

New Hampshire Surgical Specialists
PATIENT HISTORY FORM

Patient name _____ Today's date ___/___/___ Age _____

PCP _____ Referred by _____ HT _____ WT _____

Reason for visit today _____

Pharmacy _____ Pharmacy phone _____

Past Medical History (Check all that apply to you)

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Bleeding tendencies | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Gastric disease | <input type="checkbox"/> HIV | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Breast lump |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Anesthesia problems | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Seizures | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anemia | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> NONE | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Other _____ |

Women's History

Age period began ___ Age first pregnancy ___ Age of menopause ___ # of pregnancies ___ # of children ___
 Last menstrual cycle _____ Last mammogram _____

Past Surgical History (Check all that apply to you)

- | | | |
|--|---|---|
| <input type="checkbox"/> Gallbladder removal | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> C-section | <input type="checkbox"/> Breast surgery |
| <input type="checkbox"/> Hernia repair | <input type="checkbox"/> Colon surgery | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Vasectomy | <input type="checkbox"/> Vascular surgery |
| <input type="checkbox"/> Laparoscopy | <input type="checkbox"/> Tubal ligation | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> NONE | | |

Other Hospitalizations (Please list)

NONE

Medications	Dose	Frequency	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

NONE

Allergies/Sensitivities

NONE KNOWN

- | | | |
|--------------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> Medications | <input type="checkbox"/> Latex | <input type="checkbox"/> Foods |
| Reaction _____ | _____ | _____ |

Occupational

Occupation _____ Heavy lifting Hazardous substances

Health Habits (Check all that apply to you)

- Tobacco use ___ packs/day ___ years of use ___ quit date
- Alcohol intake
- Caffeine intake _____ source _____ amount
- Regular exercise
- Herbal supplements
- NONE OF THE ABOVE

Family History (Check all that apply to your immediate family)

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Breast disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Anesthesia reaction | <input type="checkbox"/> Obesity | <input type="checkbox"/> Gallbladder disease |
| <input type="checkbox"/> NONE OF THE ABOVE | | |

Review of Systems (Circle YES or NO as they apply to you – leave blank if unsure)

- | | | | |
|--|--------|--|--------|
| Fever | NO YES | Uncontrolled urination | NO YES |
| Chills | NO YES | Blood in urine | NO YES |
| Weight loss | NO YES | Jaundice | NO YES |
| Weight gain | NO YES | Difficulty controlling bowel movements | NO YES |
| Decreased energy | NO YES | Pain with urination | NO YES |
| Change in appetite | NO YES | Frequent urination | NO YES |
| Difficulty sleeping | NO YES | Scrotal mass | NO YES |
| Blurry or double vision | NO YES | Back pain | NO YES |
| Eye pain | NO YES | Neck pain | NO YES |
| Ear pain | NO YES | Joint pain | NO YES |
| Ear drainage | NO YES | Joint swelling | NO YES |
| Hearing difficulty | NO YES | Muscle soreness | NO YES |
| Nosebleeds | NO YES | Breast lump | NO YES |
| Sinus problems | NO YES | Nipple discharge | NO YES |
| Hoarseness | NO YES | Breast pain | NO YES |
| Mouth problems | NO YES | Skin changes | NO YES |
| Require antibiotics before dental work | NO YES | Rash | NO YES |
| Chest pain | NO YES | Itching | NO YES |
| Chest pressure | NO YES | Change in moles | NO YES |
| Palpitations | NO YES | Frequent boils | NO YES |
| Swollen legs | NO YES | Headaches | NO YES |
| History of rheumatic fever | NO YES | Memory loss | NO YES |
| History of heart valve problems | NO YES | Dizziness | NO YES |
| Unable to sleep with less than 2 pillows | NO YES | Difficulty speaking | NO YES |
| Shortness of breath | NO YES | Weakness in arm or leg | NO YES |
| Cough | NO YES | Seizures | NO YES |
| Wheezing | NO YES | Tremors | NO YES |
| Heartburn | NO YES | Increased stress | NO YES |
| Nausea | NO YES | Anxiety | NO YES |
| Vomiting | NO YES | Depression | NO YES |
| Difficulty swallowing | NO YES | Suicidal feelings | NO YES |
| Abdominal pain | NO YES | Psychological problems | NO YES |
| Diarrhea | NO YES | Irregular periods | NO YES |
| Constipation | NO YES | Hot flashes | NO YES |
| Change in bowel habits | NO YES | Intolerance to heat/cold | NO YES |
| Blood in stool | NO YES | Bruise easily | NO YES |
| Vaginal discharge | NO YES | Enlarged glands | NO YES |
| Penile discharge | NO YES | Frequent infections | NO YES |
| <input type="checkbox"/> NONE OF THE ABOVE | | | |

Any other information of which the doctor should be aware:

To the best of my knowledge, I have answered the questions on this form accurately. I understand that it is my responsibility to inform the physician of any changes in my medical status.

Signature of Patient, Parent or Guardian

Date

Reviewed by: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU, AS A PATIENT OF THIS PRACTICE, CONNIE J. CAMPBELL, MD, PLLC, MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Please direct any questions and send any notices required under this policy to our Privacy Officer, Connie Campbell, MD, at the address and telephone number below.

**Connie Campbell, MD
Notre Dame Pavilion
87 McGregor St. Suite 2100
Manchester, NH 03102
603.656.0326**

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. Connie J. Campbell, M.D., PLLC (the "Practice") is dedicated to maintaining the privacy of your PHI.

We are required to abide by the terms of this Notice of Privacy Practices. We may revise or amend the terms of our notice, at any time. The new notice will be effective for all PHI that we have at that time and for future information. We will post our current Notice in our office in a visible location at all times and upon your request, we will provide you with any revised Notice.

I. DISCLOSURES

A. Uses And Disclosures To Carry Out Treatment, Payment Or Health Care Operations:

Under HIPAA regulations, we do not need to obtain permission to use health information for treatment, payment and health care operations. However, New Hampshire state laws may require patient consent before health information is used or disclosed by health care providers.

We may use and disclose your PHI for the following reasons:

1. Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice, including, but not limited to, our doctors and nurses, may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

3. Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of the practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may share your PHI with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

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B. Uses And Disclosures To Which You Can Agree Or Object:

We may use and disclose your PHI in the following instances, to which you have the opportunity to object:

1. Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. Emergencies: We may use or disclose your PHI in an emergency treatment situation. If this happens, you will be able to object to future disclosures as soon as reasonably practicable after the delivery of treatment.

C. Uses And Disclosures For Which We Will Obtain Your Written Authorization:

1. Psychotherapy Notes: We may only disclose your psychotherapy notes for limited purposes such as carrying out treatment. For other purposes we will obtain your written consent.

2. Marketing: For most marketing purposes we will obtain your written consent; exceptions include if the product or service is directly treatment related, discussed face-to-face or given as a promotional gift of nominal value.

D. Uses And Disclosures For Which An Authorization Or Opportunity To Agree Or Object Is Not Required:

We may use or disclose your PHI in the following situations:

1. Required By Law: We may use or disclose your PHI to the extent that the law requires such use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

2. Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is required or permitted by law to receive the information. The disclosure will be made for the purpose of controlling or reporting disease, injury or disability. We may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

3. Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

4. Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

5. Food and Drug Administration: We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

6. Maintenance of Vital Records: We may report data such as births and deaths.

7. Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

8. Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

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9. Law Enforcement: We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

10. Coroners, Funeral Directors, and Organ Donation: We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

11. Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI. Otherwise, we will ask for a written authorization from you.

12. Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

13. Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

14. Workers' Compensation: Your PHI may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

15. Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.

II. YOUR RIGHTS

Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

A. You have the right to inspect and copy your PHI. This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you. This may not include psychotherapy notes.

You must submit your request in writing to the Practice's Privacy Officer in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews. Please contact the Practice's Privacy Officer if you have questions about access to your PHI.

B. You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction in writing to the Practice's Privacy Officer.

C. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Practice's Privacy Officer, specifying the requested method of contact, or the location

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where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

D. You may have the right to have your physician amend your PHI. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, for example if we think the information is correct, or was not created by our practice, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact the Practice's Privacy Officer to determine if you have questions about amending your medical record. To file an amendment, your request must be in writing and must be submitted to the Practice's Privacy Officer.

E. You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. Accounting is not required for disclosures we may have made to you, incidental disclosures, disclosures you have authorized, disclosures for a facility directory, disclosures to family members or friends involved in your care, or disclosures made to carry out treatment, payment or health care operations. You have the right to receive specific information regarding disclosures that occurred after April 14, 2003, for up to a six years thereafter. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. In order to obtain an accounting of disclosures, you must submit your request in writing to the Practice's Privacy Officer. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

F. You have a right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices even if you have agreed to receive an electronic copy of the Notice. You may ask us to give you a copy of this notice at any time.

G. You have a right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with our 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 for filing a complaint.

This notice was published and becomes effective on March 31, 2003.

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,

, have received a

copy of the Notice of Privacy Practices of Connie J.

Campbell, M.D., P.L.L.C.

Signature of Patient

Date

**Patient Information Form
New Hampshire Surgical Specialists**

06/29/2008

Patient Information			
SSN:		Home Tel:	
First Name:		Work Tel:	
Last Name:		Sex:	
Middle Initial:		Date of Birth:	
Street:		Referring Physician:	
Unit:		Primary Care Physician:	
City:	State:		
Zip:		Emergency Contact Name & Phone Number:	
Cell Phone:			
Primary Insurance			
Insurance Company:			
Certificate #:		Group #:	
Address:		Subscriber Name:	
		Subscriber SSN#:	
City:	State:	Zip:	Subscriber DOB:
		Home/Work Phone:	
Additional/Secondary Insurance			
Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Insurance Company:			
Certificate #		Group #:	
Address:		Subscriber Name:	
		Subscriber SSN#:	
City:	State:	Zip:	Subscriber DOB:
		Home/Work Phone:	
Assignment and Release			
<p>I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Campbell all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Campbell to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.</p> <p>I also authorize Dr. Campbell to release all patient information to my providers for the purpose of continuity of care.</p>			
_____		_____	_____
Responsible Party Signature		Relationship	Date