E.K. NORCH, MD
6447 FRANK AVE. NW
NORTH CANTON OHIO 44720
PH# 330-305-9919 FAX# 330-305-9920

Date: _____

The doctors and staff at E.K. Norch would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visits as convenient as possible.

PATIENT INFORMATION: (Please *fill out completely*)

Legal Name: _____

Please circle one: Female Male *Please circle one:* Married Single Divorced Widowed

Birthdate: ____/____/____ Social Security#_____

Phone phone# _____ Alternate phone # _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

☐ Check here to authorize correspondence via EMAIL

Occupation:_____ Employer:_____ Employer's #_____

Emergency Contact:_____Relationship:_____Phone#_____

INSURANCE INFORMATION (*Please fill out completely*)

PRIMARY Insurance Company: _____

Name of POLICY HOLDER:_____

DOB: ___/___/___ Relationship: Self___ Spouse___ Child___ Other___

ID# _____GROUP#_____ Copay: _____

SECONDARY Insurance Company: _____

Name of POLICY HOLDER:_____

DOB: ___/___/___ Relationship: Self____ Spouse____ Child____ Other____

ID# _____GROUP#_____ Copay: _____

EK NORCH, INC
Patient History Form
E. K. Norch, MD Terri Barnes, PA

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

E.K.NORCH M.D. INC
6447 FRANK AVE A.W.
NORTH CANTON OH 44720
330-305-9919
(FAX) 330-305-9920

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete the following information:

Patient name in full: _____

Address: _____

Phone: _____ DOB: _____ SSN: _____

I hereby authorize E. K. Norch Inc.to ☐**RELEASE** ☐**OBTAIN** (Please check appropriate box) all or any part of my medical record including treatment for physical and mental illness, HIV, alcohol, Drug and/or substance abuse.

I request my medical records

☐ 1 Year ☐ 2 Years ☐ Entire Chart ☐ Other, *specify* _____

☐ All Records ☐ History and physical

☐ Laboratory/pathology records ☐ Discharge Summary

☐ X-ray/radiology records ☐ Other: _____

	FAX #	✓	PURPOSE OF REQUESST	COST OF COPIES
RELEASE TO	FAX #		SELF OR OTHER	$25.00
	FAX #		PHYSICIAN	NO CHARGE
OBTAIN FROM	FAX #		DISABILITY	NO CHARGE
	FAX #		ATTORNEY	$30.00
	FAX #		INSURANCE	$30.00

Records:

- Will not be sent untill payment is received in full

This Authorization:

- Will expire in 12 months or _____

Notice of rights:

- I understand that the organization will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on my signing this authorization.
- I have a right to receive a copy of this authorization
- I understand that laws may prevent certain records from being release or sent to other facilities

PATIENT-SIGNATURE	DATE
WITNESS- SIGNATURE	DATE
PERSON AUTHORIZED TO SIGN FOR PATIENT-SIGNATURE	DATE

E.K. NORCH, MD
6447 FRANK AVE. NW
NORTH CANTON OHIO 44720
PH# 330-305-9919 FAX# 330-305-9920

Name:_____

PHI DISCLOSURE

We cannot discuss your protected health information (PHI) with anyone than yourself unless you authorize us to do so. Please list below the name(s) of the individual(s) you authorize our office to discuss your care with. Your PHI will be disclosed to the individual(s) listed below until you notify us otherwise in writing.

Name: _____ Phone Number: _____
Name: _____ Phone Number:_____
Name: _____ Phone Number: _____

CONSENT TO TREAT

The purpose of medical care is to facilitate the treatment of disease, injury and disability. Medical services and provided through examination, testing and use of procedures to the aid of diagnosis or treatment of a medical condition. I request and authorize E.K. Norch Inc. to provide me with medical services as described above. I agree to cooperate fully and to participate in all medical procedures and to comply with the plan of medical care/services that is established.

Initials _____

FINANCIAL POLICY

- It is your responsibility to inform our office of any insurance, address or telephone number changes.
  - Your account is to be kept current--- all self-pay or insurance co-payments, will be collected at the time of services.
- A return check will result in a $25 service charge and all future payment will be required in cash or credit card
- If unable to keep you appointment, please notify us in advance so that we may offer that time to another patient. A pattern of repetitive "No Show" or late cancellations may regretfully result in an assessment of a cancellation/ no show fee.

INSURANCE COVERAGE

- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy.
- You are responsible for any non-covered charges not payable by your insurance
- You are responsible to inform the staff and doctor if your appointment is specifically for a Wellness or Physical.

NOTICE OF PRIVACY

- You will receive a copy of the "Notice of Privacy Practices" at your first appointment.
- I acknowledge I received a copy of the E.K. Norch Inc. "Notice of Privacy Practice". I have read and understand all of the above and agree to comply.

Initials _____

I have read and understand all of the above and agree to meet all financial obligations.

Patient Signature: _____ Date: _____

E.K. Norch, Inc.

Internal Medicine

6447 Frank Avenue NW • North Canton, OH 44720
Phone: 330-305-9919 • Fax: 330-305-9920

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES THE POLICIES AND PRCOCEDURES THAT OUR MEDICAL PRACTICE UTILIZES TO EFFECTIVELY MANAGE THE USE AND DISCLOSURE OF HEALTH INFORMATION ABOUT YOU IN A MANNER THAT PROTECTS YOUR PRIVACY AND COMPLIES WITH APPLICABLE LAW.

PLEASE REVIEW THIS NOTICE CAREFULLY

WHO WILL FOLLOW THIS NOTICE

Our medical practice (E.K. Norch, Inc.) provides health care to our patients in a clinically integrated health care setting. The components of this setting include:

- All departments and units that are part of the health care operations of our practice, and
- All employees, staff, students and other members of our medical staff and other licensed professionals treating you at any of our locations.

All these entities, persons and locations will follow the terms of this notice. In addition, each may share health information with others for treatment, payment or hospital operations purposes as permitted by law.

OUR PLEDGE TO YOU

We understand that health information about you is personal. We are committed to protecting your health information. We create a record of the care and services you receive to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care that we maintain, whether generated by our practice, or by other healthcare facilities or providers who may have different policies or notices regarding the use and disclosures of your health information created or maintained in their office.

The law requires us to:

- Maintain the privacy of our patient's health information;
- Provide you with this notice of our legal duties and privacy practices with respect to your health information; and
- Follow the terms of the noticed that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Your Authorization: Except as outlined below, we will not use or disclose your health information for any reason unless you have signed a form authorizing us to do so. You have the right to cancel your authorization in writing unless we have taken any action in reliance on the authorization.

Uses and Disclosures for Treatment: We will use and disclose your health information as needed for your treatment. For example, doctors and nurses and other professionals involved in your care will use information in your medical record, and/or information that you give them, in order to treat you. We may also disclose your health information to another health care facility of professional outside of our practice who is or may be providing treatment to you.

For instance, if after you leave the hospital you are going to receive home health care, we may release you health information to that home health care agency so that they can treat you.

Uses and Disclosures for Payment: We will use and disclose your health information for the purpose of allowing us, as well as other entities, to secure payment for the health care services provided to you. For example, we may forward information regarding your medical treatment to your health plan to arrange payment for the services given to you. We also may tell your health plan to arrange payment for the services given to you. We also may tell your health plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment.

Uses and Disclosures for Health Care Operations: We will use and disclose your health information as needed, and as permitted by law, in the process of our daily operations. For example, we may use and disclose your health information for purposes of improving clinical treatment and care our patients. We may also disclose your health information to another health care facility, health care professional or other entity for such things as quality assurance and case management, but only if they have or had a patient relationship with you.

Family and Friends Involved in Your Care: With your written approval, we may disclose your health information to family, friends and others who are involved in your care or in payment of your care. If you are unable to give approval facing an emergency, we may also disclose limited health information to an entity that is authorized to assist in emergency or disaster relief efforts so you family can be notified of your condition, status and location.

Business Associates: Some of our health care operations such as auditing, accreditation, legal services, etc., may be performed through contracts with outside persons or organizations. At times, we may need to give some of our health information to these outside persons or organizations, in all cases; we require these persons or organizations to protect the privacy of your information.

Appointments and Services: We may contact you with reminders or test results. You may request that we provide this information by another means or at another location. For example, if you do not want appointment reminders left on voice mail or sent to a certain address, we will make every effort to accommodate reasonable requests. Please make this request in writing to the Privacy Officer listed at the end of this notice.

Health Products and Services: We may from time to time use your health information to communicate with you about health products and services necessary for our treatment, to advise you of new products and services we offer, and to provide general health and wellness information.

Research: In limited cases, we may use or disclose your health information for research. For example, a research organization may wish to compare all patients that received a certain drug and will thus need to review medical records. In all cases where you specific authorization has not been obtained; your privacy will be protected by strict confidentiality requirements. These requirements arc applied by an Institutional Review Board or privacy board, which oversees the research, or by the representations of the researchers that limit their use and disclosure of patient information.

Other Uses or Disclosures of Information: We are permitted or required by law to make certain other uses and disclosures of your health information without your consent or authorization as follows:

- For any purpose required by law.
- For public health activities, such as required reporting of disease, injury, birth, death, and for public health investigations.
- If we suspect child abuse or neglect or if we think you are a victim of abuse, neglect, or domestic violence.
- To the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls.
- To your employer when we have provided health care to you at the request of your employer to determine workplace-related illness or injury.
- To government agencies conducting audits, investigations, or civil or criminal proceedings.
- If required by subpoena or discovery request; in some cases you will have noticed of such.
- To law enforcement officials as required by law or to report wounds or injuries and crimes.
- To coroners and/or funeral directors consistent with the law.
- If necessary to arrange an organ or tissue donation from you or a transplant for you.
- For certain research purposes when such research is approved by an institutional review board with established rules to ensure privacy;
- In limited instances, if we suspect a serious threat to health or safety.
- If you are a member of the military, as required by armed forces services; we may also release your health information if necessary for national security or intelligence activities.
- To worker's compensation agencies if necessary for our workers compensation benefit determination.
- As required by Ohio law. Ohio law requires that we obtain a consent from you in many instances before disclosing the performance or results of an HIV test **or** diagnoses of AIDS or an AIDS related condition; before disclosing information about drug or alcohol treatment you have received in a drug or alcohol treatment program; and before disclosing information about mental health services you have received.

YOUR RIGHTS AND OBLIGATIONS REGARDING DISCLOSURE

Right to an Accounting of Disclosures: You have the right to an accounting of certain disclosures we have made of your health information after April 14, 2003. Requests must be made in writing and signed by you or your representative. The first accounting in any 12-month period is free; you will be charged our regular fees for each subsequent accounting you request form and a fee schedule from our practice's Medical Records department.

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of you health information for treatment, payment or health care operations. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests as appropriate, and we may terminate an agreed-to restriction if 'we believe such termination is appropriate. We will notify you if we terminate a requested restriction. You may also terminate, in writing or orally, any agreed-to restriction. You may obtain a restriction request form from our practice.

Changes to This Notice: We reserve the right to change the terms of this Privacy Practices as necessary and to make the new Notice effective for all health information maintained by us. You may obtain a copy

of any revised notices at the Canton Urology Registration Desk or a copy may be obtained by mailing a request to the Privacy Office listed below listed at the end of this notice.

Complaints: If you believe your privacy rights have been violated, you may file a complaint in writing or by phone with: E.K. Norch MD 6447 Frank Avenue N.W. Canton Ohio 44720. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retribution for filing a complaint.

Acknowledgement of Receipt of Notice: You will be asked to sign a form that you received this Notice of Privacy Practices.

For Further information about this Notice Contact: Privacy Officer, E.K. Norch MD., 6447 Frank Avenue N.W. Canton Ohio 44720. You have the right to obtain a paper copy of this Notice upon Request. Paper copies may be obtained from the registration Desk or from Privacy Office listed above.

Right to Amend: You have the right to request in writing that the health information we maintain about you be amended or corrected. We are not required to make all the changes/corrections you request; however you will give each request careful consideration. All requests must be in writing, be signed by you or our representative and must state the reasons for the amendment/correction. If an amendment or correction you request is made by us, we may also notify other who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain an amendment request form for our practice's Medical Records department.