CAPITAL SURGICAL ASSOCIATES

PLEASE FILL OUT EACH SECTION COMPLETELY- THANK YOU

PATIENT'S LEGAL NAME	DATE OF BIRTH	SEX ☐ M ☐ F	AGE	MARITAL STATUS
MAILING ADDRESS	CITY	STATE/ZIP CODE		
PRIMARY PHONE#	CELL PHONE#	WORK PHONE #	PREFERRED CONTACT METHOD	
PATIENT'S EMPLOYER	EMPLOYER ADDRESS	SOCIAL SECURITY #		
RACE	ETHNICITY ☐ HISPANIC ☐ NON-HISPANIC	LANGUAGE		
WHO IS YOUR REFERRING PHYSICIAN?	WHO IS YOUR PRIMARY CARE PROVIDER?	EMAIL		

SPOUSE'S NAME (if married)	SPOUSE'S SSN #	DATE OF BIRTH
SPOUSE'S EMPLOYER	SPOUSE'S PHONE#	
FATHER'S NAME (if minor)	FATHER'S SSN #	DATE OF BIRTH
FATHER'S EMPLOYER	FATHER'S CONTACT PHONE#	
MOTHER'S NAME (if minor)	MOTHER'S SSN #	DATE OF BIRTH
MOTHER'S EMPLOYER	MOTHER'S CONTACT PHONE#	

PLEASE CIRCLE ONE: ☐ INSURANCE ☐ WORKER'S COMP ☐ AUTO ☐ OTHER ☐ SELF-PAY ☐ MEDICARE ☐ MEDICAID

WERE YOU INJURED AT WORK? ☐ YES ☐ NO

WERE YOU INJURED IN AN AUTO ACCIDENT? ☐ YES ☐ NO

DO YOU HAVE A LIVING WILL OR ADVANCED CARE PLAN? YES☐ NO☐

WHO IS YOUR SURROGATE DECISION MAKER? _____

WHICH PHARMACY DO YOU USE?

NAME:_____ LOCATION:_____

INSURANCE COMPANY NAME (PRIMARY)			**INSURANCE COMPANY NAME** (SECONDARY)		
ADDRESS		PHONE#	ADDRESS		PHONE#
ID#		GROUP#	ID#		GROUP#
POLICYHOLDER	BIRTH DATE	RELATIONSHIP	POLICYHOLDER	BIRTH DATE	RELATIONSHIP

EMERGENCY CONTACT INFORMATION

NEAREST FRIEND/RELATIVE NOT LIVING WITH YOU	
RELATIONSHIP	PHONE #

I authorize Capital Surgical Associates to render treatment. I authorize Capital Surgical Associates to release/obtain any medical records/x-rays from any medical care providers and my insurance carrier to facilitate processing of my claims. I authorize my insurance carrier to pay all benefits directly to Capital Surgical Associates. This authorization shall continue to be in force and effect until revoked in writing by me. By signing, I acknowledge that I am ultimately responsible for any and all charges incurred by this office.

SIGNATURE (PATIENT, OR PARENT/GUARDIAN IF UNDER 18)	DATE

CAPITAL SURGICAL ASSOCIATES

DESIGNATION FOR RELEASE OF MEDICAL INFORMATION TO A FAMILY MEMBER, FRIEND OR LEGAL REPRESENTATIVE

Introduction

It is the physician's responsibility to ensure that the physician-patient relationship is confidential. The Health Portability and Accountability Act (HIPAA) will allow physicians to use their professional judgment on disclosing certain personal health information to family, friends, etc. without an authorization. This form is an aid to the physicians in making a determination on disclosing such information. Capital Surgical Associates realizes that there are times when you, the patient, may want another person to be knowledgeable about your medical condition or medical needs. Your doctor wants you to be able, if you so desire, to name a person to whom you want the office staff to speak with about your medical condition. To enable that, we would ask that you complete the form listed below. Please note the following points:

- If you designate no one, Capital Surgical Associates will not release information to any family member, friend or legal representative.
- This Release of Information expires 1 year from the date it is signed.
- This designation is valid until you cancel it in writing.

Designation Statement

I, _____, designate the following person(s) to be able to speak to a physician at Capital Surgical Associates, or other staff member, should it be necessary, on my behalf. I hereby give permission to Capital Surgical Associates through its physicians and staff to release to my designee(s) any information about my medical condition or medical needs or the status of my account and I release Capital Surgical Associates its physicians, and staff, from any claim of confidentiality in connections with the release of this information.

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

Patient's Name:_____ Patient's Signature_____

Date: _____

I decline to designate another person to speak with my physician or clinical staff.

Patient's signature:_____ Date:_____

You have the right to receive a "Good Faith Estimate" explaining how much your health care will cost

Under the law, health care providers need to give **patients who don't have certain types of health care coverage or who are "self-pay"** an estimate of their bill for health care items and services before those items or services are provided.

•You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

•If you schedule a health care item or service at least 3 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate inwriting within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the healthcare provider or facility gives you a Good Faith Estimate in writing within 3business days after you ask.

•If you receive a bill that is at least $400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.

•Make sure to save a copy or picture of your Good Faith Estimate and the bill.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov

If you believe you've been wrongly billed, visit the CMS website for instructions on disputing charges as well as additional information about surprise billing protections.

CAPITAL SURGICAL ASSOCIATES

UROLOGY MEDICAL HISTORY FORM

Name: _____ DOB:_____Date: _____

- **Reason for your visit today/ What are your symptoms? _____**
- **Who referred you? _____**
- **Primary care provider: _____**
- **Preferred Pharmacy:_____**
- **Insurance company name: _____**

MEDICATIONS: Please list ALL prescriptions, over the counter medications, and herbal supplements you are currently taking.

Medication	Dosage	Frequency	Medication	Dosage	Frequency

ALLERGIES: Do you have medication/medical supply allergies? ☐YES ☐NO

If yes, please explain:

MEDICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

Respiratory conditions:
Type: _____
Who manages care for this issue?
_____
Kidney disease:
Type:_____
Who manages care for this issue?
_____
Heart disease and/or previous heart attacks and/or strokes:
Type:_____
Who manages care for this issue?
_____
Cancer:
Type:_____
Who manages care for this issue?
_____

☐Diabetes
☐HIV/AIDS
☐Hepatitis
☐Liver disease
☐Emphysema
☐GERD
☐Hypertension
☐Hernia
☐Anemia
☐Arthritis
☐Asthma
☐Clotting disorder
☐Crohn's disease
☐Depression
☐Varicose Veins
☐High Cholesterol

Other:

CAPITAL SURGICAL ASSOCIATES

Name: _____ **DOB:**_____**Date:** _____

PAST SURGICAL HISTORY:

SURGERY	**YEAR/LOCATION OF SURGERY**

AGES 45 AND UP - DATE OF LAST COLONOSCOPY:_____

FAMILY HISTORY: (Check and provide which relative, indicating if on **maternal** or **paternal** side of family.)

☐	Diabetes	☐	Aneurysms **(where)**
☐	Breast Cancer	☐	Colon Cancer
☐	Colon Polyps	☐	Other Cancer **(type)**
☐	Issues with Anesthetic	☐	Bleeding Problems

Any other major family history of disease? _____

SOCIAL HISTORY:

Age:	Marital Status:	Occupation:
Height:	Weight:	
Do you drink alcohol: Yes ☐ No ☐		If so how much?
Do you use tobacco? Yes ☐ No ☐ Never ☐		If so which product?
If yes, how often?	How much per day?	
Have you ever used recreational drugs? Please Specify.		

Have you had an influenza (flu) shot? ☐YES ☐NO If yes, when?_____
Have you had the COVID-19 vaccine? ☐YES ☐NO If yes, when?_____
Do you have a living will or advanced care plan? ☐YES ☐NO
Who is your surrogate decision maker?_____

CAPITAL SURGICAL
ASSOCIATES

REVIEW OF SYSTEMS : Please check all that are applicable to you

GU			**GENERAL**		
	☐	Blood in Urine		☐	Fever
	☐	Flank pain (side pain)		☐	Weight gain due to appetite increase
	☐	Testicle pain		☐	Weight loss due to appetite decrease
HEMAT/LVMPH				☐	Unintended weight loss
	☐	Swollen Glands	**EYES**		
	☐	Night Sweats		☐	Eye Pain
	☐	Bleeding problems		☐	Vision loss
	☐	Bruise easily	**CARDIO**		
PSYCH				☐	Chest Pain
	☐	Depression		☐	Leg swelling
	☐	Anxiety		☐	Syncope (fainting/black out)
	☐	Other mental health conditions	**MUSCULOSKELETAL**		
				☐	Joint aches
		Explain:		☐	Muscle aches
				☐	Weakness – Where?
			RESPIRATORY		
				☐	Cough
				☐	Coughing up blood
NEURO				☐	Shortness of Breath
	☐	Headaches		☐	Wheezing
	☐	Passing out	**GYN**		
	☐	Seizures		☐	Date of first menstruation
SKIN				☐	Still menstruating
	☐	Moles that have changed in color	**ENDOCRINE**		
	☐	Rash		☐	Hot flashes
	☐	Hives		☐	Trouble sleeping
	☐	Skin color changes	**BREAST REVIEW**		
GI				☐	Any changes-What?
	☐	Difficulty swallowing		☐	Nipple changes
	☐	Abdominal Pain		☐	Nipple discharge
	☐	Rectal Bleeding		☐	Lumps
	☐	Hemorrhoids			
	☐	Nausea			
	☐	Vomiting			

International Prostate Symptom Score (I-PSS)

Patient Name: **Date:**	Not at all	**Less than 1 time in 5**	**Less than half the time**	**About half the time**	**More than half the time**	**Almost always**	**YOUR SCORE**
1.Incomplete Empyting Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	**0** ☐	**1** ☐	**2** ☐	**3** ☐	**4** ☐	**5** ☐	
2. Frequency Over the past month, how often have you had to urinate again less than two hours after you have finished urinating?	**0** ☐	**1** ☐	**2** ☐	**3** ☐	**4** ☐	**5** ☐	
3. Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	**0** ☐	**1** ☐	**2** ☐	**3** ☐	**4** ☐	**5** ☐	
4. Urgency Over the past month, how often have you found it difficult to postpone urination?	**0** ☐	**1** ☐	**2** ☐	**3** ☐	**4** ☐	**5** ☐	
5. Weak Stream Over the last month, how often have you had a weak urinary stream?	**0** ☐	**1** ☐	**2** ☐	**3** ☐	**4** ☐	**5** ☐	
6. Straining Over the past month, how often have you had to push or strain to begin urination?	**0** ☐	**1** ☐	**2** ☐	**3** ☐	**4** ☐	**5** ☐	
	NONE	ONCE	TWICE	3 TIMES	4 TIMES	5 OR MORE	YOUR SCORE

7. Nocturia Over the past month how many times did you most typically get up each night to urinate from the time you went to bed until the time you got up in the morning?	**0** ☐	**1** ☐	**2** ☐	**3** ☐	**4** ☐	**5** ☐	
Total I-PSS Score							
Quality of Life due to Urinary Symptoms	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Unhappy	Unhappy	Terrible

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	**0** ☐	**1** ☐	**2** ☐	**3** ☐	**4** ☐	**5** ☐	**6** ☐

The I-PSS is based on the answers to seven questions concerning urinary symptoms. Each question is assigned points from 0 to 5 indicating increasing severity of the particular symptom. The total score can therefore range from 0 to 35 (asymptomatic to very symptomatic).

Although there are presently no standard recommendations into grading patients with mild, moderate or sever symptoms, patients can be tentatively classified as follows: **0-7 = mildly symptomatic; 8-19 = moderately symptomatic; 20-35 =severely symptomatic**.

The international Consensus Committee (ICC) recommends the use of only a single question to assess the patient's quality of life. The answers to this question range from "delighted" to "terrible" or 0 to 6. Although this single question may or may not capture the global impact of BPH symptoms on quality of life, it may serve as a valuable starting point for doctor-patient conversation.

CAPITAL SURGICAL ASSOCIATES NOTICE OF PRIVACY PRACTICE
(SHORT VERSION)

EFFECTIVE DATE: APRIL 14, 2003

THIS NOTICE DECRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY:

We understand that medical information about you and your health is personal. Capital Surgical Associates is required by law to maintain the privacy of your health information, to follow the terms of this Notice, and to provide you with this notice of our legal duties and privacy practices with respect to your health information. We are required to follow the terms of the Notice that is currently in effect. A paper copy of this notice may be obtained upon request.

How Capital Surgical Associates May Use or Disclose Your Health Information:

Capital Surgical Associates protects the privacy of your health information. We must have your written authorization to use or disclose your health information. However, the law permits Capital Surgical Associates to use or disclose your health information for the following purposes without your authorization:

- **For Treatment**- Information obtained by Capital Surgical Associates will be used for medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.
- **For Payment**- We may use and disclose your health information about you so that treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or third party.
- **For Health Care Operations**- We may use and disclose health information about you, in order to run the office and make sure that you and our other patients received quality care.
- **As Required by Law**- We will disclose health information about you when required to do so by federal, state or local law.
- **To avert a Serious Threat to Health or Safety**- We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- **Public Health Risks**- We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
- **For Health Oversight Activities**- We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities, which are necessary for the government to monitor the health care system, include audits, investigations, inspections and licensure.
- **Lawsuits and Disputes**- If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court order or administrative order. We may also disclose health information about you 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 (which may include written notice to you) or to obtain an order protecting the information requested.
- **For specific Government Functions**- Capital Surgical Associates may disclose health information for the following specific government functions (1) health information of military personnel, as required by military command authorities; (2) health information of inmates, to a correctional institution of law enforcement official; (3) in response to a request from law enforcement, if certain conditions are satisfied; and (4) for national security reasons.

When Capital Surgical Associates May Not Use or Disclose Your Health Information:

Except as described in this Notice, Capital Surgical Associates will not use or disclose your health information without your written authorization. If you do authorize Capital Surgical Associates to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

You Have the Following Rights with Respect to Your Health Information:

- You have the right to request restrictions on certain uses and disclosures of your health information. Capital Surgical Associates is not required to agree to a restriction that you request. If we do agree to any restriction, we will put the agreement in writing and follow it, except in emergency situations. We cannot agree to limit the uses or disclosures of information that are required by law.
- You have the right to inspect and copy your health information as long as Capital Surgical Associates maintains the health information. Your health information usually will include your medical records and billing records. To inspect or to receive a copy of your health information, you must submit a written request to 8854 W Emerald, Ste 140, Boise, Idaho 83704. We may charge a fee for the costs of copying, and mailing, that are necessary to grant your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed. You have a right to choose to obtain a summary instead of a copy of your health information.
- You have the right to request that Capital Surgical Associates amend your health information that is incorrect or incomplete. To request an amendment, you must submit a written request to the privacy officer, Lisa Jack, 8854 W Emerald Ste 140, Boise, Idaho 83704, along with the reason for the request. Capital Surgical Associates is not required to amend health information that is accurate and complete.
- You have the right to receive an accounting of disclosures of your health information we have made April 14, 2003 for purposes other than disclosures.
- (1) for Capital Surgical Associates treatment, payment or health care operations, (2) to you or based upon your authorization and (3) for certain government functions. To request an accounting, you must submit a written request to 8854 W Emerald, Ste 140, Boise, Idaho 83704. You must specify the time period, which may not be longer than six years.
- You may request communications of your health information by alternative means or at alternative locations. For example, you may request that we contact you about your health matters only in writing or at different residence or post office box. To request confidential communication of your health information, you must submit a written request to Orthopaedic Associates. Your request must state how or when you would like to be contacted. We will accommodate all reasonable requests.

Changes to this Notice of Privacy Practices:

Capital Surgical Associates reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we have about you as well as any information we receive in the future. Any revised Notice will be posted in the front office of Orthopaedic Associates. Upon request, we will provide a revised Notice to you.

For More Information or to Report a Problem:

If you have questions or would like additional information about Capital Surgical Associates privacy practices, you may contact the Privacy Officer, Lisa Jack, 8854 W Emerald , Ste 140, Boise, Idaho 83704 or phone 208-321-4790 or FAX 208-321-4836. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer above or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.