

List ALL Surgeries and Procedures you have had: (You may give us a copy of a list to copy or write on additional paper)

<u>Surgery / Procedure</u>	<u>Date</u>	<u>Doctor</u>	<u>Location Performed</u>

Has any of your Blood Relatives had any of the following?

If yes, please circle the family members associated with each associated condition

<u>Family Member</u>	<u>Alive/Dec</u>	<u>Conditions</u>						
Daughter	A / D	Diabetes	Hypertension	Heart Disease	Stroke	Mental	Cancer	Unknown
Father	A / D	Diabetes	Hypertension	Heart Disease	Stroke	Mental	Cancer	Unknown
Son	A / D	Diabetes	Hypertension	Heart Disease	Stroke	Mental	Cancer	Unknown
Spouse	A / D	Diabetes	Hypertension	Heart Disease	Stroke	Mental	Cancer	Unknown
Mother	A / D	Diabetes	Hypertension	Heart Disease	Stroke	Mental	Cancer	Unknown
Paternal Gdfather	A / D	Diabetes	Hypertension	Heart Disease	Stroke	Mental	Cancer	Unknown
Paternal Gdmother	A / D	Diabetes	Hypertension	Heart Disease	Stroke	Mental	Cancer	Unknown
Maternal Gdfather	A / D	Diabetes	Hypertension	Heart Disease	Stroke	Mental	Cancer	Unknown
Maternal Gdmother	A / D	Diabetes	Hypertension	Heart Disease	Stroke	Mental	Cancer	Unknown
Siblings	A / D	Diabetes	Hypertension	Heart Disease	Stroke	Mental	Cancer	Unknown
Children	A / D	Diabetes	Hypertension	Heart Disease	Stroke	Mental	Cancer	Unknown

Do you smoke tobacco? No/Never Current Former - How long ago did you stop? (date/year) _____

If Current, what year did you start? (month/year) _____

If Current, how many packs do you smoke per day? _____

Do you use illegal drugs? No/Never Current Former

If Current, what kinds and how often? _____

Do you drink alcoholic beverages? No/Never Current Former

If Current, what kinds and how often? _____

Do you drink caffeinated beverages? No/Never Current Former

If Current, what kinds and how often? _____

When was the LAST time you had either of the following:

<u>Immunization</u>	<u>Date</u>	<u>Location Performed (Drs Office / Clinic/Pharmacy)</u>
Pneumonia Immunization		
Flu Immunization		



Patient: _____

Patient Date of Birth: _____

1.03 HIPAA Patient Acknowledgment

I hereby permit Northern Ohio Medical Specialists to release any information acquired throughout the course of my examination and treatment as needed to process any claims on my behalf.

HIPAA Notice of Patient Privacy Practices

I hereby agree, in accordance with HIPAA regulations, that I have been advised of NOMS Healthcare privacy policy. I may request a paper copy of the NOMS Healthcare Notice of Privacy Practices at any time. I permit NOMS to release or obtain any information throughout the course of my examination and treatment as needed to process any claims on my behalf. I permit NOMS Healthcare to send me any information via email or by calling the telephone number (s) I have authorized, regarding my account, treatment, appointments and/or any advertisements or specials offered by the offices. In the event that I cannot be reached directly, I give my consent for NOMS Healthcare to leave a message on my voicemail, answering machine or with any individual who answers any of the telephone numbers I've provided.

I give permission for the following individuals to receive my medical information:

Patient only

_____ (name)	_____ (relationship)	_____ (phone number)	_____ (leave message Yes/No)
_____ (name)	_____ (relationship)	_____ (phone number)	_____ (leave message Yes/No)
_____ (name)	_____ (relationship)	_____ (phone number)	_____ (leave message Yes/No)
_____ (name)	_____ (relationship)	_____ (phone number)	_____ (leave message Yes/No)
_____ (name)	_____ (relationship)	_____ (phone number)	_____ (leave message Yes/No)

PAYMENT AUTHORIZATION

I HEREBY AGREE TO PAY ANY AND ALL CO-PAYS, DEDUCTIBLES, CO-INSURANCE, AMOUNTS OVER UCR, AND/OR EXCLUDED CHARGES FROM INSURANCE COMPANIES WITH WHOM NOMS HEALTHCARE DOES NOT ACCEPT ASSIGNMENT, AND ANY AND ALL CO-PAYS, DEDUCTIBLES AND CO-INSURANCE WITH THOSE THEY DO ACCEPT ASSIGNMENT.

I hereby request my insurance carrier to pay on my behalf insurance benefits to NOMS Healthcare for services rendered. I understand this authorization will be effective until revoked in writing. I understand that if necessary, a credit bureau report may be obtained. I understand in some cases it may be necessary to obtain insurance / employer verification. NOMS Healthcare cannot be held responsible for collecting my insurance claim(s) nor for negotiating a settlement(s) on a disputed claim(s). NOMS Healthcare fees are not established by insurance companies. I am responsible for my account. It is solely my responsibility to know who my insurance is in net-work with.

No Show Policy

I hereby understand that NOMS Healthcare has a posted No-Show Policy and that if I do not cancel an appointment 24 hours prior to the scheduled appointment, I may be subject to the fees associated with said policy.

**Permission to Communicate with Your Primary Care Physician, Other Community
Care Providers and/or Mental Health Providers**

In order to ensure continuity of care, it is often necessary to communicate information to your primary care physician and other community care providers including mental health providers, and to your insurance company. These communications may include information about your medical treatment and mental health or substance abuse treatment. This information is limited to that which is necessary to the determination of coverage and the coordination of your care.

Many insurance companies require us to document whether or not you will allow your clinician to communicate with your primary care physician, Health Insurance Company and/or mental health providers.

Consent for RX Hub Inquiry

I hereby provide my consent for NOMS Healthcare, LLC to obtain my Rx History using the SureScripts-RxHub network or the Ohio Automated Rx Reporting System (OARRS). I understand that this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that SureScripts-Rx Hub has certified that Rx History Capture follows strict security protocols to align with HIPAA requirements and respect patient privacy. All queries and responses are made automatically through secure system-to-system communications.

Imaging Radiation Exposure

Your physician has ordered a procedure, which requires the use of radiation. The radiation exposure enables the radiologist to view the area of interest and then submit a written report to your doctor. By signing below you give consent to have this procedure and any future procedures performed that requires radiation.

Health Information Exchange

We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying Human Resources or the IT Department.

Signed _____ Date _____



Date: _____

Legal Last Name _____ First Name _____ Middle Initial _____ Nickname _____

Social Security # _____ Date of Birth ____ / ____ / ____ Sex: Male Female

Address _____ Apt _____

City _____ State _____ Zip _____

Marital Status: Married Single Legally Separated Divorced Widowed

Race _____ Language _____ Ethnicity _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____

Primary Care Physician _____ Referring Doctor _____

Pharmacy _____ City, State _____

Employer _____ Employer Address _____

City _____ State _____ Zip _____ Phone Number _____

Occupation _____ Status: Full Time Part Time Retired

Are You Homeless? Yes No Do You Have Any Special Communication Needs? Yes No

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Person Responsible for Any Patient Balance (Head of Household): _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Employer _____ Work Phone _____

.....

Spouse's Name _____ Date of Birth ____ / ____ / ____ SS# _____

Are you covered under your Spouse's insurance: Y N Employer _____ Work Phone _____

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In case of an emergency who should we contact?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

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Is this a work related injury? Yes No

MCO: _____ Claim#: _____ Date of injury ____ / ____ / ____ Time of injury _____

1st Report of Injury complete? Yes or No _____ Employer at time of injury _____

Employers Phone _____ Employers Fax _____

Insurance Information:

Primary Insurance _____ Policy Holder Name _____

Check if below policy holder information is same as front Patient ID Number _____

Date of Birth ____/____/____ Sex: M F SS# _____ Relationship to Patient _____

Address _____ City/State/Zip _____ Home Phone _____

Employer _____ Work Phone _____

Address _____ City/State/Zip _____



Secondary Insurance _____ Policy Holder Name _____

Check if below policy holder information is same as front Patient ID Number _____

Date of Birth ____/____/____ Sex: M F SS# _____ Relationship to Patient _____

Address _____ City/State/Zip _____ Home Phone _____

Employer _____ Work Phone _____

Address _____ City/State/Zip _____



If you are covered under you parents insurance, OR a minor, you MUST complete the following:

Mother's Name _____ Date of Birth ____/____/____ SS# _____

Are you covered under your mother's insurance? Y or N Employer _____ Work Phone _____

Check if below is same as above

Address _____ City/State/Zip _____ Home Phone _____

Father's Name _____ Date of Birth ____/____/____ SS# _____

Are you covered under your father's insurance? Y or N Employer _____ Work Phone _____

Check if below is same as above

Address _____ City/State/Zip _____ Home Phone _____

In the event that I (or in the case of a minor, the personal representative of said minor) cannot be reached directly to discuss Patient Health Information, NOMS Healthcare is authorized to leave a message by voice mail, answering machine, with any individual listed above as Emergency Contact(s), or with any individual who answers any of the telephone numbers as listed on Page One (I) of this form.

Patient Signature: _____ Date: _____

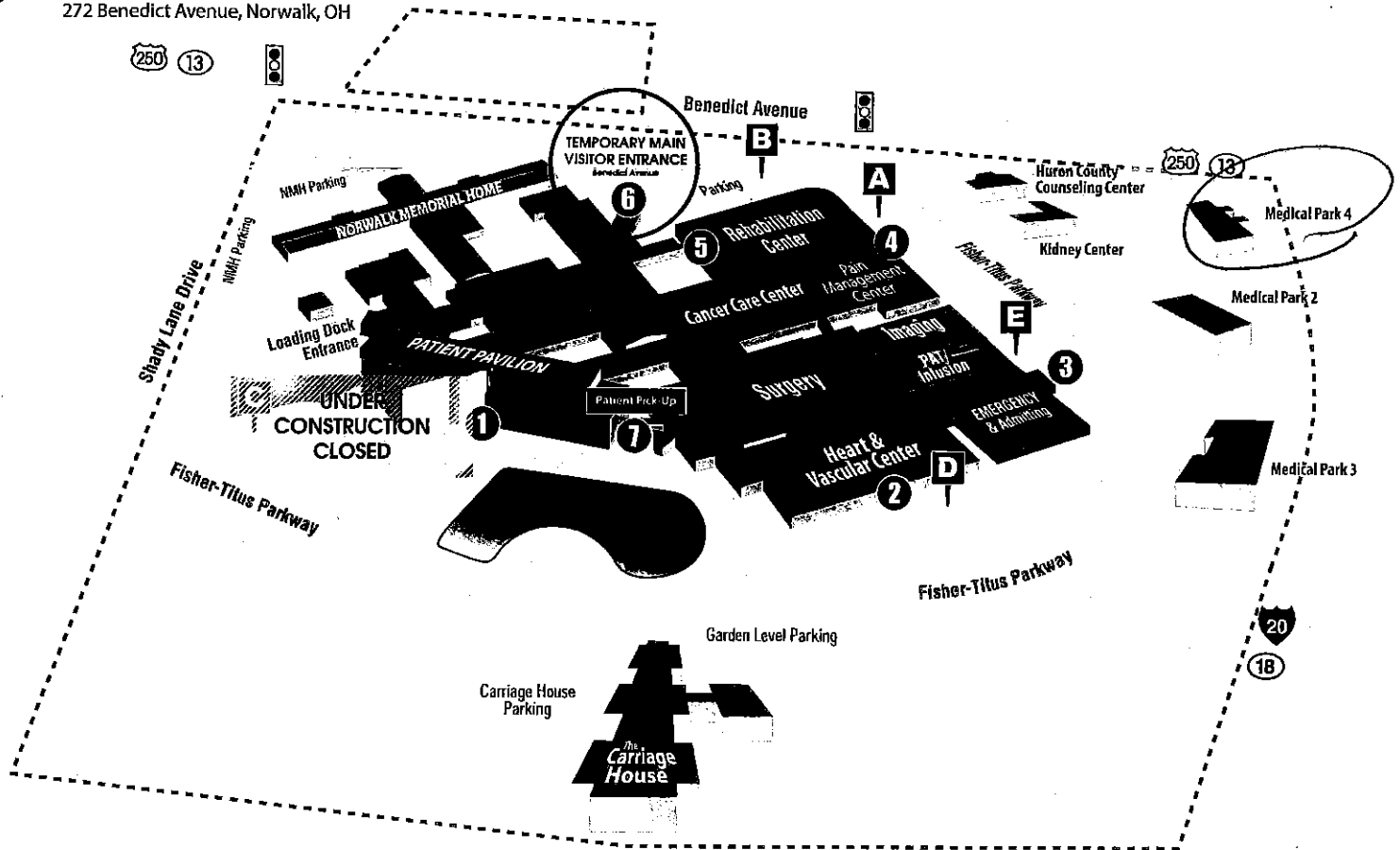
Parent of Guardian Signature: _____ Date: _____

Initials of person completing the form, if other than the patient: _____



FISHER | TITUS MEDICAL CENTER

272 Benedict Avenue, Norwalk, OH



C The Main Visitor Entrance

Temporarily closed while under construction. Please use the Benedict Avenue Entrance.



B Temporary Main Visitor Entrance Benedict Avenue

- Administrative Offices
- Business Office
- Gift Shop
- Health Information Management
- Meeting Rooms
- Health Ministry & Clergy Office
- Jennings Auditorium
- Patient Pavilion/ Patient Rooms
- Shady Lane Cafe
- Sheri's Coffee House
- Transitional Care Unit
- Volunteer Office



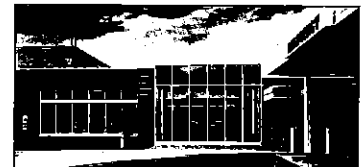
D Snyder/White Heart & Vascular Center Entrance

- Cleveland Clinic Heart & Vascular Physicians
- Cardiac Rehabilitation
- Cardiac Diagnostic Testing
- Cardiac & Vascular Cath Lab
- Pulmonary Medicine & Rehabilitation



A Ralph & Alice Walcher Rehabilitation Center

- Adult and Pediatric Rehabilitation Services
- Audiology Center
- Akron Children's Orthopedic Clinic
- Pain Management Center
- EEG Lab



E Emergency/Admitting Entrance

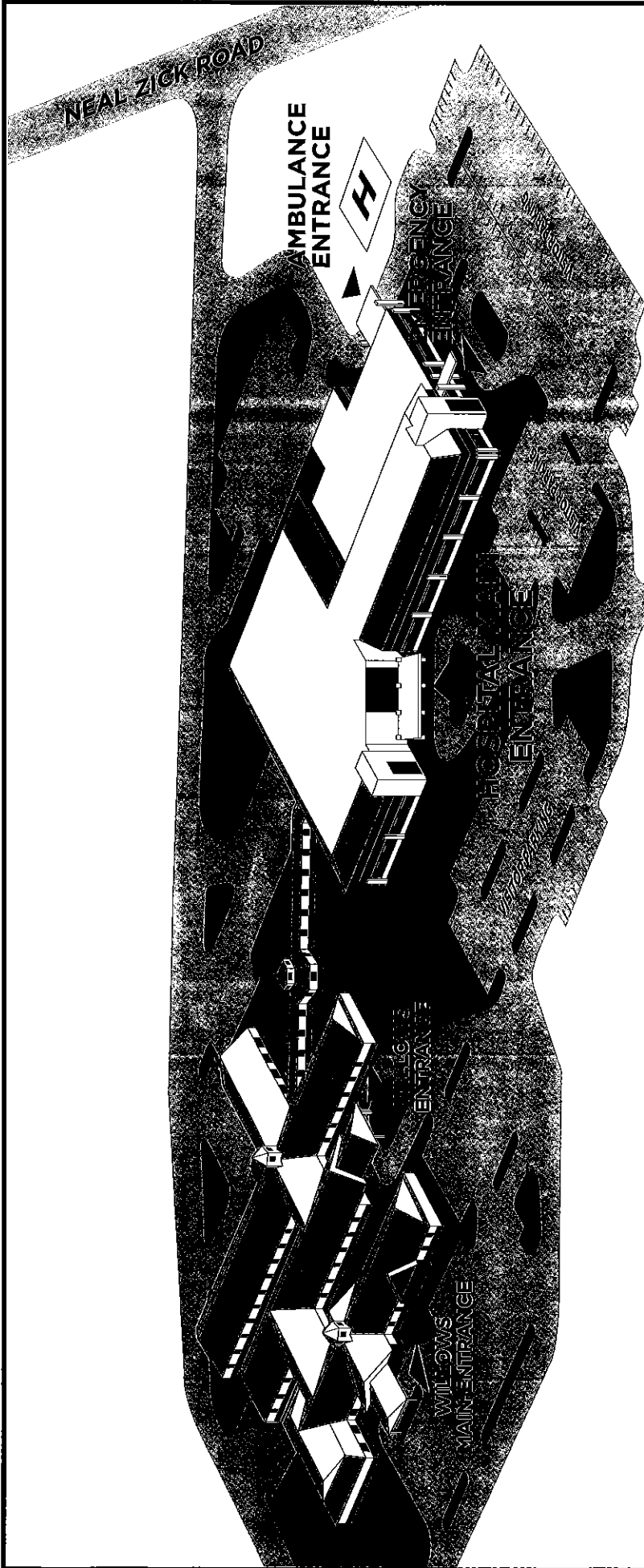
- Diabetes Education
- Endoscopy Patients
- ER Patients
- Imaging Services
- Infusion Services
- OB Patients
- Outpatient Lab
- Pre-Admission Testing (PAT)
- Surgery Patients
- Wound Healing Institute



B Cancer Care Center Entrance

- Cleveland Clinic North Coast Physicians
- Oncology/Hematology
- Patient Treatments

7 Now Open: Patient Pick-Up




MERCYHEALTH
Willard Hospital

