SURGICAL ASSOCIATES OF COLLIN COUNTY

Sheetal M. Patel, M.D.

NAME: _____ DATE: _____

For office use only: HEIGHT _____ WEIGHT _____ BMI _____ HR _____ BP _____ O_2 sats _____

How Did You Hear About Us

How did you hear about us: _____

Have you attended a patient information seminar: Yes No If Yes, When: _____

FEMALE PATIENTS ONLY

Are your periods any of the following: Irregular Painful Heavy Absent

Difficulty conceiving? Y N

Are you post menopausal? Y N

How many pregnancies have you had? _____

How many live births? _____

How many miscarriages? _____

How many abortions? _____

Have you ever had Uterine Fibroids? Y N

Have you ever had Ovarian Cyst? Y N

Do you take birth control pills? Y N

Other contraceptive method? _____

Have you had any obstetric complications?: _____

Sleeping Habits and Emotional Health

Do you snort or gasp awake at night? Y N

Do you snore? Y N

Do you have restless sleep or frequent awakening? Y N

Have you ever been told that you hold your breath while sleeping? Y N

Are you easily distracted? Y N

Are you usually tired? Y N

Do you have trouble sleeping Y N

Do you have daytime sleepiness? Y N

Please use the following ratings to rate your level of dozing when doing the following activities.

0 = Never Dose 1 = Slight chance of dozing

2 = Moderate Chance of dozing 3 = high chance of dozing

Activity	Rating
Sitting & Reading	
Watching TV	
Sitting quietly after lunch	
Sitting & talking to someone	
Sitting inactive in a public place	
Lying down to rest in the afternoon	
In a car, while stopped for a few minutes	
Passenger in a car for an hour without a break	
Total EPWORTH Sleepiness Score	

How would you rate your self esteem? Low Medium High

How would you rate your energy level? Low Medium High

Have you ever been emotionally, physically or sexually abused? Y N

Does weight affect your life? Physically Financially Socially N/A

Have you ever been diagnosed with? Anxiety Bipolar Depression Manic Depressive Schizophrenia

Have you ever been hospitalized for psychiatric reasons? Y N When (mm/yyyy)? _____

Why? _____

Have you ever seen a psychiatrist? Y N Reason? _____

Dr. Name: _____ Dr. Phone: _____

Authorization to Disclose Health Information

I hereby authorize the use or disclosure of information from the medical records of:

Patient Name	Date of Birth	Social Security Number
_____	_____	_____

I authorize the following individual or organization to disclose the above named individual's health information:

_____ PHONE: _____ FAX: _____

This information may be disclosed to and used by the following individual or organization:

Sheetal M. Patel, MD PHONE: 972-596-5225 FAX: 972-596-2684

Please release the following: **Medical Weight History- 2021, 2020, 2019, 2018, and 2017. Please send ONE complete visit note per year that the patient has been seen.**

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency (AIDS), or human immunodeficiency (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Initials required: _____

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.

If I fail to specify and expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-closure and the information may not be protected by federal confidentially rules. If I have questions about discloser of my health information, I can contact Joyce Snell, Privacy Officer for Surgical Specialists of Plano at 972-596-5225.

_____	_____
Signature of Patient or Legal Representative	Date
_____	_____
Relationship to Patient (If Legal Representative Signs Above)	Witness

Complete only if information is to be released directly to patient:

I understand that my medical records may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Surgical Specialist of Plano liable of any misinterpretation of information in my medical record as a result of not consulting my physician for the correct interpretation.

_____	_____
Signature of Patient or Legal Representative	Date
_____	_____
Relationship to Patient (If Legal Representative Sign Above)	Witness

Date request completed_____ # of pages copied_____ Staff Initials_____

SURGICAL ASSOCIATES OF COLLIN COUNTY
Sheetal M. Patel, M.D.

PATIENT PHYSICIAN LIST

PATIENT NAME: _____ **DATE:** _____

Please provide the names and contact information of the doctors and specialists you have visited and have participated in your care over the last five years.

Primary Care Physician
Name: _____ City: _____

Phone: _____ Fax: _____

Cardiology:
Name: _____ City: _____

Phone: _____ Fax: _____

Pulmonary:
Name: _____ City: _____

Phone: _____ Fax: _____

Gastroenterdology:
Name: _____ City: _____

Phone: _____ Fax: _____

Endocrinology:
Name: _____ City: _____

Phone: _____ Fax: _____

Hematology:
Name: _____ City: _____

Phone: _____ Fax: _____

Gynecologist:
Name: _____ City: _____

Phone: _____ Fax: _____

Other:
Name: _____ City: _____

Phone: _____ Fax: _____

_____

Patient Signature Date:

SURGICAL ASSOCIATES OF COLLIN COUNTY

ALAN LONDON, MD SHEETAL PATEL, MD

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.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.
This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time.
You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect a copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.
We are legally obligated to maintain the privacy of your protected health information, to provide you with this Notice of Privacy Practices, and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

I will allow messages to be left on my answering machine or voice mail: Y N

Persons authorized to discuss Medical Information:

Name: _____ Relationship_____ Phone_____

Name: _____ Relationship_____ Phone_____

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.
You may speak with the Office Manager or Privacy Officer to obtain additional information regarding any questions you may have concerning this Notice or to receive a printed copy of the Notice. This Notice of Privacy Practices went into effect April 14, 2003.
E-PRESCRIPTIONS - Do we have your consent to download the medication list from your pharmacy?
Y N
Patient Name (print): _____

Patient Signature: _____ Date: _____

(Or Legal Guardian) For No Expiration Please Initial: _____

SURGICAL ASSOCIATES OF COLLIN COUNTY

Alan A. London, M.D., F.A.C.S. Sheetal M. Patel, M.D., F.A.C.S.
4001 W 15th St, Ste 335
Plano, TX 75093
(972) 596-5225 phone / (972) 596-2684 fax

Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting Surgical Associates of Collin County, PLLC at 972-596-5225.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

Patient/Parent/Guardian Printed Name	Patient/Parent/Guardian Signature
Witness Signature	Date