AARON T. SASAKI, M.D.
OHANA MEDICAL AND SPA

441 30th Street Astoria, Oregon 97103

Phone: 503-338-4325 Fax: 877-635-7917

PATIENT INFORMATION

Name _____ SSN _____

Address _____

City _____ State _____

Phone _____ Zip _____

Cell _____ DOB _____

Email _____

FOR PORTAL ACCESS

How did you hear about Dr. Sasaki? _____

_____

Preferred Pharmacy _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____

Phone _____

EMPLOYER INFORMATION

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

PRIMARY INSURANCE

Insurance Company _____ Phone # _____

Insurance ID # _____ Group # _____

Individual Responsible for Primary Insurance

Complete this section only if different from the patient

Name _____ SSN _____

Birth Date _____ Phone _____

Address _____

City _____ State _____ Zip _____

Employer Information

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

SECONDARY INSURANCE

Is patient covered by additional insurance? Yes No

Insurance Company _____ Phone # _____

Insurance ID # _____ Group # _____

Individual Responsible for Primary Insurance

Complete this section only if different from the patient

Name _____ SSN _____

Birth Date _____ Phone _____

Address _____

City _____ State _____ Zip _____

Employer Information

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

ASSIGNMENT AND RELEASE

I hereby certify that I have insurance coverage with the above listed companies and that I assign to Aaron T. Sasaki, M.D. any benefits otherwise payable to me for services rendered in the course of treatment by him. I understand that I am liable fo payment of services whether paid by insurance or not. I authorize my signature on all insurance claims. I authorize Aaron T. Sasaki, M.D. to use my above listed health information and to disclose such information to obtain legal payment from insurance carriers for his services. This consent wil end one year from the date of signature of this form or if I request it in writing prior to that date.

_____ _____

Signature of Patient Date

_____ _____

Print name of Patient, Guardian or Legal Representative Relationship to Patient

rev. 8-2018

HEALTH HISTORY

CONFIDENTIAL

AARON T. SASAKI, M.D.

OHANA MEDICAL AND SPA

Name _____

Birthdate _____ AGE _____

Date of last physical examination _____

What is you reason for this visit? _____

SYMPTOMS Check the symptoms you currently have or have had in the last year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROA
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistant cough
- ☐ Ring in ears
- ☐ Sinus problems
- ☐ Vision-Flashes
- ☐ Vision-Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN ONLY
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN ONLY
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstraul period _____

Date of last Pap Smear _____

Have you had a mammogram YES NO

Are you pregnant _____

Number of children _____

CONDITIONS Check the condition you currently have or have had in the last year.
- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal Disease

MEDICATIONS: List all medications & doses you are currently taking

ALLERGIES & REACTION

TO MEDICATION OR SUBSTAN

All information is strictly confidential

FAMILY HISTORY: Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

check if any blood relatives had/have the following Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Stroke	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

HOSPITALIZATIONS

Year	Hospital	Reason / Outcome

PREGNANCY HISTORY

YR	SEX	COMPLICATIONS

Have you ever had a blood transfusion? YES NO

If yes please give approximate dates. _____

_____

HEALTH HABITS-Check which substances you use and describe how much you use:

	Alcohol	
	Tobacco	
	Drugs	
	Other	

SERIOUS ILLNESS/INJUF	DATE	OUTCOME

OCCUPATIONAL CONCERNS:

Check if your work exposes you to the following

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date

Aaron T. Sasaki, M.D.
Ohana Medical and Spa
441 30th Street Astoria, OR 97103
Phone: 503-338-4325 Fax: 877-635-7917

OFFICE HOURS:

Our office is open by appointment only Monday through Friday from 8 - 12 and 1:20 - 5:00pm with the exception of major holidays. If you need to be seen urgently outside of these hours you should visit your nearest emergency room or urgent care clinic. If you call our office outside of these hours you will reach a voicemail system. Please leave a detailed message. Your call will be returned in a timely manner.

We understand that your time is as valuable as ours. We will make every effort to see you promptly with minimum wait time. In turn, please understand that much paperwork and preparation is done prior to your office visit. **If you need to cancel or change an appointment please do so at least 24 hours prior to appointment. If we do not receive a 24 hour cancellation notification a fee will be billed to you and is due at your next appointment.**

PRESCRIPTION REFILLS:

Due to the volume of refills we are not able to accept phone request from patients. Please contact your pharmacy and they will send us a request to refill your medications. All the local pharmacies are familiar with this procedure and will handle it for you. Please allow three business days for all medication refills.

FINANCIAL POLICIES:

The responsibility for the payment for our services is your direct obligation. We require that you pay your copay at the time of your visit prior to being seen by the doctor. We will bill your insurance for the rest of the cost of services. We accept cash, check, credit and debit cards.

Signature _____ Date _____

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Ohana Medical and Spa
441 30th Street Astoria, OR 97103
Phone: 503-338-4325 Fax: 877-635-7917

ASSIGNMENT AND RELEASE

I hereby certify that I have the insurance coverage presented to Dr. Aaron T. Sasaki, and that I assign to him any benefits otherwise payable to me for services rendered in the course of treatment by him. I understand that I am liable for payment of service whether paid by insurance or not. I authorize my signature on all insurance claims. I authorize Aaron T. Sasaki M.D. to use my insurance and health information to obtain legal payment from insurance carriers for his services. This assignment and release is a permanent agreement to bill for services rendered by Dr. Aaron Sasaki.

Printed Name of Patient _____

Signature _____ Date _____

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NOTICE OF PRIVACY PRACTICES

This notice will describe to you how your personal information may be used to disclosed and how you can access the information. Please review this notice carefully and ask questions if you are unsure about any part of it.

Introduction

Aaron T. Sasaki, M.D. is committed to comply with all legal and ethical guidelines outlined by state and federal agencies regarding your protected health information. This notice will outline the type of information we gather from you and how, when and why we might disclose that information. You will also be notified of your rights regarding your protected health information.

Your Records and Information

Each time you visit the clinic, a record of your visit is added to your patient chart. In this record we will describe your symptoms, exam and test results, your diagnosis and the recommended treatment. Your medical records as kept by us serve as a:

- basis for planning your care and treatment.
- means of communication among the many health professionals who may treat you during your time with us.
- legal document describing the care you received.
- means by which you or a third party payer (i.e. an insurance company) can verify that services billed were provided.
- tool in educating health professionals.
- source of information for public health officials working toward improving state and federal health policies.
- source of data for our planning and marketing
- means of evaluating and improving the care we give thereby improving our results

By knowing what is in your records, you can understand in what ways others may access and use your information. This can help you make more informed decisions when authorizing disclosure to others.

Your Rights to Your Information

Your actual chart and the records contained in it are the physical property of Aaron T. Sasaki, M.D; however, you have the right to the following:

- Obtain a paper copy of this notice upon request. (fee applies).
- Inspect and copy your health record as provided for in 45 CFR 164.524 (fee applies).
- Amend your health record as described in 45 CFR 164.528.
- Obtain a list of all disclosures made of your information as described in 45 CFR 164.528.
- Request communication of your health information by alternate means or at alternate locations.
- Request a restriction on certain uses and disclosures of your information as outlined in 45 CFR 164.522
- Revoke any previous authorizations to disclose or use your information except to the extend that action has already been taken.

Our Responsibilities

Aaron T. Sasaki, M.D is required to:

- Maintain the privacy of your health information.
- Provide you with this notice as to our legal duties and privacy practices with respect to your information.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or locations.

We reserve the right to change our practices and to make the new policies effective for all protected health information. Should our practices change, we will issue to you a revised notice at the most current address in your record. No disclosure of your information will be made without your authorization except where outlined in this notice. We will discontinue any disclosures of your information following a written request to revoke such authorization.

For More Information or to Report a Problem

If you have questions about anything you have read in this notice, you may contact the Practice Manager at 503-338-4325. If you believe that your rights have ben violated, you may file a complaint with the practice's Privacy Office/Practice Manager or with the Office for Civil Rights, U.S. Dept of Health and Human Services. No retaliation will be taken against you for filing a complaint with either office. The address for the Office for Civil Rights is: Office for Civil Rights, U.S. Department of Health and Human Services

200 Independence Avenue S.W. Room 509F, HHH Building Washington, D.C. 20201

Signature:_____ Date:_____

Examples of Disclosures for Treatment, Payment and Health Operations

Treatment Example:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your personal health information. We might disclose your information as necessary to a home health agency that provides care to you. We will also disclose personal information to any physicians who may be treating you when we have the necessary permission from you to disclose such information. This information would be provided to ensure that the physician has the necessary information to diagnose and treat you. We may also disclose your personal health information to another physician or health care provider such as a specialist or lab who at the request of your physician becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment Example:

A bill may be sent to you or your third-party payer and the information accompanying the bill may include information that identifies you as well as your diagnosis, procedures, supplies used and medications prescribed.

Regular Health Operations Examples:

Your personal health information may be used to support the business activities of your physician's practice. These activities include by are not limited to quality assessment, employee performance reviews, training medical students, licensing, marketing and fundraising activities.

Business associates: Some services are provided in our organization through contacts with business associates. Examples of this might be physician services in the emergency room and radiology and certain lab tests. When we contract for these services, we may disclose your health information to our associate so that they can perform the services contracted for and bill the appropriate party. To protect your privacy, we do require these associated to protect your information as well.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care your location and general condition.

Communication with family: Health professionals using their best judgment may disclose to a family member, other relative, or any other individual you identify your information relevant to that persons involvement in your care or payment for your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure that privacy of your information.

Organ procurement organizations: consistent with applicable law, we may disclose health information to organ procurement organizations or any other person involved in the banking or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration: we may disclose to the FDA and information relative to adverse results relating to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacements.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs as established by law.

Public Health: Your information may be disclosed to any public health or legal authority charged with preventing or controlling disease, injury or disability.

Correctional institution: Should you become an inmate of a correctional institution, we may disclose to that institution or their agents any health information necessary for your health and the health and safety of others.

Law enforcement: We may disclose information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards an dare potentially endangering one or more patients, workers or the public.

Signature:_____ Date:_____

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SERVICES CONSENT FORM

I, _____, understand that as part of my health care, **Aaron T. Sasaki,** M.D. originates and maintains paper Electronic Medical Records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment, I understand that this information serves as:

* A basis for planning my care and treatment.
* A means of communication among the many health professionals who contribute to my care.
* A source of information for applying my diagnosis and surgical information to my bill.
* A means by which a third-party payer can verify that services billed were actually provided.
* A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Policies that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

* The right to review the notice prior to signing this consent.
* The right to object to the use of my health information for directory purposes.
* The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that **Aaron T. Sasaki, M.D.** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that **Aaron T. Sasaki, M.D.** reserves the right to change their notice and practices and prior to implementaion, in accordance with Section 164-520 of the Code of Federal Regulations. I may obtain a revised Notice of Privacy Policies by request.

I wish to give permission to disclose and/or replace the following restricitons on the use & disclosure of all my health information.

NAME _____ PHONE _____

NAME _____ PHONE _____

NAME _____ PHONE _____

I understand that as a part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures, via fax.
I fully understand and accept the terms of this consent.

_____ _____ _____

Patient's Signature Date of Birth Date Signed

Aaron T. Sasaki, M.D.
Ohana Medical and Spa

441 30th Street Astoria, OR 97103
Phone: 503-338-4325 Fax: 877-635-7917

Authorization to Receive and Disclose Protected Health Information

Patient's name: _____ Date of Birth: _____

Patient's address: _____

City: _____ State: _____ Zip: _____

I give permission for Aaron T. Sasaki MD, to_____receive _____disclose (check 1)
a copy of the health information listed below to:

Name of Doctor/Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

The reason for using this information or giving it out is:

_____

_____

Information that I give permission to be received or disclosed:

_____ ***The entire record, including those things initialed below:***

(Please put your initials next to the information that can be received or disclosed)

_____ Drug/alcohol diagnosis, treatment, or referral information
_____ Mental health treatment
_____ Genetic testing records
_____ Human Immunodeficiency Virus (HIV) or AIDS Information

_____ **Only give records for the following information or Date(s) of Service:**

(Please put your initials next to the information that can be received or disclosed)

____Drug/alcohol diagnosis, treatment or referral information	____Medication list	____Immunization records
____ Mental health treatment	____List of allergies	____Laboratory results
____Genetic testing records	____Visit/encounter notes	____Billing records
____Human Immunodeficiency Virus (HIV) or AIDS information	____X-Ray report	____Other _____

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I understand that if the person or organization that gets this information is not a healthcare provider or health plan covered by Federal privacy laws, the information listed above could be given out by them and will no longer be protected by those regulations. However, I also understand that Federal or State law may restrict re-disclosure ov HIV/AIDS information, mental health information, genetic testing information and drug/alcohol treatment or referral information.

I understand that I may refuse to sign this form, and that I do not need to sign it to receive healthcare, or in order for payment for healthcare to be made. However, if the health care services are going to be provided solely for the purpose of providing health information to someone else and my signature on this authorization is necessary to make that disclosure, I will not receive these health care services if I refuse to sign.

I understand that I may change my mind and decide to cancel my authorization to use and disclose this protected health information at any time. I understand that if I do that, I need to do it in writing, and I will need to send a letter to the person or organiztion that gave out the information, and who is shown above. I also understand that if I cancel this authorization, the information may have already been received or disclosed before I changed my mind.

I have read this authorization and I understand it. Unless I revoke the authorization sooner, it expires on _____ (Insert the date or the reason that would cancel this authorization.)

_____ _____

Signature of patient, or legal representative Date

_____

Printed name of patient or patient's leaga representative

_____

Legal representative's relationship to the patient