Bhadresh Nayak, MD

Board Certified Oncology, Hematology, and Internal Medicine

Patient Health Assessment Questionnaire

Name: _____ **Age:** _____ **Date:** _____

Address: _____

Phone #: _____ **Occupation:** _____ **Sex:** M F

SSN#: _____ **Email:** _____ **DOB:** _____

Marital Status: Single Married Widowed Divorced Preferred Language: _____

Race: American Indian or Alaska Native Black or African American Asian
Native Hawaiian or Pacific Islander Caucasian Do Not Wish To Provide

_____

Please list any Hearing, Vision or Reading issues: _____

Do you have an Advanced Directive? Yes No

Would you like to make or revise your Advanced Directive? Yes No

_____

Emergency Contact Information

Name: _____ **Relationship:** _____

Address: _____

Phone: _____ **Secondary Phone:** _____

If your insurance policy is in your spouse's name please provide their DOB: _____

I herby authorize Dr. Bhadresh Nayak's office to bill my insurance company for services rendered.

Patient Signature: _____ Date: _____

Name: _____ **DOB:** _____

Reason For Today's Visit:

_____

_____

Please bring **all** your prescription medicines and over-the-counter vitamins and supplements to your appointment, OR list all prescriptions and over the counter medication, supplements and vitamins you take, including the dose or strength.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to latex? Yes No

Allergies: _____

Past Medical History

Do you have now or have you ever have any of the following?

Heart Disease	Yes	No	Arthritis	Yes	No
High Blood Pressure	Yes	No	Depression	Yes	No
Glaucoma	Yes	No	Diabetes	Yes	No
Thyroid Disease	Yes	No	Stroke	Yes	No
Asthma	Yes	No	Anemia	Yes	No
Epilepsy	Yes	No	Back Pain	Yes	No
Ulcers	Yes	No	Parkinson's Disease	Yes	No
Colitis	Yes	No	Hearing Loss	Yes	No

HIV/AIDS	Yes	No	Insomnia	Yes	No
Hepatitis	Yes	No	Heart Attack	Yes	No
Kidney Failure	Yes	No	Blood Disorders	Yes	No
Tuberculosis	Yes	No	GERD/Reflux	Yes	No
Frequent UTI	Yes	No	Psychiatric Disorders	Yes	No
Pancreatitis	Yes	No	Cholesterol	Yes	No
Liver Disease	Yes	No	Colon Polyps	Yes	No
Prostate	Yes	No	Migraines	Yes	No
Neuropathy	Yes	No	Blood Clots	Yes	No
Cataracts	Yes	No	COPD	Yes	No
Anxiety	Yes	No	Bleeding Disorders	Yes	No
Drug Abuse	Yes	No	Seizure Disorders	Yes	No

Other: _____

Family/Social History

Do you have a family history of:		Relationship
Heart Disease	Yes	No _____
High Blood Pressure	Yes	No _____
Diabetes	Yes	No_____
Stroke	Yes	No _____
Cancer	Yes	No_____
Thyroid Disease	Yes	No_____
Depression	Yes	No_____
Dementia	Yes	No_____

Other _____

Your Personal Habits	Do You?	
Exercise regularly?	Yes	No
Smoke or use tobacco?	Yes	No
How much _____		
How many years _____		
Past tobacco use?	Yes	No
Drink Alcohol	Yes	No
How Much? _____		
Would you like to cut down? _____		

Past Surgical History

_____

_____

_____

Cancer History

Type: _____ **Date Diagnosed:** _____

Treatment: _____

Treating Physician: _____

Health Maintenance

Colonoscopy Date: _____ **Findings:** _____

Mammogram Date: _____ **Findings:** _____

Other: _____

_____

Pharmacy Information

Pharmacy Name: _____

Phone Number: _____

Current Symptoms (Circle All That Apply)

General

Weight Loss
Weight Gain
Fever
Chills
Weakness
Nausea
Vomiting
Loss of Appetite
Night Sweats

Eyes and ENT

Blurred Vision

Respiratory

Cough
Coughing up blood
Shortness of breath
Wheezing

Gastrointestinal

Abdominal Pain
Heartburn
Bloating
Belching
Diarrhea
Constipation

Musculoskeletal

Joint Pain
Muscle Pain/Weakness
Back Pain
Bone Pain

Neurological

Numbness/Tingling
Arm/Leg Weakness
Headache
Tremors

Skin

Rash/Itching

Double Vision

Hearing Loss

Ringing in the Ears

Sore Throat

Trouble Swallowing

Painful Swallowing

Jaw Pain

Voice Changes

Taste Changes

Smell Changes

Cardiovascular

Chest Pain

Irregular Heart Beat

Palpitations

Poor Circulation

Rapid Heart Beat

Slow Heart Rate

Rectal Bleeding

Black/Tarry Stool

Blood in Stool

Changes in Bowel Habits

Stool Incontinence

Genitourinary

Kidney Stones

Pelvic Pain

Incontinence

Painful Urination

Frequent Urination

Blood in Urine

Trouble Urinating

Prostate Problems

Frequent Infections

Vaginal Bleeding

Skin or Mole Changes

Skin Lesions

Endocrine

Heat or Cold Intolerance

Excessive Thirst

Weight Problems

Hot Flashes

Breasts

Rash/Itching

Lump

Dimpling

Other: _____

_____

_____

_____

_____

Permission to Release Diagnostic/Medical Information to Another Individual

Effective Date:_____

Print Patient's Full Name:_____

Patient's Date of Birth:_____ **MR#**_____

I give Dr. Bhadresh Nayak permission to release diagnostic test results to, and discuss protected health information with, the following person(s):

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name:_____ **Physician:**_____

Name: _____ **Physician:** _____

Name: _____ **Physician:** _____

I give Dr. Bhadresh Nayak permission during the course of providing care, to share either written or electronic patient information with other providers who are involved in my treatment:

Yes No

I give Dr. Bhadresh Nayak permission to leave any protected health information on an answering machine or voicemail:

Yes No

By signing this form I give Dr. Bhadresh Nayak permission to send office correspondence to the address provided.

Indicate your relationship to the patient: Patient Patient Representative

Print Name (if other than patient): _____

Signature: _____

Date: _____

This form is good for one year from effective date.

Bhadresh D. Nayak, M.D., P.L.C

Board Certified in Oncology, Hematology and Internal Medicine

Health Insurance Portability and Accountability Act ("HIPAA") Acknowledgement

The office of Dr. Bhadresh Nayak, M.D. is required by law to provide you with a copy of the Notice of Privacy Practices, which describes how your health care information is used and disclosed.

To ensure our records are accurate please complete and sing below and return this form to our receptionist to acknowledge that you have been provided with a copy of our notice. Also, please be advised that our office may use and disclose de-identified health information for purposes of data collection and statistical analysis. De-identified information is considered to be health information from which all personal or identifying information is removed. This means the health information can no longer be identified as yours and is no longer considered protected under HIPAA. I acknowledge the use or disclosure of my Protected Health Information by the office of Dr. Bhadresh Nayak, M.D. for purposes of Treatment, Payment and Health Care Operations.

I have received a copy of the Notice of Privacy Practices and understand I have the right to review prior to singing this document.

I authorize the following people to be involved in my care that may require a disclosure of Protected Health Information. This consent for disclosure includes both health and financial information as it relates to my care:

Contacts:

Name:_____ Relationship: _____ Number: _____

Name:_____ Relationship: _____ Number: _____

Name:_____ Relationship: _____ Number: _____

This agreement/consent will remain in effect unless revoked by me in writing.

I HAVE READ AND ACCEPT THE TERMS AND CONDITION OF THE ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILIES AGREEMENT, AS WELL AS THE PHYSICIAN OWNERSHIP DISCLOSURE AND THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ACKNOWLEDGEMENT.

Patient/Guardian Signature: _____ Date: _____

Financial Policy

For The Patient To Keep

Dr. Bhadresh Nayak wants to provide our community with healthcare services and, at the same time, keep costs under control. To do this, we need your help. We ask you to read our payment policy listed below:

- Your bill is based on the services you received. You are responsible for paying the bill if your insurance company does not cover all the costs.
- What your health insurance covers is based on an agreement between the company, or person who employs you, and the insurance company.
- You need to contact your insurance company with any questions about what they will cover.
- We know that temporary financial problems can sometime prevent you from making a payment on your account on time. If this happens, you need to contact us at 586-268-3009 so that we can help you with this problem. Dr. Bhadresh Nayak's office will help to arrange a budget plan.

If you DO NOT have health insurance

Your Responsibility

- You must pay your entire office visit at the time of service or inform us of your inability to pay.

Our Responsibility

- Dr. Bhadresh Nayak will provide the services you need, even if you cannot pay.
- We will assist you in obtaining co-pay assistance and/or health insurance.

If you HAVE health insurance

We participate with many insurance companies. This means we have signed a contract with them to provide care for the people they cover. The contracts are not all the same, and certain services may not be covered depending on your employee health benefits. If we DO participate with Your insurance plan (including Medicare):

Your Responsibiliy

- You must pay any co-payment at the time you receive the service.
- You must pay any deductible amount or any amount that you know is not covered at the time of service.
- You must pay the amount or any amount that you know is not covered at the time of service.
- You must pay the amount not paid by your insurance, payment is due upon receipt of the statement, except for those from whom Dr. Bhadresh Nayak can not collect by law or agreement.

- If your insurance requires a referral, you must obtain that prior to your appointment. If you do not have your referral we are not required to see you.

Our Responsibility

- We will send a bill to your insurance company for all services done in our office.

If we DO NOT participate with your insurance plan:

Your Responsibility

- You must pay for the service at the time it is given.
- To make it simple, our office accepts cash, checks, VISA, MasterCard, Discover, American Express, and bank cards.
- We will charge you a $25.00 fee for any returned checks.

Statement of Financial Responsibility

The patient who receives care and treatment from Dr. Bhadresh Nayak must pay any charges that are not paid by insurance or any other party.

Other providers, such as x-ray or laboratory services, will bill the patient separately.

The patient must pay any amount not paid by insurance upon receipt of the statement.