Samuel C. Bieligk, M.D.

(All information is confidential) Date:_____

Name:_____ Birthdate: _____/_____/_____ Age:____

MEDICAL HISTORY Check (✓) the medical conditions you have or have had:

☐ AIDS / HIV positive	☐ Diabetes Type? _____	☐ Kidney Stones	☐ Thyroid problems
☐ Anemia	☐ Emphysema	☐ Liver Disease	☐ Tonsillitis
☐ Anorexia / Bulimia	☐ Epilepsy	☐ Migraine headaches	☐ Tuberculosis
☐ Arthritis	☐ Gall Bladder Disease	☐ Multiple Sclerosis	☐ Ulcers Where? _____
☐ Asthma	☐ Goiter	☐ Pacemaker/Defibrillator	☐ Other (please list below)
☐ Bleeding disorders	☐ Gout	☐ Pneumonia	
☐ Blood in Urine	☐ Heart Disease	☐ Prostate problem	
☐ Bronchitis	☐ Hepatitis	☐ Rheumatic Fever	
☐ Cancer	☐ Hernia Site?_____	☐ Scarlet Fever	
☐ Chemical Dependency	☐ Hypertension	☐ Stroke	
☐ Chicken Pox	☐ Kidney Disease	☐ Suicide attempt	

SURGICAL HISTORY

Year	Type of Surgery

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate date: _____

FAMILY HISTORY (Fill in health information about your family.)

	Age	State of Health	Age at Death	Cause of Death			Age	State of Health	Age at Death	Cause of Death
Father						Mother				
Brothers						Sisters				

Check (✓) if your blood relatives had any of the following.

☐ Arthritis, Gout	☐ Dialysis	☐ Kidney Disease	☐ Other _____
☐ Cancer	☐ Heart Disease, Strokes	☐ Kidney Stones	☐ Other _____
☐ Diabetes	☐ High Blood Pressure	☐ Tuberculosis	☐ Other _____

SOCIAL HISTORY

Check (✓) if your work exposes you to the following.	Check (✓) which substances you use and indicate how much you use per day/week.	
Hazardous substances	Caffeine	Drugs
Other	Tobacco	Alcohol

Signature:_____ Date:_____

Reviewed by:_____ Date:_____

MEDICATION SUMMARY

PATIENT _____ DOB _____/_____/_____

PHARMACY _____PHARMACY PHONE # _____

ALLERGIES _____

_____

START DATE	MEDICATION/STRENGTH	DIRECTIONS	PRESCRIBED BY

PATIENT INFORMATION

Please print clearly and complete all blanks

DATE:_____ REFERRED BY:_____ SEX:_____

NAME:_____ BIRTHDATE:_____
LAST FIRST MIDDLE

MAILING ADDRESS:_____
CITY STATE ZIP

TELEPHONE:_____ CELL PHONE:_____ WORK NUMBER:_____

SS #_____ MARITAL STATUS:_____ EMAIL:_____

EMPLOYER:_____ OCCUPATION:_____

EMPLOYER'S ADDRESS:_____

****

RACE (circle one): AMERICAN INDIAN – ALASKAN – ASIAN – BLACK – WHITE – HISPANIC

SMOKER STATUS (circle one): EVERY DAY – SOME DAYS – FORMER – NEVER

RELIGION:_____

****

NEXT OF KIN:_____ BIRTHDATE:_____

ADDRESS IF DIFFERENT:_____
ADDRESS CITY STATE ZIP CODE

RELATIONSHIP:_____ MALE_____ FEMALE_____ TELEPHONE:_____

****

EMERGENCY CONTACT:_____

ADDRESS IF DIFFERENT:_____
ADDRESS CITY STATE ZIP CODE

RELATIONSHIP:_____ MALE_____ FEMALE_____ TELEPHONE:_____

****

RESPONSIBLE PARTY FOR BILLING (if other than patient):

NAME:_____ RELATIONSHIP TO PATIENT:_____

ADDRESS:_____
ADDRESS CITY STATE ZIP CODE

SS #:_____ BIRTHDATE_____ TELEPHONE:_____

****

PRIMARY INSURANCE:_____ ID#:_____ GROUP#_____

NAME OF INSURED:_____ INSURED'S BIRTHDATE:_____

SECONDARY INSURANCE:_____ ID#_____ GROUP#_____

NAME OF INSURED:_____ INSURED'S BIRTHDATE:_____

All professional services rendered are charged to the patient's account. Necessary forms will be completed to expedite insurance claims for those plans which the physician files. The patient is responsible for all fees, regardless of insurance coverage.

I hereby assign to the physician all payments for medical services rendered and authorize the physician to release any medical information necessary to process claims and request payments from insurance companies or Medicaid payers. A photocopy of this assignment and authorization shall be considered as valid as the original.

SIGNATURE:_____ DATE:_____

Tahlequah Medical Group

OWNED & OPERATED BY NORTHEASTERN HEALTH SYSTEM

CONSENT FOR TREATMENT

CONSENT TO TREAT
Tahlequah Medical Group, Northeastern Health System and the physicians in charge of this patient are hereby authorized to administer any medical, diagnostic or therapeutic treatment, as may be deemed necessary or advisable during my care. I also give consent for Tahlequah Medical Group to view my SureScripts history. SureScripts is the electronic prescription service used by Tahlequah Medical Group.

MEDICAL AND BILLING INFORMATION RELEASE
Tahlequah Medical Group and Northeastern Health System is authorized to release all or part of the patient's medical record to any person or corporation which is or may be liable for any part of my charges, including but not limited to, medical or hospital service companies, insurers, compensation carriers or government agencies. It is understood that this authorization or a photocopy of this form is valid.

I understand that my medical records may contain information that I have a communicable or venereal disease, which may include, but is not limited to, Hepatitis, Syphilis, Gonorrhea, or the Human Immunodeficiency Virus, also known as AIDS.

ASSIGNMENT OF INSURANCE BENEFITS
I agree that insurance benefits for Tahlequah Medical Group and Northeastern Health System charges payable to the insured are to be made payable to Tahlequah Medical Group and Northeastern Health System. Any payment received for my care may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits.

STATEMENT OF FINANCIAL RESPONSIBILITY
In consideration of the services to be rendered to the patient, the undersigned assigns all insurance benefits and guarantees the payment of any amount due for such services by Tahlequah Medical Group, Northeastern Health System and certain hospital-based physicians. I understand the full amount of such charges is due at time of service, and filing of the claim forms by the hospital is a courtesy to me.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
A complete description of how your medical information will be used and disclosed by this facility is in our NOTICE OF PRIVACY PRACTICES, which you should read before signing this agreement.

I have received a copy of Tahlequah Medical Group's Notice of Privacy Practices.

☐Accepted ☐Rejected ☐Previously Received

I was given the opportunity to read or have read to me the agreement and my signature gives my consent to these terms.
A photocopy of this document has the same effect as an original.

_____ _____
Signature of Patient or Legal Representative Witness

_____ _____
Date Relationship to Patient

_____
Reason Patient Unable to Sign

Tahlequah Medical Group

1500 E Downing, Suite 103
Tahlequah, OK 74464
Telephone – 918.207.1410
Fax – 918.207.0335

VERBAL DISCLOSURE OF PROTECTED HEALTH INFORMATION TO INDIVIDUALS INVOLVED IN PATIENT CARE

PATIENT NAME_____

DATE OF BIRTH_____

In accordance with the provisions of Section 164.510(b) of the Health Insurance and Accountability Act (HIPPA), I agree that any healthcare provider of the Tahlequah Medical Group and its' duly authorized agents and employees may disclose Protected Health Information directly relevant to relatives, close personal friends and/or any other individuals that I indicate below who may contact any provider listed above on my behalf.

NAME OF INDIVIDUAL(S) AND RELATIONSHIP (Please Print)
Check the box next to the name to identify the type of information to be disclosed.

☐ **Medical** ☐ **Billing** _____

☐ **Medical** ☐ **Billing** _____

☐ **Medical** ☐ **Billing** _____

I understand:

- **At any time, I may add or remove individuals from this list by notifying my provider of my desire to do so. I understand that until I notify my provider of requested changes to this list, my provider may rely on this list and disclose information the individuals listed above.**
- **Information disclosed to the individuals identified above may be subject to re-disclosure by the recipient and no longer protected by federal law.**

I understand that my medical information may indicate that I have a communicable or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency viruses also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____
Signature of Patient **Date**

_____ _____
Signature of Personal Representative **Date**

_____ _____
Description of Representatives Authority of Act for Patient **Date**

Notice of Rights: Information in your medical records that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposure, disclosure pursuant to an order of the court or the Department of Health, disclosure among healthcare providers or for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by and order of the court or the Department of Health or by law.

Missed Appointments Policy
Tahlequah Medical Group
Effective date September 1, 2014

Policy:

No-shows, no notifications, and missed appointments can present scheduling problems for the Providers within the Practice as well as for Patients wishing to be seen by a Provider in a timely manner.

To decrease no shows/no notification/missed appointments, the Tahlequah Medical Group, providing care under the Northeastern Health System, utilizes the following Missed Appointment Policy.

1. If a patient is unable to keep a scheduled appointment they are asked to notify the office at least 24 hours in advance.
2. After the first no-show/no notification/missed appointment, the patient will be rescheduled to another time and date.
3. After the second no-show/no notification/missed appointment, the patient will be rescheduled for a third appointment, but the patient must prepay the co-payment or normal required fees.
4. After the third no-show/no notification/missed appointment, the patient may be discharged from the Providers practice, at the discretion of the Provider.

This Missed Appointment Policy will be made available to each patient for review at the point of registration.

Sign: X _____ Date: _____

Tahlequah Medical Group

1500 E Downing, Suite 103
Tahlequah, OK 74464
Telephone – 918.207.1410
Fax – 918.207.0335

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT AND CONSENT

PATIENT NAME_____

DATE OF BIRTH_____

The Notice of Privacy Practices tells you how we may use and share your health records. ***Please read it.*** We will use and share your health records:

- **To treat you**
- **To bill for the services we provide**
- **To run our business**
- **As required by law**

All the way we may use and share your health records are explained in more detail in the *Notice of Privacy Practices.* You have the right to:

- **Look at and receive a copy of your health records**
- **Receive a list of whom we have given your health records to**
- **Ask us to correct a mistake in you health records**
- **Ask that we not use or share your health records**
- **Ask us to change the way we contact you**

All of these rights are explained I more detail in the *Notice of Privacy Practices.*

I have received a copy of Tahlequah Medical Group *Notice of Privacy Practices.*

Signature of Patient	**Date**
Signature of Personal Representative	**Date**
Description of Representatives Authority of Act for Patient	**Date**

Notice of Rights: Information in your medical records that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposure, disclosure pursuant to an order of the court or the Department of Health, disclosure among healthcare providers or for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by and order of the court or the Department of Health or by law.