Timothy W. Teslow M.D., P.C.
1275 Sadler Way, Suite 102
Fairbanks, AK 99701
(907)457-7874 fax (907)457-7060

WELCOME TO OUR PRACTICE

Patient Name ____________________ ____________________ ____________________
First Middle Last

Male__ Female__ Date of Birth ________________ SSN _______ _______ _______

Am Indian/AK Native__ Asian__ African Am__ Hawaiian__ Hispanic/Latino__ White__

Single __ Married__ Other__ If Minor Parent/Guardian ______________________________

Mailing Address______________________________City______________State_____Zip_______

Home Phone ____________ Cell Phone ______________ Work Phone _______________

Contact Preference Home __ Cell __ Work __

Employer ____

Spouse Name ______________________________________ Phone ____________________

EMERGENCY CONTACT

Name ____ Relationship ____________________

Address ____

City ____________________________State _______ Zip ___________ Phone _____________

INSURANCE INFORMATION

Primary Insurance ____

Subscriber Name____ DOB ____________

Subscriber Address ____ Phone _____________

Secondary Insurance ____

SubscriberName____DOB_____________

Subscriber Address ____Phone _____________

*****SIGNATURE** _______________________________________ **DATE**___________________

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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.

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of TIMOTHY W. TESLOW M.D., P.C. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses and Disclosures Require Your Authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. Our policy allows that we may discuss your health information and financial information with your spouse or family member, unless specifically requested that this information not be released. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment Reminders: Your health information will be used by our staff to call and/or leave a message regarding appointment reminders.

Information About Treatments: Your health information may be used to send you information on the treatment and/or management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Individual Rights: You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Timothy W. Teslow M.D., P.C. Duties:
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Request to Inspect Protected Health Information: As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Receptionist or Privacy Officer.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Timothy W. Teslow M.D., P.C.
Attn: Privacy Officer
1275 Sadler Way, Suite 102
Fairbanks, AK 99701

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person: The name and address of the person you can contact for further information concerning our privacy practices is:

Privacy Officer
Timothy W. Teslow M.D., P.C.
1275 Sadler Way, Suite 102
Fairbanks, AK 99701
907-457-7874

Effective Date: This Notice is effective on or after **February 14, 2003**
Revised: April 23, 2018

Consent for Use and Disclosure of Protected Health Information

This consent acknowledges that you received or have been given the opportunity to receive our Notice of Privacy Practices. By signing below, you consent to the use and disclosure of your protected health information by Timothy W. Teslow, M.D., staff and other business associates for treatment, payment and healthcare operations.
You have the right to review the Notice prior to signing this consent. The terms of this Notice may change. In such a situation you may obtain a revised Notice at any time.

Information Release

☐ I Do Not want my information released to anyone.

☐ I authorize Dr. Teslow and/or staff to release my medical or financial information to (spouse, partner, parent, adult child, other family member or friend):

Name ____________________ Relationship ____________ Phone ____________

Name ____________________ Relationship ____________ Phone ____________

Name ____________________ Relationship ____________ Phone ____________

Patient Name or Legal Guardian (Print) ______________________________

Signature ______________________________________ Date ______________

We have made an attempt to obtain the patient's signature acknowledging receipt of our Notice of Privacy Practices.

Staff Name ______________________________________ Date ______________

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FINANCIAL POLICY

We are committed to providing our patients with the highest quality of care available. We believe that a clear understanding of your financial responsibility for the services provided to you or your family is fundamental to assuring a healthy professional relationship with our staff.

SELF PAY: Payment in full at the time of service is appreciated, but not required. Monthly payments are required to keep your account in good standing. Surgery fees require prior financial arrangements.

INSURANCE: As a COURTESY to you, we will file your insurance for you. It is your responsibility to contact your insurance company regarding their allowable for your office visits and any surgeries you may have. You will receive monthly statements on your account after your insurance has responded. If your insurance carrier does not pay in full, you will be billed the balance. Monthly payments will be accepted on the balance due. Insurance is a contract between you and your insurance carrier. We are not a party of your contract and will not become involved in any disputes between you and your carrier regarding deductibles, co-payments, secondary insurance, or their "usual and customary" charges. We will provide information as requested.

USUAL AND CUSTOMARY: All Insurance companies set their own usual and customary rate. They may use different methods, percentiles or databases to determine this as there is no universal standard or **regulatory** guidelines for determining the calculation. Your insurance will pay a percentage of their allowable (or usual and customary) amount. Any balances above that is the patient responsibility. Payment is expected on balances that are in dispute between you and your insurance company. Upon receipt of payment from your carrier, our office will promptly refund any overpayment on your account.

COLLECTIONS: Past due accounts may be sent to our collection agency. We will attempt to contact you prior to processing for collections.

Thank you for choosing our office to provide your surgical care. If you have any questions regarding our fees or your responsibility for payment, we will be pleased to discuss your concerns.

Patient Signature ____

Patient Questionnaire

Patient Name________________________ Nickname ________________________ Date ______________
Height __________ Weight __________ Age __________

Circle answers below:

Marital Status: Single Married Separated Divorced Widowed
Use of Alcohol: Never Rarely Moderate Daily
Use of Tobacco: Never Previously but quit Current packs per day ______________
Use of Illicit Drugs Never Type/Frequency ______________

Primary Care Physician ______________
Reason for visit today ______________
Have you been treated for this before? ______________
List names and dosages of all medications/vitamins/herbs:

____
____
____
____
____
____
____

List any known drug allergies:

____
____
____

Indicate any of the following surgeries and dates you have had:

Gallbladder______________ Hysterectomy______________
Appendectomy______________ Heart______________
Eye or Cataract______________ Lung ______________
Orthopedic______________ Hernia______________
Ulcers ______________ Breast ______________
Thyroid ______________ Colon/Stomach ______________
Tonsillectomy______________ Other______________

Have you had any of the following conditions?

Cancer__________Yes No Convulsions__________Yes No
Arthritis/Gout__________Yes No Venereal disease__________Yes No
Acute Infection__________Yes No Hypertension__________Yes No
Diabetes__________Yes No Bleeding tendency__________Yes No
Stroke__________Yes No Hereditary defects__________Yes No
Heart trouble__________Yes No Sleep apnea__________Yes No

Family Medical History:

Briefly state your parents' health and the number of siblings and children you have:

Mother __________ Father __________ Siblings __________ Children __________

Please tell us about your family medical history by circling Yes or No. If Yes, who was affected? (e.g. father, mother, brother, sister, grandparent)

Hypertension__________Yes No Who? __________
Diabetes__________Yes No Who? __________
Asthma__________Yes No Who? __________
Emphysema__________Yes No Who? __________
Heart__________Yes No Who? __________
Cancer__________Yes No Who? __________
Thyroid__________Yes No Who? __________

Patient Questionnaire

Name________________________________ DOB________________________________

IN THE LAST **3 MONTHS** HAVE YOU EXPERIENCED THE FOLLOWING? Please answer all questions.

Date

CONSTITUTIONAL

			Date
Good general health lately	Yes	No	
Recent weight change	Yes	No	
Fever	Yes	No	
Fatigue	Yes	No	
Headaches	Yes	No	

EYES

			Date
Eye disease or injury	Yes	No	
Wear glasses or contacts	Yes	No	
Blurred or double vision	Yes	No	
Glaucoma	Yes	No	

ENT

			Date
Hearing loss	Yes	No	
Ringing in ears	Yes	No	
Earaches or drainage	Yes	No	
Sinus problems	Yes	No	
Nose bleeds	Yes	No	
Mouth sores	Yes	No	
Bleeding gums	Yes	No	
Bad breath or bad taste	Yes	No	
Sore throat or voice change	Yes	No	
Swollen glands in neck	Yes	No	

CARDIOVASCULAR

			Date
Heart trouble	Yes	No	
Chest pains	Yes	No	
Sudden heart beat changes	Yes	No	
Swelling of feet, ankles, hands	Yes	No	

RESPIRATORY

			Date
Frequent coughing	Yes	No	
Spitting up blood	Yes	No	
Shortness of breath	Yes	No	
Asthma or wheezing	Yes	No	

GASTROINTESTINAL

			Date
Loss of appetite	Yes	No	
Change in bowel movements	Yes	No	
Nausea or vomiting	Yes	No	
Frequent diarrhea	Yes	No	
Painful bowel movements	Yes	No	
Constipation	Yes	No	
Blood in stool	Yes	No	
Stomach pain	Yes	No	

PSYCHIATRIC

			Date
Memory loss or confusion	Yes	No	
Nervousness	Yes	No	
Depression	Yes	No	
Sleep problems	Yes	No	

Date

MUSCULOSKELETAL

			Date
Joint pain	Yes	No	
Joint stiffness or swelling	Yes	No	
Weakness of muscles or joints	Yes	No	
Muscle pain or cramps	Yes	No	
Back pain	Yes	No	
Cold extremities	Yes	No	
Difficulty walking	Yes	No	

SKIN

			Date
Rash or itching	Yes	No	
Change in skin color	Yes	No	
Change in hair or nails	Yes	No	
Varicose veins	Yes	No	
Breast pain	Yes	No	
Breast lump	Yes	No	
Breast discharge	Yes	No	

NEUROLOGICAL

			Date
Frequent or recurring headaches	Yes	No	
Light headed or dizzy	Yes	No	
Convulsions or seizures	Yes	No	
Numbness or tingling sensations	Yes	No	
Tremors	Yes	No	
Paralysis	Yes	No	
Stroke	Yes	No	

ENDOCRINE

			Date
Glandular or hormone problems	Yes	No	
Thyroid Disease	Yes	No	
Excessive thirst or urination	Yes	No	
Heat or cold intolerance	Yes	No	
Dry skin	Yes	No	

HEMATOLOGICAL/LYMPATHIC

			Date
Slow to heal after cuts	Yes	No	
Bruise or bleed easily	Yes	No	
Anemia	Yes	No	
Phlebitis	Yes	No	
Past transfusions	Yes	No	
Enlarged glands	Yes	No	

GENITOURINARY

			Date
Frequent urination	Yes	No	
Burning or painful urination	Yes	No	
Blood in urine	Yes	No	
Change in force of strain when urinating	Yes	No	
Incontinence or dribbling	Yes	No	
Kidney stones	Yes	No	