Majed Jandali, MD FACS
Mustafa Badrudduja, MD FACS

JANDALI SURGICAL ASSOCIATES

9555 76th St Suite 4880
Pleasant Prairie, WI. 53158
(262) 748-1001 tel
(262) 748-1020 fax

REGISTRATION FORM

Today's Date			
Section I – Patient Information			
Last Name	First Name		Middle
Date of Birth (m/d/y)	Age	Social Security #	
Address			
City	State		Zip
Home Phone	Cell Phone	Work Phone	
Email address			
Marital Status (circle)	Single	Married	Divorced Widowed
Sex (circle)	Male	Female	Other (specify)_____
Race (circle)	White	Black	Hispanic Other _____
Language spoken	***if not English, patient is responsible for translator***		
Occupation	Employer		
Primary/Family Doctor	Referring provider (if different)		
Section II – Responsible Party (If same as above, proceed to Section III)			
Relationship to patient:			
Last Name	First Name		Middle
Address			
City	State		Zip
Home Phone	Cell Phone	Work Phone	
Section III – Insurance Information (provide card at time of check-in)			
Name of Subscriber	Relationship to patient		
Date of birth	Social Security #		
Insurance Co	ID #	Group #	
Secondary Insurance (if applicable)			
Name of Subscriber	Relationship to patient		
Date of birth	Social Security #		
Insurance Co	ID #	Group #	

The signature below affirms that the information provided above is correct to the best of my knowledge

Signature _____ Date: _____

Printed Name _____ Relationship to Patient _____

(if someone other than patient is signing)

Majed Jandali, MD FACS

Mustafa Badrudduja, MD FACS

JANDALI SURGICAL ASSOCIATES

9555 76th St Suite 4880
Pleasant Prairie, WI. 53158
(262) 748-1001 tel
(262) 748-1020 fax

MEDICAL HISTORY

Name:_____ Date of Birth:_____Age:_____

Reason for Visit:_____ Height:____ft____in

Medical History

Do you take Aspirin or other blood thinners □ Yes □ No	Do you take immune system modifying medications □ Yes □ No

List Medications with dosages: (□ Check here if providing a separate list of medications with the dosages)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies: _____ LATEX Allergy □ Yes □ No

Pharmacy Used (Name, location, phone number): _____

Medical Illnesses

List any not mentioned:

High blood pressure	□ Yes	□ No	_____	_____
Heart disease/Heart attack	□ Yes	□ No	_____	_____
Diabetes	□ Yes	□ No	_____	_____
Asthma	□ Yes	□ No	_____	_____

Surgical History

List your surgeries	Surgeon	Approx Date

Other History

Tobacco □ No □ Yes □ Quit →→→→→→ **please fill tobacco questionnaire at the end**

Alcohol □ No □ Quit How long ago? _____ □ Yes. How much? _____

Work □ No □ Disabled □ Retired □ Yes. Occupation: _____ / Heavy lifting □ Yes □No

Have you ever had a colonoscopy? ☐ No ☐ Yes: Year _____

Have you ever had a mammogram? ☐ No ☐ Yes: Year _____

Family History

Heart disease/Heart Attack: □ No □ Yes, relationship:_____

Diabetes: □ No □ Yes, relationship:_____

Cancer: □ No □ Yes, relationship:_____

Other: _____

TOBACCO QUESTIONNAIRE

NONSMOKER	CURRENT SMOKER	FORMER SMOKER
○ I do not smoke, use tobacco or other nicotine products ○ I do not smoke, but I do use other tobacco or nicotine products. (please explain below) _____ _____ _____ _____	How often do you smoke ○ Every day ○ Some days, but not every day How many cigarettes per day ○ 5 or less ○ 6-10 ○ 11-20 ○ 21-30 ○ 31 or more How soon after waking up do you smoke ○ Within 5 minutes ○ 6-30 minutes ○ 31-60 minutes ○ After 60 minutes **Are you interested in quitting** ○ **Ready to quit** ○ **Thinking about quitting** ○ **Not ready to quit**	How long since you last smoked: ○ <1 month ○ 1-3 months ○ 3-6 months ○ 6-12 months ○ 1-5 years ○ 5-10 years ○ >10 years

Name:_____

REVIEW OF SYSTEMS

(non-selection will be taken to mean absence of the symptom)

General	**NONE APPLY**
□fatigue □fever □night sweats □weight gain more than 10 lbs □weight loss more than 10 lbs	□
Skin	
□change in wart/mole □itching □new lesions □rash	□
HEENT	
□headache □visual disturbance □hearing loss □frequent colds □bleeding gums □hoarseness	□
Neck	
□swollen glands	□
Respiratory	
□cough □difficulty breathing □snoring □sleep apnea	□
Breast	
□breast mass □breast pain □nipple discharge □breast cancer	□
Cardiovascular	
□chest pain □elevated blood pressure □shortness of breath □swelling of extremities □leg pain/swelling	□
Gastrointestinal	
□abdominal pain □constipation □diarrhea □difficulty swallowing □bloating □nausea □vomiting □heartburn □rectal bleeding	□
Female GU (females only)	
□absence of menstruation □incontinence □irregular menstruation □painful urination □ pelvic pain □urgency □vaginal bleeding □vaginal discharge	□
Male GU (males only)	
□frequency □incontinence □urination at night □testicular mass □testicular pain	□
Musculoskeletal	
□calf pain □joint pain □muscle cramps	□
Neurological	
□dizziness □weakness	□
Psychiatric	
□anxiety □depression	□
Endocrine	
□cold intolerance □excessive thirst □excessive urination □thyroid problems	□
Hematology	
□anemia □enlarged lymph nodes □prolonged bleeding	□

The above has been filled to the best of my knowledge	Patient/caregiver signature & date→
The above has been reviewed and confirmed with the patient	Physician signature & date→

Majed Jandali, MD FACS

Mustafa Badrudduja, MD FACS

JANDALI SURGICAL ASSOCIATES

9555 76th St Suite 4880
Pleasant Prairie, WI. 53158
(262) 748-1001 tel
(262) 748-1020 fax

FINANCIAL POLICY

We are committed to providing you with the best care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship.

Charges for office visits and surgery are determined by the time spent and vary with the severity and complexity of the problem. Please do not hesitate to discuss our fees if you have any questions. Please be aware that we can only discuss our professional fees. Surgical procedures are often undertaken in the hospital and this will incur fees from the hospital, anesthesiologist, pathologist, and others.

Insured Patients: Your co-payment is expected and due at the time of service. A $25 administrative fee will be assessed if you are unable to pay the co-payment at the time of service.

Self-Pay Patients: You are required to pay a fee of $150 towards the office visit at the time of service. Payment in full is expected prior to any elective procedures. In the event of emergency surgery, please ask to speak to our financial department.

For your convenience, we accept Cash, Checks, Visa, MasterCard, and Discover

If you have insurance, please understand that this is an agreement between you and your insurance company. We will inform you if we are a participating provider with your insurance company and will handle your claims according to our agreement with the insurance company.

Insurance plans vary, and your insurance may cover anywhere from 0 to 100% of your medical and surgical costs. We file insurance claims as a courtesy to you, but you are *responsible for the timely payment of your account regardless of any dispute between you and your insurance company*. If your insurance company has not paid within 60 days from the date of service, you have 30 days to make arrangements to pay the balance.

I, the undersigned, certify that I have insurance coverage with the company listed on the Registration Form and assign directly to Jandali Surgical Associates, SC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. It is also my responsibility to inform the office of any insurance changes.

I hereby authorize the physician indicated to release to your insurance company any information including diagnosis and records of any treatment and/or examination rendered to me. I authorize the physician to initiate a complaint to the Insurance Commissioner for any reason on my behalf or to file an appeal to my insurance company on my behalf.

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This forms gives consent to Jandali Surgical Associates, SC to use and disclosure of your protected health information to carry out treatment, payment, or other healthcare related operations. By signing below, you also give consent to obtain your medication history from your pharmacy. Your records may be released to disability, FMLA, or workmans' compensation. For a more complete description of such uses and disclosures, please refer to our Notice of Privacy Practices.

You have the right to review our Notice of Privacy Practices prior to signing this consent. However, we reserve the right to change our privacy practices and change the terms of this notice. Any new notice provisions will be effective for all protected health information that we maintain. Should you wish to obtain a revised notice, you may contact our privacy officer or office manager.

You have the right to request that Jandali Surgical Associates, SC restrict how we use and disclose your protected health information. We are not required to agree to such a restriction, but if we do, the restriction will be binding on us. If we do agree, we will restrict our use and disclose to the extent we document such in writing and notify you of the same.

CONSENT FOR TREATMENT

You have the right as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatments or procedures after knowing the risks and hazards involved. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and the treatment recommended, and you consent to treatment at out practice. You also recognized that medicine is not an exact science and that your diagnosis and treatment may involve risk of injury or even death. Further, I acknowledge that no guarantees can be made to me as to the results of examinations or treatments during my episodes of care. I also understand that no experimental or investigational treatment will be rendered to me without my expressed consent. This consent will remain fully effective until is it revoked in writing. You have the right at any time to discontinue services.

It is important that you comply with the medical treatment recommendations provided by your doctor. If you are unable to comply, please notify your doctor immediately. You have the right to discuss your treatment plan with your physician about the purpose, potential risk and health benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommendations by your healthcare provider, we encourage you to ask questions.

I certify that I have read and fully understand the above and consent fully and voluntarily to its contents

Signature _____ Date: _____

Printed Name _____ Relationship to Patient _____
(if someone other than patient is signing)

Majed Jandali, MD FACS
Mustafa Badrudduja, MD FACS

JANDALI SURGICAL ASSOCIATES

9555 76th St Suite 4880
Pleasant Prairie, WI. 53158
(262) 748-1001 tel
(262) 748-1020 fax

HIPAA NOTICE AND CURES ACT

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

The HIPAA Privacy Rule (Health Insurance Portability and Accountability Act) provides individuals with the right to request confidential communications or that a communication of PROTECTED HEALTH INFORMATION be made by other means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

Home telephone number _____
□ Please leave a call back number only
□ I give permission to leave a message with detailed information

Cell phone number _____
□ Please leave a call back number only
□ I give permission to leave a message with detailed information

Work telephone number _____
□ Please leave a call back number only
□ I give permission to leave a message with detailed information

Exceptions to the above: _____

Emergency Contact: Relation to patient: Phone:

Do you authorize your PROTECTED HEALTH INFORMATION to be disclosed to your emergency contact?

□ YES □ NO

□ I authorize my PROTECTED HEALTH INFORMATION to be disclosed verbally or in writing to the following:

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

OR

□ My PROTECTED HEALTH INFORMATION is not to be released to any person other than myself

CURES ACT

The information blocking (aka "open notes") rule of the federal 21st Century Cures Act dictates certain information created in an electronic health record (EHR) must be immediately available to patients through a secure online portal. Test results may be available for you (the patient) to see, even before the provider has seen them. It is important to understand that not all abnormal test results are clinically significant, nor urgent. It may take several days for the provider to review the results. Patients will be contacted sooner if urgent or emergent action is required. Certain test results may require a follow-up appointment to fully discuss and form a treatment plan.

The signature below affirms that the information provided above is to the best of my knowledge
This form remains in effect for one year from the date of signature.

Signature _____ Date: _____

Printed Name _____ Relationship to Patient _____
(if someone other than patient is signing)

Majed Jandali, MD FACS

Mustafa Badrudduja, MD FACS

JANDALI SURGICAL ASSOCIATES

9555 76th St Suite 4880
Pleasant Prairie, WI. 53158
(262) 748-1001 tel
(262) 748-1020 fax

PRIVACY STATEMENT
NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("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.

We are required by law to keep your health information private. We will provide you a copy of this notice. We are also required by law to follow the terms of this Notice as long as it is in effect. If you have any questions about this Notice, please contact our office at the number above.

Who will follow this Notice?
Jandali Surgical Associates, S.C. Provides health care to our patients in partnership with physicians and other professionals and organizations. The privacy practices summarized in this Notice will be followed by:

- Treating health care professionals and others who enter information into the health record we maintain about you.
- Our employees, physicians, allied health professionals, students, and volunteers at our facility.
- Members of our organized health care arrangement with whom we share health information.
- Any business associate with whom we share health information.

This Notice applies to all of the records relating to your care maintained by Jandali Surgical Associates, S.C. regardless of whether such records are generated by and/or received by Jandali Surgical Associates, S.C. Staff or the doctor.

How we may use and disclose health information about you.
We may use and disclose health information about you to:

- Provide you with medical treatment or services (such as sharing information with a consulting physician who has been asked to examine your health information).

- Unless you object, we also may share health information about you with people outside our organization who may be involved with your medical care after you leave the organization. These people include but not limited to family members, home health agencies, nursing homes, or others we use to help provide services that are part of your ongoing care.

- Bill and collect payment from you, an insurance company or a third party. For example, we may need to give a health plan information about a procedure performed on you so that they will pay us, or reimburse you, for the cost of the procedure. We also may share health information with our business associates include billing companies, collection agencies, clearing houses and others that process our health care claims.

- To assist us with our healthcare operations. For example, we may use health information about you to review our treatment and services and/or to evaluate the performance of our staff.

- We may contact you to remind you that you have an appointment, to follow up on health care services that were provided to you, to tell you about treatment alternatives or to tell you about other health related benefits and services that may be of interest to you.

- We may share health information about you with family members or friends whom you indicate are involved in your medical care. In certain disasters and related emergency situations, we share health information about you with disaster relief organizations (such as Red Cross, etc.) so that your family can be notified about your condition, status and location.

- In certain situations, we may use and share health information about you for research purposes. However, all research projects are subject to a special review and approval process designed, among other things, to ensure the privacy of your health information. We may disclose health information about you to people preparing to conduct research.

- We may use or disclose health information about you without your permission only as allowed by law. Examples of situations where we may be required to release health information about you include: emergencies, public health, health or safety threats, reporting abuse or neglect, health oversight and audit activities, national security, coroners, medical examiners, funeral directors, organ/tissue donation, and workers' compensation. We also may be required by law to provide health information about you in response to requests from law enforcement officials in limited circumstances, correctional institutions or as part of legal proceedings in response to valid judicial or administrative orders and/or other valid legal authority.

Other uses of health information

- Uses or disclosures of your health information that are not covered by this Notice or the law will be made only with your written permission. In further support of your right to privacy, we cannot accept your blanket authorization to disclose health information for treatment you have not yet received. If you permit us to use or share health information about you, you may take back that permission, in writing, at any time. If you take back your permission, we will no longer use or share the health information you specified for the reasons you noted in writing. You understand that when you take back your permission we are unable to retrieve any information we may have already shared with your permission. We also are required to maintain original records of the care that we provide to you.

Your rights regarding health information about you

- You have the right to see and receive a copy of health information about you. To do so, you must submit your request in writing to the address provided above. If you request a copy, it must be requested in advance and we may charge a fee for the cost of copies, postage and/or supplies. In certain situations, we may deny your request. If we deny your request, we will tell you, in writing, why your request was denied and explain to you your right to have the denials reviewed.

- If you feel that our record of your health information is incorrect or incomplete, you have the right to request to amend the information. You may do this by sending your request in writing to Jandali Surgical Associates, SC at the above address, including your reason for the request. We may deny your request if the information was not created by us, is not part of the health information maintained by us, or if it is determined that the health information is correct. You may appeal our decision by sending a written request to us.

- You have the right to request a list of all of our disclosures of your health information, except for information disclosed for treatment, payment or health care operations, or for those disclosures you specifically authorized. To request this list, you must send your request in writing to Jandali Surgical Associates, SC at the above address. Your request must tell us a specific time period (beginning after April 14, 2003) of not more than six years. We may charge a fee for the list.

- You have the right to ask that we limit how we use and disclose health information about you. You may do so by submitting a request in writing, to Jandali Surgical Associates, SC at the above address, telling us how and what information to limit. We will consider your request but are not legally required to accept it. We also are not required to agree to your request. If we do agree, we will follow your request unless the information is needed to provide you with emergency treatment.

- You have the right to ask us to send information to you at a different address or telephone number (for example, sending information to your work address instead of your home address) or in a different way (for example, in an unmarked envelope instead of our regular mailing envelope). You may do so by sending a request in writing to Jandali Surgical Associates, SC at the above address. We have the right to decide whether the request is reasonable. We do not have to comply with an unreasonable request.

- You have a right to receive a paper copy of this Notice. You may ask to give you a copy of this Notice at any time.

Complaints

If you feel that your privacy rights have been violated, you may file a complaint in writing to:

Jandali Surgical Associates, SC
Privacy Officer
9555 76th St Suite 4880
Pleasant Prairie, WI. 53158

You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Changes to this Notice

We reserve the right to change this Notice and our privacy policies at any time. Before we make an important change to our policies, we will promptly revise this Notice. Any changes will apply to the health information we have on file and health information we create or receive after the effective date of the new Notice. You may request a copy of the current Notice from the contact person listed above. The effective date of this Notice is April 14, 2003.