PATIENT DEMOGRAPHIC INFORMATION

DATE: _____/_____/_____ SSN: _____

NAME: _____ BIRTHDATE: _____/_____/_____

ADDRESS: _____
Street City State Zip

HOME PHONE: _____ CELL: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPERATED

If married, spouse's name: _____

Do you have a Living Will? ☐ Yes ☐ No Do you have a Power of Attorney? ☐ Yes ☐ No

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

HOME#: _____ CELL#: _____

EMPLOYMENT INFORMATION

Employer Name: _____ Phone: _____

Address: _____

If not employed: ☐ Retired ☐ Student ☐ Self Employed ☐ Unemployed ☐ Disabled

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Subscriber: _____	Subscriber: _____
Policy No.: _____	Policy No.: _____
Group No.: _____	Group No.: _____
Insured's DOB: _____/_____/_____	Insured's DOB: _____/_____/_____

PHYSICIAN(S) INFORMATION

Referring Physician: _____ Phone#: _____

Primary Care Physician: _____ Phone#: _____

Pharmacy Name: _____ Phone#: _____

Address: _____
Street City State Zip

SUDARSHAN K. SHARMA, M.D.
GYNECOLOGIC ONCOLOGY
121 N Elm Street
Hinsdale, IL 60521
P: 630-601-7719
F: 630-887-1668

Receipt of Notice of Privacy Practices Form

I, _____, hereby acknowledge receipt of the Physicians Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the Physician has reserved a right to change his privacy practices that are detailed in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signed:_____ Date:_____

If you are not the patient, please specify your relationship to the patient:

_____

CONSENT TO TREATMENT AND FINANCIAL AGREEMENT

We participate in many major insurance companies, however, due to constant changes in their products, we recommend that you review your benefits with your insurance company, checking to make sure we are in your provider network and whether a referral is required for your appointment(s).

Please bring your insurance benefit card(s) with you to our office and present them at the time of your appointment. We must have a current copy on file at all times. If you have a co-pay with your insurance policy, it is due at the time of you visit. We accept cash, checks, debit and all major credit cards (Visa, MasterCard, American Express, Discover).

MEDICARE PATIENTS: We are a participating provider with Medicare and accept assignment for services provided to you. We will submit the 20% balance of Medicare approved charges to your secondary insurance. If you do not have a secondary insurance, you will be responsible for the balance due.

PPO/POS PATIENTS: Non-contracted or out of network services will be billed as a standard insurance. You will be responsible for all balances and non-covered services.

HMO PATIENTS: You are responsible for obtaining an authorized referral from your primary care or referring physician for any/all appointment(s).

SELF PAY PATIENTS: Full payment is due at the time of service.

SURGICAL PATIENTS: It is my practice to work exclusively with Certified surgical assistant, Eleanor Pagulayan, in all surgical procedures enabling me to be prepared for a successful, complication free surgery. Eleanor attended additional training in robotic surgery to enhance her skills and is a crucial team member. You may receive a bill from Eleanor's billing service if your insurance does not cover her charges completely.
Initial_____

PLEASE NOTE: You are responsible for providing our office with current, accurate insurance information and we will do everything possible to assist in filing your claim. Loss of payment due to inaccurate insurance information resulting in untimely filing, will be your responsibility. If needed, you will be asked to assist in insurance processing issues. Any balance remaining due to deductible, co-insurance, out-of-pocket, non-covered services, pre-existing conditions after the insurance processes the claim(s), will be billed to you and we expect full payment within 30 days of receiving a statement. Thereafter, your account will be considered past due. Seriously past due accounts will be referred to a collection agency.

Your signature confirms understanding of our financial policy and agreement. It also authorizes our office to release information necessary to file a claim with your insurance company and assign benefits payable to: Dr. Sudarshan K. Sharma 121 N. Elm Street, Hinsdale, IL 60521.

CONSENT TO TREATMENT: Your signature confirms your voluntary permission to receive medical treatment by Dr. Sudarshan K. Sharma and associated clinicians

_____ _____/_____/_____

Patient Signature Date

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

If you have any questions about this Notice, please contact our HIPPA Officer.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information.
- Give you this Notice of our legal duties and privacy practices regarding health information about you.
- Follow the terms of our Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

Described as follows are the ways we may use and disclose health information that identified you ("Health Information"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

Treatment: We may use and disclose Health Information for your treatment and to provide you with treatment related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside of our office, who are involved in your medical care and need the information to provide you with medical care.

Payment: We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may gibe your health plan information so that they will pay for your treatment.

Health Care Operations: We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services: We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We may also use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

Workers' Compensation: We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose Health Information for public health activities. These activities generally include

Individuals Involved in Your Care or Payment for Your Care: When appropiate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research: Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law: We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert A Serious Threat to Health or Safety: We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates: We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on your behalf. All of our business associates are obligated to protect the privacy or your information and are not allowed to use or disclose any information other than specified in our contract.

Organ and Tissue Donation: If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans: If you are a member of the Armed Forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropiate foreign military authorities if you are a member of a foreign military.

Inmates or Individuals in Custody: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be necessary if: (1) For the institution to provide you with health care; (2) To protect your health and safety or the health and safety of others; or (3) The safety and security of the correctional institution.

disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

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

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release Health Information if asked by a law enforement offical if the information is: (1) In response to a court order, subpoena, warrant, summons or similar process; (2) Limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) About the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) About a death we believe may be the result of criminal conduct; (5) About a criminal conduct on our premises; and (6) In an emergency to report a crime, the location of the crime or victim(s), or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: We may release Health Information to a coroner o medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities: We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy: You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must request, in writing, to the above address.

Right to Amend: If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an accounting of disclosures, you must make your request, in wiriting, to the above address.

Right to Request Restrictions: You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the above address. **We are not required to agree to your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing, to the above address. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at any time at the above address.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have, as well as, any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the HIPPA officer at the above address. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

Consent for Release of Confidential Information Form

I, _____, hereby give my consent to Sudarshan K. Sharma, MD and/or physician's staff to give/leave test results with one/more of the following:

1. _____ Only to myself (patient)
2. _____ With (name and relation): _____
   _____
   _____
3. _____ May leave results and/or a message on the answering machine at the number(s) listed below:
   - Home: _____
   - Cell: _____
   - Work: _____
   - Other: _____

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any given time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

_____ _____/_____/_____
Signature of Patient Date

_____ _____/_____/_____
Signature of Witness Date

Meaningful Use Form

Patient's Full Legal Name: _____

Date of Birth: _____/_____/_____

Patient's Email Address: _____

Primary Telephone Contact Number*: _____
*This is the number you will receive appointment reminder phone calls and medical information

Primary Pharmacy Preference: _____

_____

_____

Mail Order Pharmacy: _____

We are now required to collect Race, Ethnicity and Language by the Federal Government. If you prefer not to report that information, you may choose REFUSED TO REPORT/UNREPORTED.

Why are we collecting race and ethnicity information?

Race or ethnic identity, despite its imprecise categorization, is a useful means of identifying population differences in mechanisms of disease and treatment effects. Therefore, race and other arbitrary demographic and physiological variables have appropriately served as a helpful guide to clinical management and to clinical trial participation.

Race:

- ☐ White
- ☐ Black or African
- ☐ Asian
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ More than one
- ☐ Undefined
- ☐ Refused to Report/Unreported

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Undefined
- ☐ Refused to Report/Unreported

Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ Polish
- ☐ Chinese
- ☐ German
- ☐ French
- ☐ Korean
- ☐ Tagalog
- ☐ Refused to Report/Unreported
- ☐ Other: _____

Patient Initials: _____

Sudarshan K. Sharma, MD
Gynecologic Oncology

PATIENT MEDICAL HISTORY

Please Complete and Return at Office Visit

Name: _____ Date: _____

Referring Physician: _____ Phone#: _____
Family Physician: _____ Phone#: _____

Reason for Visit: _____
_____
_____

History of Present Illness (physician to complete this section): _____
_____
_____
_____

Do you have an Advanced Directive? Yes No

OB Gynecologic History

Number of Children: _____
Number of Miscarriages: _____

Gynecologic History

Date of first menses: _____
Last menstrual period: _____
Describe Periods: _____
Date of last mammogram: _____
Date of last Pap smear: _____
Date of Colonoscopy: _____
Date of last Bone Density Scan: _____

Medications

_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

_____	_____	_____
_____	_____	_____
_____	_____	_____

Sudarshan K. Sharma, MD
Gynecologic Oncology

Past Medical History (Circle the correct response)

Yes No Autoimmune Disease
Yes No Blood Disorders
Yes No Liver Disease
Yes No Gallbladder Disease
Yes No Diabetes Mellitus
Yes No Hypertension
Yes No Gastrointestinal Disease
Yes No Cardiac Problems
Yes No Renal Disorders
Yes No Cancer
Yes No Asthma
Yes No Emphysema
Yes No Prior Heart Attack
Yes No Osteoporosis – Dexa Scan: Yes No If yes, when? _____
Yes No Other: _____

Surgical History

_____
_____
_____
_____

Social History

Yes No Taking Narcotics for Pain
Yes No Alcohol Use
Yes No Smoking
Yes No Drug Use

Family History **Maternal/Paternal**

Yes No Breast Cancer _____/_____
Yes No Ovarian Cancer _____/_____
Yes No Pancreatic Cancer _____/_____
Yes No Colon Cancer _____/_____
Yes No Other: _____ _____/_____

Systemic Symptoms

Yes No Weight Change
Yes No Chills
Yes No Fever
Yes No Night Sweats
Yes No Feeling Tired or Poorly (malaise)
Yes No Other Constitutional Symptoms: _____

Sudarshan K. Sharma, MD
Gynecologic Oncology

Head Symptoms

Yes No Headache

Hematological Symptoms

Yes No Easy Bruising Tendency
Yes No Easy Bleeding

Eye Symptoms

Yes No Eyesight Problems

Otolaryngeal Symptoms

Yes No Earache
Yes No Nosebleeds (Epistaxis)

Neck Symptoms

Yes No Neck Pain
Yes No Lump or Swelling in the Neck
Yes No Other Neck Symptoms: _____

Breast Symptoms

Yes No Breast Pain
Yes No Nipple Discharge
Yes No Breast Lump
Yes No Other Breast Symptoms: _____

Cardiovascular Symptoms

Yes No Chest Pain or Discomfort
Yes No Fast Heart Rate
Yes No Palpitations
Yes No Other Cardiovascular Symptoms: _____

Pulmonary Symptoms

Yes No Shortness of Breath
Yes No Wheezing
Yes No Other Pulmonary Symptoms: _____

Sudarshan K. Sharma, MD
Gynecologic Oncology

Gastrointestinal Symptoms

Yes No Appetite
Yes No Difficulty Swallowing (Dysphagia)
Yes No Heartburn
Yes No Nausea
Yes No Vomiting
Yes No Abdominal Pain
Yes No Diarrhea
Yes No Constipation
Yes No Other Gastrointestinal Symptoms: _____

Genitourinary Symptoms

Yes No Increased Urinary Frequency
Yes No Other Genitourinary Symptoms: _____

Skin Symptoms

Yes No Itching (Pruritus)
Yes No Rashes
Yes No Other Skin Symptoms: _____

Musculoskeletal Symptoms

Yes No Joint Pain, localized
Yes No Muscle Aches
Yes No Other Musculoskeletal Symptoms: _____

Neurological Symptoms

Yes No Dizziness
Yes No Vertigo
Yes No Fainting (Syncope)
Yes No Motor Disturbances
Yes No Sensory Numbness
Yes No Other Neurological Symptoms: _____

Psychological Symptoms

Yes No Sleep Disturbances
Yes No Anxiety
Yes No Depression
Yes No Other Psychological Symptoms: _____

_____ _____ _____
Patient's Signature Date Physician's

Sudarshan K. Sharma, MD
Gynecologic Oncology

MEDICATION CHECKLIST

Patient Name: _____ Pharm. Name: _____

DOB: _____/_____/_____ Pharm. Address: _____

Allergies: _____ _____

Height: _____ Weight: _____lbs. Pharm. Phone: _____

Medication/dosage	Indication	Frequency	Start Date	Stop Date or Ongoing	Prescribing MD or Over the Counter (OTC)

NURSE SIGNATURE/INITIALS: _____