



Chart # _____

Date: _____

NEW PATIENT INFORMATION

GENERAL INFORMATION

Name: _____
(Last) (First) (Middle)

Responsible Party: _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip Code)

Birthdate: ___ / ___ / _____ Social Security Number (SSN): ___ - ___ - ___

Age: _____ Sex: (Please Check One) Marital Status: (please check one)
 Male Divorced
 Female Legally Separated
 Married
 Single
 Widowed

Employer: _____ Phone Number: _____

Who Referred you to Healthways? _____

CONTACT INFORMATION

Home Phone: () _____ - _____ would you like a text or email reminder? Y/N

Work Phone: () _____ - _____ Signature: _____

Cell Phone: () _____ - _____

Email Address: _____

INSURANCE INFORMATION

Insurance Company: _____

Policy Number: _____

We may deny your request for an amendment if it is not in writing or does not include a reason for wanting the amendment. We also may deny your request if the information: a) was not created by us, unless the person or entity that created the information is no longer available to amend the information, b) is not part of the information maintained by the Practice, c) is not information that you would be permitted to inspect and copy or d) is accurate and complete.

If your request is granted the Practice will make the appropriate changes and inform you and others, as needed or required. If we deny your request, we will explain the denial in writing to you and explain any further steps you may wish to take.

Right to an Accounting of Disclosures – You have the right to request an accounting of disclosures. This is a list of certain disclosures we have made regarding your PHI. To request an accounting of disclosures, you must write to the Practice’s Privacy Officer. Your request must state a time period for the disclosures. The time period may be for up to six years prior to the date on which you request the list, but may not include disclosures made before April 14, 2003.

There is no charge for the first list we provide to you in any 12-month period. For additional lists, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost in advance. You may withdraw or change your request to avoid or reduce the fee.

Certain types of disclosures are not included in such an accounting. These include disclosures made for treatment, payment or healthcare operations; disclosures made to you or for our facility directory; disclosures made with your authorization; disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in some circumstances.

Right to a Paper Copy of this Notice – You have the right to receive a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically. You may request a paper copy of this Notice at any time.

Right to File a Complaint – You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice’s Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice’s Privacy Officer as follows:

Name: Danita Deichert

Address: 1033 Basin Ave., Bismarck, ND 58504

Telephone No.: 701-223-6613

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient: _____ Date: _____



Jeffrey Smith, M.D.

CONSENT FOR DIAGNOSTIC AND/OR SURGICAL PROCEDURE

1. I hereby authorize Dr. Jeffrey Smith and whomever he may designate as his assistance, to perform upon

(state name of patient or "myself")

the following procedure or operation

(state nature of procedure(s) to be performed)

and if any unforeseen condition arises in the course of the procedure calling upon his judgment for procedures in addition to or different from those now contemplated. I further request and authorize him to do whatever he deems advisable.

2. The nature and purpose of the procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me, I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

3. I have been informed there are other risks that are attendant to the performance of any surgical or diagnostic procedure, I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

4. I consent to the administration of anesthesia and to the use of such anesthetics.

5. I consent to the examination of the tissue by a pathologist if recommended by Dr. Jeffrey Smith.

6. I consent to the taking of any photographs in the course of this procedure for the purpose of advancing the medical education.

7. I certify that I have read and fully understand the above consent to procedure or operation, that any questions that I may have had have been answered to my satisfaction.

Signature of patient: _____ Date: _____

Witness: _____ Date: _____

When patient is a minor or incompetent to give consent:

Signature of authorized person: _____ Date: _____

Witness: _____ Date: _____

1033 Basin Avenue
Bismarck, ND 58504
ph: 701.223.6613
fx: 701.221.9114