Hernia Center of Arizona

Center for Minimally Invasive and Robotic Surgery

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Rm 1 _____ Rm 2 _____

Hospital follow up Questionnaire

Name: ______________________________ Date of Birth ______________

Emergency contact: Name ______________________________ Phone # ______________________________

Relationship: __________________________ May we discuss your medical care with this person? Yes _____ No _____

Who is your primary care physician? ______________________________ Phone # _________________________

If you do not have a primary care physician, would you like a referral today? Yes _____ No _____

Which hospital were you seen at? Banner Thunderbird _____ Abrazo Arrowhead _____ Dignity Westgate _____

What were you seen for? ______________________________

When were you seen? _____________________ Did you have surgery? No ___ Yes ___

If yes, what surgery did you have? ______________________________

Do you have any concerns about the surgery?______________________________

How would you relate your pan level at this time? None 1 2 3 4 5 6 7 8 9 10 highest (please circle)

Do you have any of the following symptoms? (Please circle) Nausea Vomiting Fevers

Chills Cough Shortness of breath Dizziness Generalized pain Other?

Any drainage from incision at this time? Yes _____ No _____, if yes: Color? __________________ Odor? _______________

Do you need a refill on medication prescribed by the surgeon? If yes, what medication? _______________________________

Are you eating normally? Yes _____ No _____, if no, what is different? ______________________________

Are you back to normal activity? Yes _____ No _____

Are you back to work? Yes _____ No _____ If yes, what date did you return? __________________

Do you need a note for work? Yes _____ No _____

How many narcotic pain pills did you take? ___________ How many days did you require pain medication? _____________

Did you need to be seen anywhere prior to your appointment today? If yes, why?

Have you changed any medications since surgery? If Yes, please list changes with doses:

Any other questions of comments about your experience with us?

Notice of Privacy

To Our Patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy:

-CMIRS is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

-We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances:

The following circumstances may require us to use or disclose your health information:

-To public health authorities and health oversight agencies that are authorized by law to collect information.

-Lawsuits and similar proceedings in response to a court or administrative order.

-If required by a law enforcement official.

-When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.

-If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

-To federal officials for intelligence and national security activities authorized by law.

-To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

-For workers Compensation and similar programs.

Your rights regarding your health information:

-Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests

-You can request a restriction of disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

-You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing.

-You may ask to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing.

-Right to copy this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk.

-Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our front desk. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

-Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

I hereby acknowledge that I have been presented with a copy of Notice of Privacy

Signature: ______________________________ ***Date:*** ________________