NEW PATIENT BASIC INFORMATION

NAME: DATE:

ADDRESS:

PRIMARY PHONE:
Is this your Home/cell/work phone?

SECONDARY PHONE:
Is this your Home/cell/work phone?

DATE OF BIRTH:

OCCUPATION:

EDUCATION:

EMAIL ADDRESS:

Circle one: Single Married Life Partner Divorced Widowed

Circle one: Female Male

Please explain your main concern(s) prompting you to consult with us:

MEDICAL HISTORY:

Recurring problems:

Major illnesses and/or hospitalizations:

Surgeries:

Current medications (attach list if needed):

Current supplements (attach list if needed):

Recent physicians and other medical professions:

Recent tests and results (bring copies of blood work or reports if possible):

Allergies to medications:

Environmental allergies:

Toxic exposure history:

Trauma (physical and/or emotional):

What are your treatment goals (what do you hope to accomplish as a result of working with us)?

New Patient Basic Information

Spouse/Partner/or Parent Information:

Last Name: First: Initial:

Age: Date of Birth:

Address (if different from above):

Primary Phone: Secondary Phone:

FAMILY HISTORY:

Mother's age:_____ or deceased at age:_____ Medical problems:

Father's age:_____ or deceased at age:_____ Medical problems:

# of Sisters:_____ ages:_____ Medical problems:

# of Brothers:_____ ages:_____ Medical problems:

# of Children:_____ ages:_____ Medical problems:

Others, if significant (grandparents, aunts/uncles, etc.):

Hobbies:

Use of tobacco (now and in the past):

Menthol cigarette use now? YES NO

Caffeine intake (coffee, tea, energy drinks):

Use of alcohol (now and in the past):

Recreational drug use (now and in the past):

Are you concerned about your use of alcohol or other substances?

Do you get regular physical activity/exercise?

Do you have concerns about your diet?

Do you follow any particular diet or have dietary restrictions (vegan, vegetarian, paleo, gluten free, dairy free, soy-free, etc.)?

So you feel safe in your home environment?

TESTING:

When was your most recent:

_____ Blood work

_____ Colonoscopy/Cologuard

_____ Annual physical

_____ Vitamin D screening

_____ Pap/pelvic (women)

_____ Rectal/prostate exam (men)

_____ Mammogram/breast thermogram

_____ Chest CT (smokers, former heavy smokers)

_____ Vaccinations

Please bring copies of any blood-work and/or test results from the last 1-2 yrs.

OR: If you are a patient at any Cleveland Clinic facility, or had any testing done there, you can add Dr. Cseak as one of your doctors in your MyChart. Please see our website ('New Patient Forms' page) for instructions on how to do this. She'll have access to your medical records within a few days.

How did you hear about us?

Preferred Pharmacy
with Phone #:

Preferred Hospital:

Nearest Relative not at your address,
with Phone #:

In case of an emergency, who do we contact?
What is their phone number?

What is their relationship to you?

Do you have a Primary Care Physician (PCP) ____Yes ____ No
Please include PCP information-Including name, phone number, and address/location:

Name/Office:_____

Phone Number:_____

Address:_____

Consent Forms

ALL PATIENTS PLEASE READ AND SIGN IN 4 PLACES BELOW:

Consent for Holistic Medical Care:

I, the undersigned, accepting responsibility for educating myself regarding the major differences between holistic and conventional medical care, do hereby acknowledge my desire and consent to holistic treatment for myself or my dependent (which may include various modalities of treatment, including but not limited to: homeopathy, osteopathy, anthroposophic medicine, etc.).
I understand that by seeking a this approach to treatment that I will be receiving medical care according to the prevailing standard of the relevant holistic medical communities, and that this type of care may not always include the medications, screenings, physical exam, X-rays, blood or other laboratory tests that are the prevailing standard of conventional care.
I understand also that I am financially responsible for my account and/or my dependents account. A copy of this signature is as valid as the original.

Patient Name
(Printed):_____

Signed:_____Date:_____

Medical Malpractice and Medicare:

Karin Cseak, DO, who is a valid certificate holder of a medical license to practice Osteopathic Medicine in the state of Ohio, is not covered by medical malpractice insurance.
Karin Cseak, DO, has opted out of the Medicare program, effective Oct. 1, 2014. Medicare cannot be billed for any services rendered by Dr. Cseak, and the Patient is responsible for all fees incurred for services by Dr. Cseak and/or her staff.
The undersigned acknowledges the receipt of these notices.

Signed:_____Date:_____

Consent Forms

HIPAA Compliance Patient Consent:
Our Notice of Privacy Practices (below) provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent.
The Terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have a right to restrict how your protected health information is used and disclosed for treatment, payment and healthcare operations. The HIPAA (Health insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.
By signing this form, you consent to our use of your protected healthcare as defined above, and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

Circle your answers:

May we phone you to confirm appointments? YES NO

May we leave detailed messages on your answering machine at home or on your cell? YES NO

May we leave detailed messages at your employment? YES NO

May we email to your specified email address personal private health information including but not limited to laboratory reports, treatment, recommendations, relevant scientific articles and medical forms? YES NO

Would you like a copy of our Notice of Privacy Practices?: YES NO

Would you allow us to take a photo for your electronic health record? YES NO

Print name: _____

Signature:_____Date:_____

Permission for Telehealth Visits p.10

What is telehealth?

Telehealth is a way to visit with healthcare providers, such as your doctor or nurse practitioner.

You can talk to your provider from any place, including your home. You don't go to a clinic or hospital.

How do I use telehealth?

- You talk to your provider by phone, computer, or tablet.
- Sometimes, you use video so you and your provider can see each other.

How does telehealth help me?

- **You don't have to go to a clinic to see** your provider.
- You won't risk getting sick from other people.

Can telehealth be bad for me?

- You and your provider won't be in the same room, so it may feel different than an office visit.
- Your provider may make a mistake because they cannot examine you as closely as at an office visit. (We don't know if mistakes are more common with telehealth visits.)
- Your provider may decide you still need an office visit.
- Technical problems may interrupt or stop your visit before you are done.

Will my telehealth visit be private?

- We will not record visits with your provider.
- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- Your provider will tell you if someone else from their office can hear or see you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.
- There is a very small chance that someone could use technology to hear or see your telehealth visit.

What if I want an office visit, not a telehealth visit? **p.11**

You can make an in-person appointment instead.

What if I try telehealth and don't like it?

- You can stop using telehealth any time, even during a telehealth visit.
- You can still get an office visit if you no longer want a telehealth visit. If you decide you do not want to use telehealth again:
    - call 330-923-3060 and say you want to stop, and
    - It will be as if you never signed this form.

How much does a telehealth visit cost?

- A telehealth visit will not cost any more than an office visit for the same time spent.
- If your provider decides you need an office visit in addition to your telehealth visit, you may have to pay for both visits.

Do I have to sign this document?

No. Only sign this document if you want to use telehealth.

What does it mean if I sign this document?

If you sign this document, you agree that:

- You were informed about the information in this document.
- We answered all your questions.
- You consent to a telehealth visit (now or in the future, at your request).

If you sign this document, we will give you a copy upon request.

Your name (please print):

_____

Your signature:

_____ Date: _____