Effective as of April 7, 2009
Bariatric Care Center
St. Joseph Hospital
ST. JOSEPH HEALTH SYSTEM

JEFFREY M. JOHNSRUD, M.D.
1140 West La Veta, Suite 760, Orange, CA 92868
714-541-4442 Tele, 714-835-9550 Fax

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.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the *Notice of Privacy Practices* currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

WHO WILL FOLLOW THIS NOTICE

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates, sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

FOR TREATMENT

We may use medical information about you to provide you with medical treatment of services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence medications we prescribe for the treatment process.

FOR PAYMENT

We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, your insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

FOR HEALTH CARE OPERATIONS

We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

OTHER USES AND DISCLOSURES THAT CAN BE MADE WITHOUT CONSENT OR AUTHORIZATION

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIREING YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are required to retain our records of the care we have provided you.

YOUR INDIVIDUAL RIGHTS REGARDING YOUR MEDICAL INFORMATION

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions : You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment of health care operations or to someone who is involved in your care or the payment of your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit you request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications: You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information complied for use is a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that medical information we have about you 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. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not a part of the information which you would be permitted to inspect or copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have a right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal. Statements of disagreements and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of you record.

Right to an Accounting of Non-Standard Disclosures: You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional list, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time. To obtain a paper copy of the current Notice, please request one and it shall be given to you.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper left corner of the first page.

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NOTICE OF PRIVACY PRACTICE

HIPPA (Health Insurance Portability and Accountability Act) regulations require us to provide to you, the patient or personal representative, a copy of our *Notice of Privacy Practice*. Please sign this form as a acknowledging receipt of this brochure.

In addition, this notice will serve as acknowledgment and authorization for your records to be used in the scope of this office, including but not limited to, use by the St. Joseph Hospital Bariatric Care Center multidisciplinary team and data collection members.

Please list how we may contact you and still provide the privacy and security you require as we protect your health and personal information.

Please check

_____ Please list telephone number(s) at which a message may be left.
Home _____
Work _____
Cell _____

_____ Telephone and message to another person.
Phone _____ Name _____

_____ Mail.

_____ Designated caregiver, legal guardian or relative.
_____ (Please specify)

_____ Yes. I would like to be visited by the Volunteer Ambassadors during my hospital stay.

Print Name _____ Relationship to Patient _____

Signature _____ Date _____

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PATIENT HISTORY

Name _____ DOB _____ Age _____ Height _____ Weight _____

Chief Complaint (please state your problem in your own words)

_____

_____

_____

List Present of Past Medical Problem (s)

(i.e., heart disease, high blood pressure, diabetes, kidney or liver disease, other)

_____

_____

_____

_____

List Previous Hospitalizations (dates and reasons)

_____

_____

List Previous Surgical Procedures

_____

_____

List Medications (please specify dosage, how many times per day, and what form, i.e. capsules, tablets or liquid)

_____

_____

List Drug Allergies

_____

_____

Have you had any problems with General Anesthesia or Previous Operation? ❑ Yes ❑ No

Please explain _____

Have you had Previous Transfusions? ❑ Yes ❑ No If yes, estimate how many _____

Do you smoke? ❑ Yes ❑ No If yes, how many packs per day _____

If none, have you ever smoked _____ If yes, when did you quit? _____

Alcohol _____ ounces per month (i.e. 1 oz =1 can of beer or 8 oz glass of wine or 1 shot of hard liquor)

Have you ever been treated for Drug Abuse or Alcholism? ❑ Yes ❑ No

If yes, how long ago _____

Do you have any problems with bleeding? (i.e., bruise easily, recurrent nosebleeds, heavy menstrual flow, etc.)

❑ Yes ❑ No If yes, please describe _____

Do you take aspirin? ❑ Yes ❑ No

If yes, when is the last time you took aspirin? _____

Do you take Birth Control Pills? ❑ Yes ❑ No Type of Dosage _____

Do you take one/more of the following

	Yes	No
Aspirin		
Motrin		
Ibuprofen		
Dicofenac		
Advil		
Alleve		

Have you ever had the following:

	Yes	No
Rheumatic Fever		
High Blood Pressure		
Shortness of Breath		
Asthma, Emphysema, Previous lung disease		
Diabetes		
Fainting or Blackout Spells		
Dentures, Bridges, Capped Teeth		
Cold or Flu in last two months		
Recent Headache or Blurred Vision		
Back Pain, Spine Trouble, Sciatica		
Kidney Trouble		
Do you wear a Hearing Aid?		

What diseases run in your family? (List disease, which relative, and their current status)

_____

_____

Please indicate if you have had one/more of the listed exams

	Date	Facility	Ordering MD
Ulatrasound/Sonogram			
CAT/CT Scan			
MRI			
HIDA Scan			
Nuclear Medicine			
Other Diagnostic Exam			

Date and place of most recent Chest X-Ray _____

Date of most Electrocardiogram or EKG _____

Date of most recent labs _____ Ordering Physician _____

Signature _____ Date _____

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PATIENT PARTNERSHIP PLAN

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your best possible health requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits With My Doctor For Routine Physical Exams And Other Recommended Screenings:

I understand that my doctor will explain to me, which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc). These health screenings are tests that can help detect life-threatening diseases and conditions. If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule a regular visit with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments:

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him/her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order test, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and do not reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call The Office When I Do Not Hear The Results Of Labs And Other Test:

I understand that my physician's goal is to report my labarotory and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor If I Decide Not To Follow His Or Her Recommended Treatment Plan:

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and test, or even asking me to return to the office within a certain period. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Patient Signature _____ Print Patient's Name _____ Date _____

Jeffrey M. Johnsrud, M.D., F.A.C.S. _____

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PATIENT REGISTRATION FORM

Date: _____

Patient Information

Patient Name _____ Social Security# _____

Address _____ City _____ State _____ Zip _____

Daytime Phone (Hm or Wk) _____ Evening Phone (Hm or Wk) _____

Date of Birth _____ Age _____ Ethnicity _____ Gender ❑ Male ❑ Female

Married _____ Single _____ Divorced _____ Widowed _____

Emergency Contact _____ Phone _____

Family Doctor/PCP _____ Phone _____

Address _____ City _____ State _____ Zip _____

Employment Information

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Date of Birth _____ Social Security # _____

Insurance Information

Insurance Carrier _____ Policy# _____ Group# _____

Claims Mailing Address _____ Phone _____

Name of Primary Insured _____ Social Security# _____

Date of Birth _____ Relationship to Patient _____ Occupation _____

Employer _____ Business Phone _____

Secondary Insurance Carrier _____ Policy # _____ Group# _____

Claims Mailing Address _____ Phone _____

Name of Primary Insured _____ Phone _____

I hereby authorize payment directly to JEFFREY M. JOHNSRUD, M.D., of the medical and/ or surgical benefits otherwise payable to me for the services, but not to exceed the charges as stated. I also understand that I am financially responsible to the physician for all the charges not covered by this authorization.

Signature _____ Date _____

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PATIENT HISTORY QUESTIONNAIRE

PATIENT: Please print in black ink. If more space is needed, attach additional sheet.

Last Name: _____ First Name _____ Date of Birth: _____

Age: _____ Stated Height: _____ Stated Weight: _____ Contact Person: _____

Primary Language: _____ Telephone #: _____ Work #: _____

Primary Care Physician: _____ Cardiologist: _____

ALLERGIES AND ALLERY REACTIONS		LIST PREVIOUS CARDIAC/MEDICAL PROCEDURES			
Name of Medication	Reaction	Procedure	Year	Compli-cations	Anesthesia Type
				Yes/No	
				Yes/No	
				Yes/No	
				Yes/No	
				Yes/No	

MEDICATIONS *Include medication for pain, herbs, diet pills, food supplements			LIST PREVIOUS SURGERIES			
Name of Medication	Dose/How Often	Reason	Procedure	Year	Compli-cations	Anesthesia Type
					Yes/No	
					Yes/No	
					Yes/No	
					Yes/No	
					Yes/No	
					Yes/No	
					Yes/No	

Chief complaint: (please state your problem in your own works): _____

Please circle YES or No for the following questions: _____

Have you used Aspirin or Aspirin-containing medications in the last 14 days? ❑ Yes ❑ No

Do you use Blood Thinners, i.e. Coumadin, Aspirin or Ibuprofen? ❑ Yes ❑ No

Medication Name: _____

Patient Name (PLEASE PRINT) _____

Are you more than 50 lbs. above your desired weight? ❑ Yes ❑ No

Have you used diet pills in the last two (2) weeks: ❑ Yes ❑ No

Medication Name: _____

Have you taken Steroids or Cortisone within the last 3 months? ❑ Yes ❑ No

If yes, medication name: _____

How long? _____

Do you take antibiotics before dental work? ❑ Yes ❑ No

Have you ever smoked? _____

If you quit smoking, when: _____

Do you drink alcohol more than 4 days per week? ❑ Yes ❑ No

How much: _____ Kind: _____

Do you use recreational drugs? ❑ Yes ❑ No

Type: _____

Do you use oxygen to perform daily activities? ❑ Yes ❑ No

Have you, or your immediate family, had unusual reactions, problems or complications associated with anesthesia. ❑ Yes ❑ No

If yes, describe: _____

Do you exercise? ❑ Yes ❑ No

If yes, how often: _____ How long? _____

Type of exercise: _____

Is your level of activity related to health limitations? ❑ Yes ❑ No

If yes explain: _____

Do you wear contact lenses? ❑ Yes ❑ No

Do you have caps, bridges, dentures or loose teeth? ❑ Yes ❑ No

If yes, explain: _____

Does your immediate family have a history of heart disease? ❑ Yes ❑ No

Age of onset: ❑ Father
❑ Mother
❑ Sibling

Medical History: Please check YES or No for the following questions:

Heart attack	❑ Yes ❑ No	Swelling feet/ankles	❑ Yes ❑ No	Dialysis	❑ Yes ❑ No
Coronary Artery Disease	❑ Yes ❑ No	Asthma	❑ Yes ❑ No	Cancer/Malignancy:	❑ Yes ❑ No
Angina, Chest Pain	❑ Yes ❑ No	COPD (lung disease)	❑ Yes ❑ No	Location: _____	
Abnormal ECG	❑ Yes ❑ No	Sleep Apnea	❑ Yes ❑ No	Radiation Therapy	❑ Yes ❑ No

Patient Name (PLEASE PRINT) _____

Irregular heart rhythm	❑ Yes ❑ No	Emphysema	❑ Yes ❑ No	Chemotherapy	❑ Yes ❑ No
Pacemaker:	❑ Yes ❑ No	History of Blood Clots:	❑ Yes ❑ No	Blood Transfusion:	❑ Yes ❑ No
Model: _____		Lung/Leg _____		Date: _____	
Implanted Defibrillator	❑ Yes ❑ No	Bronchitis	❑ Yes ❑ No	Arthritis	❑ Yes ❑ No
Congestive Heart Failure	❑ Yes ❑ No	Pneumonia	❑ Yes ❑ No	Back Pain	❑ Yes ❑ No
Cardiomyopathy	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Bleeding Disorders	❑ Yes ❑ No
Shortness of Breath	❑ Yes ❑ No	Heartburn	❑ Yes ❑ No	Anemia	❑ Yes ❑ No
Fatigue	❑ Yes ❑ No	Hyperthyroidism	❑ Yes ❑ No	Ulcers/GERD	❑ Yes ❑ No
Poor Circulation	❑ Yes ❑ No	Hypothyroidism	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No
High Blood Pressure	❑ Yes ❑ No	Hypoglycemia	❑ Yes ❑ No	Blood in Urine	❑ Yes ❑ No
Rheumatic Fever	❑ Yes ❑ No	High Cholesterol	❑ Yes ❑ No		

Please list any other medical conditions that are not listed above: _____

_____

_____

Please list previous Hospitalizations: (dates and reasons): _____

_____

Family History: Please list past or present medical problem (i.e., heart disease, high blood pressure, diabetes, kidney or liver disease, family history, other) _____

_____

Please check YES or No for the following questions:

Have you had blood drawn in the past 6 month? ❑ Yes ❑ No If yes, location: _____

Have you had an EKG done in the past 12 months? ❑ Yes ❑ No If yes, location: _____

Have you had a Chest X-Ray done in the past 12 months? ❑ Yes ❑ No If yes, location: _____

If Female, is there a possibility of being pregnant? ❑ Yes ❑ No

When did your last menstrual period begin? _____

Have you had a recent medical evaluation by your Internist, Cardiologist of Family Practitioner? ❑ Yes ❑ No

If yes, Doctor's Name: _____ Date: _____

Thank you for providing this important information.

Patient/Parent/Guardian _____

If other then patient, Indicate relationship _____ Date _____