Activates: We may disclose health information to a health oversight agency for activities authorized by law. These include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and complaint with the civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may be required to disclose your health information in response to a court order, administrative order, subpoena, discovery request or other lawful process by someone involved in the dispute.

Law Enforcement: We may disclose health information to law enforcement officials for reasons such as:

- In response to a court order, subpoena, warrant, summons or similar process
- To identify or locate a suspect, fugitive, material witness or missing person
- About the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of criminal conduct
- About criminal conduct in our facility
- In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Home Directors: We may disclose health information to a coroner or medical examiner to identify a deceased person or to determine the cause of death. We may also release health information about the patients to funeral home directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may disclose health information about you to authorized federal officials for intelligence, counter intelligence and other national security activities authorized by law.

Legal Requirement: We will disclose health information about you without your permission when required to do so by federal, state and local law.

Other Uses and Disclosures with Your Authorization

Other uses and disclosure of health information not covered by this notice or applicable laws will be made only without your written permission (called "Authorization"). If you give authorization to do so, you may revoke that authorization in writing at any time. Some typical disclosures that require your authorization are as follows:

Research Involving Your Treatment: When a research study involves your treatment, we may disclose your health information to researchers only with your authorization. For any such research study, and Institutional Review Board will often have already have established appropriate protocols to ensure the privacy of your health information and approved the research. You do not have to sign the authorization in order to get treatment from CSA, S.C. but without your authorization you cannot be part of the research study.

Drug and Alcohol Abuse and Mental Health Treatment Disclosure: We will disclose drug and alcohol abuse and mental health treatment information about you only in accordance with state and federal laws. In general, your authorization is required for such disclosures.

Disclosures Requested by CSA, S.C.: We may give you the option of authorizing us to use or disclose your health information for specific purposes such as notifying you of future educational events that might benefit you.

You have the following rights concerning your health information:

1. **Request a restriction on certain uses and disclosures of your information.** We are not required by law to agree to your request.
2. **Obtain a copy of this Notice of Patient Privacy Practices upon request.**
3. **Inspect and/or request a copy of your health record.** We may deny your request under very limited circumstances. If denied, you may request that the denial be reviewed by another health care professional chosen by our health care team. We will abide by the outcome of that review.
4. **Request an amendment to your health record** if you is incorrect or incomplete. We may deny your request if: (1) It is not in writing; (2) It does not include a valid reason; (3) The information was not created by or kept by CSA, S.C.; (4) Is not information which you would be permitted to access; (5) If the information is accurate and complete; or (6) It would require us to delete information from your health record.
5. **Obtain an accounting of disclosures of your health information.** The accounting will not include the allowed common uses and disclosures, or uses and disclosures that you authorized.
6. **Request communication of your health information by alternative means or locations.**
7. **Revoke your authorization** except to the extent that action has already been taken.
8. **File a complaint about any aspect of our health information practices** to use or to the Department of Health and Human Services of United State. You can complain to us and expect an investigation and explanation by calling or writing our Privacy Officer: John Barakat, Cardiac Surgery Associates, S.C. 2650 Warrenville Rd., Suite 280, Downers Grove, IL 60515. You can make a complaint to the Department of Health and Human Services by addressing your written complaint to Secretary Department of Health and Human Services in an email to **OCRComplaint@hhs.gov**, or to: The office of Civil Rights, U.S Department of Health and Human Services, 233 N. Michigan Ave., Suite 240, Chicago, IL 60601. Voice Phone (312) 886-2359. Fax (312) 886-1807. TDD (312) 353-5693.

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