Keith A. Knupp, MD, FACS
Board Certified General Surgery

100 Hospital Drive, Suite 109 (740)425-5232
Barnesville, OH 43713 (740)425-5233 FAX

APPOINTMENT DATE:_____
APPOINTMENT TIME:_____

Dear _____:

Enclosed are papers that you must complete before your appointment. Please bring your completed paper work with you at the time of your appointment. If you fail to complete the paper work prior to coming to our office, your appointment will be delayed while you complete the paper work at our office.

Please bring X-ray films or disc, and reports that are related to any problems you are having and you must also bring your correct insurance cards.

If your insurance company requires any referrals or per-authorization from your family physician, please contact your family physician at least one week before your appointment.

If your x-rays were done at Barnesville Hospital they will be in our computer system, so we do not need you to get them. If x-rays are done at any other hospital, you will need to call and pick them up for your appointment.

Thank you for your cooperation in making your visit pleasant and productive.

BELOW ARE SOME IMPORTANT OFFICE POLICIES FOR YOU TO BECOME AWARE OF:
* Patients who are 15 minutes late for an appointment may be required to reschedule for another day.
*A 20% discount is given for cash, check, or money order when “PAID IN FULL” on the date of service.

WE ARE ON THE LOWER LEVEL OF THE MEDICAL CENTER BEHIND THE HOSPITAL.
WE ARE THE FIRST OFFICE ON THE RIGHT WHEN YOU WALK IN THE DOORS.

Keith Knupp, MD, FACS
Board Certified General Surgery
100 Hospital Drive, Suite 109
Barnesville, Oh 43713

PATIENT INFORMATION	TODAY'S DATE:

Last Name_____ First Name_____ MI _____

Address:_____CITY_____State_____ Zip_____

Telephone#_____ Cell#_____ Birthdate_____

Social Security#_____ Drivers License#_____Male/Female(circle one)
Marital Status (circle one) Single Married Separated Divorced Widowed

Employer_____ Employer Phone_____

Employer address:_____City_____State____Zip____

Your Primary Care Physician_____

****

Primary Insurance Company_____ Effective Date_____

Address_____City_____ State_____ Zip_____

Insurance

Subscriber ID#_____Group#_____Phone#_____

Last Name_____First Name_____MI_____

Subscriber Name_____Birthdate_____SS#_____

Subscriber Address_____City_____State_____Zip_____
Relationship to patient (Circle One) Self Spouse Parent Guardian

****

Secondary Insurance Company_____Effective Date_____

Address_____City_____State_____Zip_____

Subscriber ID# _____Group#_____Phone#_____

Subscriber Name_____Birthdate_____ SS#_____

Subscriber Address:_____ City_____State_____ Zip_____

Relationship To Patient: (Circle One) Self Spouse Parent Other

****

PAYMENT RESPONSIBILITY: (Please state the PARENT/ GUARDIAN or RESPONSIBLE PERSON for payment)

Last Name:_____ First Name:_____ MI_____

Address :_____ City_____State_____ Zip_____

Phone Number_____ Social Security #_____
ALTERNATE CONTACT: (SOMEONE OTHER THAN THE ONE LISTED ABOVE)

Name______________________________________Phone#______________________Relationship___________________

RELEASE OF INFORMATION

I give my permission for the office staff to leave a message on my answering machine regarding:

_____ Appointment Reminders
_____ Test Results
_____ Requests for return phone call
_____ No answering machine available or permission not given.

I give my permission for prescriptions and/or refills for medications and/or testing supplies to be called or faxed to my pharmacy:

My pharmacy is: _____
Address: _____
Phone Number: _____

I give my permission for the office staff to speak to:

PERSON	***RELATIONSHIP***	***PHONE NUMBER***
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

REGARDING:

____ Appointment times
____ My medical condition
____ My test results
_____ Any changes in my treatment
_____ Need to return call to Clinic
_____ Other, please specify _____
_____

I give my permission for the office staff to contact me at my place of employment if absolutely necessary:

_____ Permission given _____ Permission denied

I give my permission for the following person to pick up my prescriptions/medications:

PERSON	***RELATIONSHIP***	***PHONE NUMBER***
_____	_____	_____
_____	_____	_____

I give my consent to mail to my home or other designated location, appointment reminders, laboratory requests, prescriptions, or other items that will assist in my care:

_____ Permission given _____ Permission denied

I *DO NOT* give my permission for: _____

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

PATIENT HISTORY

Patient Name:_____ Date:_____

Date Of Birth:_____ Age:_____ Social Security #:_____

Allergies:_____

REASON FOR VISIT:_____

_____

_____

PAST MEDICAL HISTORY:

____Migraines	____ COPD	____ Thyroid Disease
____Stroke	____ Bronchitis	____ Diabetes
____ Seizures	____ Home Oxygen	____ Kidney Disease
____ High Blood Pressure	____ Sleep Apnea	____ Blood in Urine
____ Heart Attack	____ Chronic Cough	____ Blood Clots
____ Heart Arrythmia	____ Anemia	____ Blood Thinner
____ Pacemaker	____ Stomach Ulcers	____ Glaucoma
____Heart Valve Disease	____ Acid Reflux	____ Hernia
____ Chest Pain	____ Abnormal Mammogram	____ Tuberculosis
____ Rheumatic Fever	____ Black or Bloody Stools	____ Breast Lump
____ Congestive Heart Failure	____ Back Trouble	____ AIDS or HIV
____ High Cholesterol	____ Abnormal Pap Smear	____ Weight Loss
____ Blood Transfusion	____ Anxiety Attacks	____ Chickenpox
____ Hives or Eczema	____ Colon Polyps	____ Measles
____ Depression	____ Diverticulosis or Crohn's	____ Polio
____ Pneumonia	____ Hepatitis	____ Mumps
____ Asthma	____ Hemorrhoids	____ Psoriasis

____ Cancer (where)_____

____ Intensive Care Unit Stay:_____

____ Other:_____

_____

PAST SURGERY/PROCEDURES:

____ Open Heart	____ Colonoscopy	____ Bronchoscopy
____ Heart Catheterization	____ Endoscopy	____ Breast Biopsy
____ Pacemaker	____ Skin Biopsy	____ Lung Biopsy
____ Exercise Stress Test	____ Echocardiogram	____ Liver Biopsy
____ Hysterectomy	____ Hip/ Knee Replacement	

____ Abdominal Surgery
(why)_____

____ Other
Surgeries:_____

MEDICATIONS AND DOSAGES:_____
_____
_____

SOCIAL HISTORY:

_____Smoker Years: _____ Packs per day:_____
____ Alcohol Drinks/Week_____
____ Caffeine Cups/Day _____
____ Illegal Drugs

Marital Status/Children:_____
Women Only*:* _____1st Day of last menstrual period.
_____# of Pregnancies _____# of Live Births _____# of miscarriages
Yes or No (please circle) Birth Control _____type

FAMILY HISTORY:

_____ Blood Clots	_____Stroke	____ Heart Disease
_____ Diabetes	_____ High Blood Pressure	____ Asthma
_____ Anemia	_____ Thyroid Disease	____ Kidney Disease
_____ Heart Attacks	_____ Lung Disease	

_____ Cancer (type)_____

_____Other_____Co
mments:

To the best of my knowledge, I certify that all information list above is correct.

Patient Signature_____Date:_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I hereby acknowledge that on _____, I received the Notice of Privacy Practices of Keith A. Knupp, MD, which sets for the ways in which my personal health information may be used or disclosed by Keith Knupp, MD, and outlines my rights with respect to such information.

_____ _____

Patient's Signature Date

For Office Use Only

Employee Initials_____ Date:_____

_____ Signature Not Obtained.

Reason: _____ Patient Refused to sign.

_____ Other _____

Description of attempts made to obtain a signature:

_____

_____

BELMONT PROFESSIONAL ASSOCIATES, INC
dba DR. KEITH KNUPP
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.

This notice also describes how you can:

- Amend your medical information;
- Receive an accounting of disclosure of your medical information;
- Request restrictions on the use and disclosure of your medical information;
- File a complaint if you feel that your privacy rights have been violated.

This notice was developed in accordance with the requirements of 45 CFR Part 164.520 of the Federal Register.

We are required by law to maintain the privacy of out patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to your personal health information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all personal health information maintained by us. You may receive a copy of any revised notice from the receptionist or a copy may be maintained by mailing a request to:

Attention: Office Manager
Dr. Keith Knupp
100 Hospital Drive, Suite 109
Barnesville, Oh 43713

You will be asked to sign an acknowledgement form to confirm thaat you have received this Notice of Privacy Practices.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Except as outlined below, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the

TREATMENT: We will make uses and disclosures of your personal health information as necessary for your treatment. For instance, doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to plan a course of treatment for you that may include procedures, medications, tests, etc.

We may also release your personal health information to another health care facility or professional who is not affiliated with our organization but who is or will be providing treatment to you. For instance, if you are going to receive home health care, we may release your
personal health information to that home health care agency so that a plan of care can be prepared for you.

PAYMENT: We will make uses and disclosures of your personal health information as necessary for the payment purpose of those health professionals and facilities that have treated you or provided services to you. For example, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you or we may use your information to
prepare a bill to send to you or to the person responsible for your payment.

HEALTH CARE OPERATIONS: We will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations, which include clinical improvement, professional peer-review, business and legal management, accreditation, and licensing, etc. We will call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may, from time to time, use your health information to communicate with you about health products and services necessary for your treatment, to advise you of new products and services we offer and to provide general health and wellness information. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have written contract that contains terms that will protect the privacy of your protected health information.

NOTICE OF PRIVACY PRACTICES

RESEARCH: In limited circumstances, we may use and disclose your personal health information for research purposes. For example, a research organization may wish to compare outcomes of all patients that received a particular drug and will need to review a series of medical records. In all cases where your specific authorization has not been obtained, your privacy will be protected by strict confidentially requirements applied by an Institutional Review Board or privacy board which oversees the research or by representatives of the researchers that limit their use and disclosure of patient information.

USES AND DISCLOSURES FOR HEALTH CARE OPERATIONS: We will use and disclose your personal health information as necessary, and as permitted by law, for our healthcare operations, which include clinical improvement, professional peer review, business and legal management, accreditation and licensing, etc.

- For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and care of out patients.

We may also disclose your personal health information to another health care facility, health care professional, or health plan for such things as quality assurance and case management, but only if that facility, progessional or plan also has had a patient relationship with you.

- **Family and Friends Invovled in Your Care:** With your approval, we may from time to time disclose your personal health information to designated individuals who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care.
  - If you are unavailable, incapacitated, or facing an emergency medical situation and we
  - determine that a limited disclosure may be in your interest, we may share limited personal
  - health information with such individuals without your approval.
  - We may also disclose limited personal health information to a pulic or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

- **Business Associates:** Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, legal services, etc. At time it may be necessary for us to provide certain aspects of your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

- **Fundraising:** We may contact you to donate to a fundraising effort for or on your behalf. You have the right to "opt-out" of receiving fundraising materials/communications and may do so by sending your name and address, together with a statement that you do not wish to receive fundraising materials or communications from us to:

  Attention: Office Manager
  Dr. Keith Knupp
  100 Hospital Drive, Suite 109
  Barnesville, Oh 43713

- **Appointments and Services:** We may contact you to provide appointment reminders or test results. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations.

  For instance, if you wish appointment reminders to not be left on your voicemail or sent to a particular address, we will accommodate reasonable requests. You may request such confidential communication in writing and may send your request to:

  Attention: Office Manager
  Dr. Keith Knupp
  100 Hospital Drive, Suite 109
  Barnesville, Oh 43713

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

NOTICE OF PRIVACY PRACTICES

- **Research:** In limited circumstances, we may use and disclose your personal health information for research purposes.

  For example, a research organization may wish to compare outcomes of all patients that received a particular drug and will need to review a series of medical records. In all cases were your specific authorization has not been obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board or Privacy Board which oversees the research or by representatives of the researchers that limit their use and disclosure of patient information.

- **Other Uses and Disclosures:** We are permitted or required by law to make certain other uses and diclosures of your personal health information without your consent or authorization. Federal laws and regulations do not protect any information about suspected abuse or neglect from being reported under State law to appropriate State or Local Authorities. Federal law regulations do not protect any information about a crime committed by you either at our facility or against any person who works for the facility or about any threat to commit such a crime.

  * We may release your personal health information for any purpose required by law.
  * We may release your personal health information for public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigation.
  * We may release your personal health information as required by law if we suspect child abuse or neglect.
  * We may also release your personal health information as required by law if we believe you to be a victim of abuse, neglect, exploitation or domestic violence.
  * We may release your personal health information to the Food and Drug Administration if necessary to report adverse events,product defects, or to participate in product recalls.
  * We may release your personal health information to your employer when we have provided health care to you at the request of your employer to determine workplace-related illness or injury; in most cases you will receive notice that information is disclosed to your employer.
  * We may release your personal health information if required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings.
  * We may release your personal health information if required to so by subpoena or discovery request, in some cases you will have notice of such release.
  *We may release your personal health information to law enforcement officials as required by law to report wounds, injuries and crimes; we may release your personal health information to coroners and/or funeral directors consistent with law.
  * We may release your personal health information if necessary to arrange an organ or tissue donation from your or a transplant for you.
  * We may release your personal health information in limited instances if we suspect a serious threat to health or safety.
  * We may release your personal health information if you are a member of the military as required by armed forces services.
  * We may also release your personal health information if necessary for national security or intelligence activities.
  * We may release your personal health information to workers' compensation agencies if necessary for your workers' compensation benefit determination.

- Ohio law requires that we obtain a consent from you before:
  * Disclosing the performance or results of an HIV test or diagnosis of AIDS or an AIDS-related condition.
  * Disclosing information about mental health services you may have received.

NOTICE OF PRIVACY PRACTICES

RIGHTS THAT YOU HAVE:

- **Access to Your Personal Health Information.** You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative. We will charge you a search
- and copying fee if you request a copy of the information. We will also charge for postage if you request a mailed copy and will charge for preparing a summary of the requested information if you request such a summary. In accordance with the provisions of House Bill 508, the applicable fees for obtaining a copy of your heath information are as follows:
- * Pages 1-10; $1.00 per page
- * Pages 11-50; $0.50 per page
- * Pages 51 & Up; $0.20 per page
- * Records copied from microfiche: $10.00 retrieval fee; $1.00 per page copied
- * Search fees: $5.00 for records maintained on premises; $10.00 for records in off-site
- storage.
- * There is no charge for copies of records required for continuation of your medical care.
- * For copies of your medical information requested by the Bureau of Workman's
- Compensation, the Industrial Commission, the Ohio Department of Job and Family
- Services, or for support of a Social Security disability benefits claim, the first copy will
- be provided at no cost. However, additional copies will be subject to the charges listed
- above.

- **Amendments to Your Personal Health Information:** You have the right to request, in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary.

- **Accounting for Disclosures of Your Personal Health Information:** you have the right to receive an accounting of certain disclosures made by us of your personal 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 a fee of $5.00 for each subsequent accounting you request within the same 12-month period.

- **Restrictions on Use and Disclosure of Your Personal Health Information:** You have the right to request restrictions on certain uses and disclosures of your personal 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 request when appropriate and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed to restriction by sending such termination notices to:
- Attention: Privacy Office — Attention: Office Manager
- Barnesville Hospital Association — Dr. Keith Knupp
- P.O. Box 309, 639 W Main St. — 100 Hospital Drive, Suite 109
- Barnesville, Oh 43713 — Barnesville, Oh 43713

- **Complaints:** If you believe your privacy rights have been violated, you can file a complaint by calling the Barnesville Hospital Complaint Hotline at 740-425-5046. you may send a written complaint to:

Attention: Privacy Officer
Barnesville Hospital Association
P.O. Box 309, 639 W, Main St

Attention: Office Manager
Dr. Keith Knupp
100 Hospital Drive, Suite 109

Barnesville, Oh 43713 Barnesville, Oh 43713

You may also file a complaint with the Secretary of the United States Department of Health and Human Services in Washington, DC in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

NOTICE OF PRIVACY PRACTICES

REQUEST FORMS:

Request forms for Access to Your Personal Health Information, Amendments to Your Personal Health Information, Accounting for Disclosures of Your Personal Health Information and Restricitons on Use and Disclosure of Your Personal Health information can be obtained from:

Attention: Privacy Officer OR Attention: Office Manager
Barnesville Hospital Association Dr. Keith Knupp
P.O. Box 309, 639 W Main St. 100 Hospital Drive, Suite 109
Barnesville, Oh 43713 Barnesville, Oh 43713

FURTHER INFORMATION:

If you have questions or need further assistance regarding this Notice, you may contact the following:

Attention: Privacy Office OR Attention: Office Manager
Barnesville Hospital Association Dr. Keith Knupp
P.O Box 309, 639 W. Main St 100 Hospital Drive, Suite 109
Barnesville, Oh 43713 Barnesville, Oh 43713
email: gramby-1@medctr.osu.edu

As a patient, you retain the right to obtain a paper copy of this Notice of Privacy Practices even if you have requested such a copy by e-mail or other electronic means. Please include your full name and return address when submitting a request by mail or e-mail.

EFFECTIVE DATE:

This Notice of Privacy Practices is effective April 14, 2003.

The terms of this Notice of Privacy Practices apply top Barnesville Hospital Association, operating as a clinically integrated health care – arrangement composed of Barnesville Hospital Home Health, Belmont County Health Services- Morristown Pharmacy and Home Care, Belmont Professional Associates- Morristown Clinic, and Barnesville Hospital Employer Self-Funded Health Insurance Plan. All of the entities listed will share personal health information of our patients as necessary to carryout treatment, payment, and health care operations as permitted by law.

PATIENT RIGHTS

We consider you a partner in our office care. When you are well informed, participate in treatment decisions, and communicate openly with your doctor and other health professionals, you help make your care as effective as possible. Dr. Keith Knupp's Office encourages respect for the personal preference and values of each individual.

While you are in the office, your rights include the following:

- You have the right to considerate and respectful care, including consideration that you psychological, spiritual, and cultural values influence your response to care given.
- You have the right to participate in the development and implementation of your plan of care. You have the right to be well informed about illness, possible treatments, likely outcomes, and unanticipated outcomes, and to discuss this information with your doctor. You have the right to know the names and roles of people treating you.
- You have the right to be free from verbal or physical abuse or harassment.
- You have the right to have an advance directive, such as a living will or durable power of attorney for healthcare and to have Dr. Knupp's staff provide care to comply with these directives.
- You have the right to privacy and to receive care in a safe setting. Your doctor and others caring for you will protect your privacy as much as possible.
- You have the right to expect that treatment records are confidential unless you have given permission to release information or reporting is required or permitted by law. When Dr. Knupp's office releases records to others, such as insurances, it emphasizes that records are confidential.
- You have the right to review and/or copy your medical records and to have the information explained, except when restricted by law.
- You have the right to expect that Dr. Knupp's office will give you necessary health services to the best of their ability. Referral may be recommended. Our staff will make the arrangements for your appointment.
- You have the right to know if Dr. Knupp has relationships with outside parties that may influence your treatment and care. These relationships may be with education institutions, other healthcare providers, or insurers.
- You have the right to consent or decline to take part in research affecting you care. If you choose not to take part, you will receive the most effective care the practice otherwise provides.
- You have the right to know about office rules that affect you and your treatment and about charges and payment methods.
- You have the right to have your pain assessed and managed to the greatest extent possible.
- Dr. Knupp's office encourages you and your family to bring to our attention any concerns, problems, or conflicts you may have during your visit. To express your concerns, please

call (740) 425-5232 and ask to speak with the office manager.