NAME: ____ BIRTH DATE: _____/_____/_____ DATE: ____/____/____

ADDRESS: ____

CITY: ____ STATE/ZIP: _____________________________________

HOME TEL: (_____)_____________________________ ALT TEL: (_____)__________________________________

EMAIL ADDRESS__________________________________ (if you would like to receive specials and news from Butterfly Landing)

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW OR IN THE PAST:

	CURRENTLY	PAST	NOTES
1. CONSTITUTIONAL			
Weight loss	☐	☐	
Weight gain	☐	☐	
Fever	☐	☐	
Fatigue	☐	☐	
2. EYES			
Double vision	☐	☐	
Spots before eyes	☐	☐	
Vision changes	☐	☐	
3. ENT/MOUTH			
Ear aches	☐	☐	
Ringing in ears	☐	☐	
Sinus problems	☐	☐	
Sore throat	☐	☐	
Mouth sores	☐	☐	
Dental problems	☐	☐	
4. CARDIOVASCULAR			
Painful breathing	☐	☐	
Chest pain	☐	☐	
Difficult breathing on exertion	☐	☐	
Swelling of legs	☐	☐	
Palpitations of heart	☐	☐	
5. RESPIRATORY			
Wheezing	☐	☐	
Spitting up blood	☐	☐	
Shortness of breath	☐	☐	
Cough, chronic	☐	☐	
6. GASTROINTESTINAL			
Diarrhea, frequent	☐	☐	
Blood stool	☐	☐	
Nausea/vomiting	☐	☐	
Constipation	☐	☐	
7. GENITOURINARY			
Blood in urine	☐	☐	
Pain with urination	☐	☐	
Urgency	☐	☐	
Frequency of urination	☐	☐	
Incomplete emptying	☐	☐	
Stress incontinence	☐	☐	
Abnormal periods	☐	☐	
Painful intercourse	☐	☐	

8. MUSCOSKELETAL **Muscle Weakness**	☐ ☐	

9. SKIN/BREAST **Pain in Breast** **Discharge** **Masses** **Rash** **Ulcers**	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
10. NEUROLOGICAL **Dizziness** **Seizures** **Numbness** **Trouble walking**	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
11. PSYCHIATRIC **Depression** **Crying, frequent**	☐ ☐ ☐ ☐	
12. ENDOCRINE **Dry Skin** **Abnormal thirst** **Hot flashes**	☐ ☐ ☐ ☐ ☐ ☐	
13. HEMATOLOGIC/LYMPHATIC **Bruises, frequent** **Cuts do not stop bleeding** **Enlarged lymph nodes**	☐ ☐ ☐ ☐ ☐ ☐	
14. ALLERGIC **Allergies** **Drugs, other**	☐ ☐ ☐ ☐	
15. MENSTRUAL HISTORY *(FOR GYNECOLOGICAL PATIENTS ONLY)* **First day of last menstrual period** ____________________ **Menarche (Age of 1st Period :)** ____________________ **Interval (# of days between Periods)** ____________________ **Length of Period** ____________________		**Are they [ ] Regular [ ] Irregular** **If irregular, shortest interval** ______________ **longest interval** ______________ **Flow: [ ] Heavy [ ] Light** **[ ] Normal [ ] Clots** **Painful periods? [ ] Yes [ ] No**

PERSONAL PAST HISTORY

MAJOR ILLNESS	YES	NO		YES	NO
Asthma			Cancer		
Pneumonia			Ulcers		
Chronic Lung Disease			Depression/anxiety		
Kidney Infections/stones			Anemia/Blood transfusions		
Tuberculosis			Seizures/convulsions/epilepsy		
Venereal Disease			Bowel trouble		
Heart Trouble/murmur			Glaucoma		
Diabetes			Arthritis/joint pain		
High Blood pressure			Fracture		
Stroke			Hepatitis/Yellow jaundice		
Rheumatic Fever			Thyroid Disease		

OPERATIONS

Reason	Date	Reason	Date

MAJOR INJURIES/ILLNESSES

Type	Date	Type	Date

CURRENT MEDICATIONS

Drug Name	Dosage	Drug Name	Dosage

FAMILY HISTORY

ILLNESS	YES	RELATIVE	ILLNESS	YES	RELATIVE
Diabetes			Drinking Problem		
Stroke			Breast Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Ovarian Cancer		

SOCIAL HISTORY

HABITS

Smoking Yes [ ] No [ ]
Packs per day _________ **Years** __________
Alcohol Yes [ ] No [ ]
Drinks per day ________ **Drinks per week**__________
Drug Use Yes [ ] No [ ]

Seat Belt Use Yes [ ] No [ ]
Regular Exercise Yes [ ] No [ ]

PERSONAL PROFILE (Optional)

Marital Status Married [ ] Single [ ] Widowed [ ] Divorced [ ]
Number of Living Children __________________________________
Number of people in household ______________________________
School Completed High School [ ] College [ ] Graduated Degree [ ] Other [ ]
Current or most recent job ____

Completed by: Patient [ ] Office Nurses [ ] Physician [ ]
Signature of patient: ____
Date reviewed by physician with patient: ____
Physician Signature: ____

Annual Review of History
Date reviewed: ________________________Physician Signature: ____

Date reviewed: _______________________ Physician Signature: ____

Date reviewed: _______________________ Physician Signature: ________________________________

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge receipt of the Notice of Privacy Practice. The notice of Privacy Practice detailed information about how the practice may use and disclose my confidential information.

I understand that Dr. Kinsella's office has reserved the right to change the privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signed: ______________________________________ Date: ____________________

Print Name: ____

If person signing this form is not the patient, please indicate your relationship to the patient:

- ☐ Parent or guardian of minor patient
- ☐ Guardian of an incompetent patient
- ☐ Beneficiary or personal representative of a deceased patient

Name of patient: ____

For office use only:

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Acknowledgement, but was unable to do so as documented below:

Reason: ____

Signed: ________________________ Date: ____________________________

Request for Confidential Communication

I, ___________________________________, hereby request Dr. Robert S. Kinsella and Butterfly Landing Med-spa offices to keep communications regarding my protected health information confidential. To accomplish this request please adhere to the following requests:

Phone:

- You can contact me by phone at ___________________
- Leave messages on answering machine? yes _______ no ________
- Leave messages with any other person? yes _______ no ________

Please list: _____________________________
____
____

Mail:

Contact me at the following address: _______________________________
____

Email: ________________________________@___________________________

Other Requests for confidential communications:

____
____
____

Signed:______________________________________Date______________
(If you are not the patient, please specify your relationship to patient________________)

Dr. Robert S. Kinsella is a physician licensed to practice medicine in all of its branches in the State of Illinois and a Board Certified Gynecologist and Gynecologic Surgeon.

Please put your initials where indicated to indicate your acceptance and understanding:

______I understand that my consent is not needed if the law requires Dr. Robert S. Kinsella to report some aspect of my protected health information to a government agency. Examples would include suspected abuse, communicable disease, and potential for serious bodily harm to others or myself.

______I understand that I have the right to review Dr. Robert S. Kinsella's privacy notice, to request restrictions on the use of my information, and to revoke my consent at a later date.

______We require 24 hour cancellation notice. I understand that one "no show" (fail to come in at the appointed time without a call) will be tolerated without charge, but <u>after my second no show on an appointment I will be charged 25% of the service missed</u>. Also, if I am 10 minutes late for a scheduled appointment, I may have to reschedule. There will be a $37.50 charge for all checks returned for insufficient funds.

______I understand that if I withhold consent for the use of my information for the purposes of treatments, payment, or operations, Dr. Robert S. Kinsella may decline to undertake my care.

______I understand that Dr. Robert S. Kinsella and/or his employees may need to use and disclose information about my health or medical problems for the purposes of arranging, conducting, or referring for my treatments, for obtaining payment for the services rendered me and for the operations of the practice. I consent to the use of my information for the purposes of treatment, payment, and health care operations.

I hereby authorize Dr. Robert S. Kinsella and his staff to provide medical services for my care and treatment.

Printed Name: ____

Signature:_________________________________ Date: __________

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.

Our Legal Responsibility

As your health care provider, we are legally required to protect the privacy of your health information, and to provide you with this notice about our legal obligations and privacy practices. This requirement applies to all patients served by Dr. Kinsella's office and Butterfly Landing Medi-Spa.

Dr.Kinsella's office and Butterfly Landing Medi-Spa are legally required to follow the privacy practices described in this notice. If you have any questions or want more information about this notice, please contact our Privacy Officer listed at the end of this notice.

Your Protected Health Information (PHI)

Throughout this notice we will refer to your protected health information as PHI. Your PHI includes data that identifies you and reports about the care and services you receive at Dr. Kinsella's office and Butterfly Landing Medi-Spa.

This notice applies to all of the records, both electronic and paper, about your care. It includes all information created by Dr. Kinsella's office and Butterfly Landing Medi-Spa staff. This staff includes physicians, nurse-midwives, other health care professionals, students, and other departmental staff.

This notice about our privacy practices explains how, when, and why we use and share your PHI. We may not use or disclose any more of your PHI than is necessary, with some exceptions. If state law is more protective of your privacy, we will follow state law.

Changes to This Notice

We reserve the right to change the terms of this notice and our privacy policies. Any changes will apply to your past, current, or future PHI. When we make an important change to our policies, we will change this notice and post a new notice in our office. You can also request a copy of our current notice at any time from the registration desk.

Uses of Protected Health Information

Dr. Kinsella's office and Butterfly Landing Medi-Spa collect health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of Dr. Kinsella's office, but the information in the medical record belongs to you.

We use and disclose health information for many reasons. The following examples describe some of the categories of our uses and disclosures. Please note that not every use or disclosure in a category is listed.

- **Treatment.** We may use and disclose medical information about you to physicians, nurses, technicians, physicians in training, or other health care professionals who are involved with your care. Different health

care professionals, such as pharmacists and lab technicians, also may share information about you in order to coordinate your care. In addition, we may send information to the physician who referred you to our office.

- **Payment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services we provided to you. For example, we may provide PHI to an insurance company or other third party payer in order to obtain approval for treatment or admission to the hospital.

- **Health care operations.** We may use and disclose your PHI as part of our routine operations. For example, we may use your PHI to evaluate the quality of health care services you received or to evaluate the performance of health care professionals who cared for you. We may also disclose information to physicians, nurses, technicians, medical students, nursing and other health professional students, and other hospital personnel.

- **Appointment reminders and health-related benefits or services.** We may use your PHI to provide appointment reminders or give you information about treatment alternatives or other health care services.

- **Public health activities.** We report information about births, deaths, and various diseases to government officials in charge of collecting that information.

- **Law enforcement.** We may disclose PHI to government agencies and law enforcement personnel when the law requires it. For example, we report about victims of abuse, neglect, domestic violence, and gunshots, or when ordered to do so in judicial or administrative proceedings.

- **Health oversight activities.** We may disclose PHI to a health oversight agency for audits, investigations, inspections, and licensure, as authorized by law. For example, we may disclose PHI to the Food and Drug Administration, state Medicaid fraud control, or the Department of Health and Human Services Office for Civil Rights.

- **Research studies.** We may disclose your PHI to help conduct research. Research may involve finding a cure for an illness or helping to determine the effectiveness of a treatment. All research studies are subject to a specific approval process by a Privacy Board or Institutional Review Board. This process evaluates a proposed research study to determine that measures are in place to balance research needs with the need for the privacy of your health information. For some research activities you may be asked to participate in a study, and if you agree, the researcher will be required to obtain your permission to use your PHI for that study.

- **Workers’ compensation purposes.** We may disclose PHI to your employer or your workers’ compensation carrier.

- **National security and intelligence activities.** We may release PHI to authorized federal officials when required by law. This information may be used to protect the President, other authorized persons or foreign heads of state, to conduct special investigations, for intelligence and other national security activities authorized by law.

Uses and Disclosures for which You Have the Opportunity to Object

- **Hospital Directory.** We will use your name, the location at which you are receiving care, your general condition, and your religious affiliation for directory purposes. All of this information, except religious affiliation, will be disclosed to people who ask for you by name. If you object to this use, we will not include this information in the directory. You will need to express your objection for each inpatient stay. To object, please notify a member of your nursing staff.

- **Disclosures to family, friends, or others.** We may provide your PHI to a family member, friend, or other person you tell us is involved in your care or involved in the payment of your health care, unless

you object in whole or in part. 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.
Except as described above, all other uses and disclosures of your PHI will require your authorization.

Your Rights Regarding PHI

You have the right to:

- **Request Restrictions.** You have the right to ask that we limit how we use and disclose your PHI. We will consider your request, but we are not legally required to accept it. If we accept your request, we will honor that request except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make. To request a restriction, contact the Privacy Officer listed at the end of this notice.

- **Request Confidential Communications.** You have the right to ask that we send PHI to you at an alternate address. For example, you may wish to have appointment reminders and test results sent to a P.O. Box or an address different from your home address. We will accommodate reasonable requests.

- **Inspect and Copy.** You have the right to inspect and obtain a copy of medical information that may be used to make decisions about your care. Usually this includes the medical record and billing records. To inspect and obtain a copy of your medical information, you must submit your request in writing. We will make every effort to respond to your request within a reasonable period of time. You may be charged a fee to cover the costs of copying, mailing, or other supplies associated with your request.

- **Accounting of Disclosures.** You have the right to obtain a list of instances in which we have disclosed your PHI. Your request must state a time period not longer than six years and your request may not include dates before April 14, 2003. The list will not include uses or disclosures made for treatment, payment, or health care operations. In addition, the list will not include uses or disclosures that you have specifically authorized in writing, such as, copies of records to your attorney or to your employer. To request an accounting of disclosures, contact the Privacy Officer listed at the end of this notice.

- **Amend.** You have the right to request an amendment of your PHI if you think that information is inaccurate or incomplete in your medical record or in a billing record. You may request an amendment for as long as that record is maintained. You may submit a written request for an amendment to our office.

  Dr. Kinsella's office may deny your request for an amendment if:

  - it is not in writing
  - it relates to information not created or produced by Dr. Kinsella's office staff.
  - we decide that the information is accurate and complete

- **Paper copy of this notice.** You have the right to request a paper copy of this notice. You may pick up a copy at the registration desk or request that a copy be sent to you.

Revocation of Permission

If you provide us with permission to use or disclose medical information about you, you may revoke that permission at any time. To request revocation of permission, contact our office.

If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written revocation. We are unable to take back any disclosures previously made with your permission. Also, we are required to keep all records of the care that we provided to you.

Complaints and Questions

If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the U.S. Department of Health and Human Services.

To file a complaint with Dr. Kinsella's office and Butterfly Landing Medi-Spa, contact the Patient Representative at our office. The address and phone number are listed at the end of this notice. You will not be penalized for filing a complaint and your care will not be compromised.

CONTACT INFORMATION

Contact:

- Inspection and copying of your medical record
- Amending your medical record
- Revoking your permission to disclose your medical information

Contact:

Privacy Officer:
Dr. Robert Kinsella
1631 4th St
Peru, IL 61354

Office for Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601
Phone:(312) 886-2350
Fax: (312) 886-1807
TDD: (312) 353-5693

If you have questions about this notice, any complaints about our privacy practices, or you would like to have more information, please contact the Privacy Officer listed above. This notice is in effect March 2019.