Dr Aaron Sasaki
1355 Exchange Street Suite 3
Astoria, OR 97103

PATIENT INTAKE FORM

PATIENT INFORMATION

Name: _____ Phone_____

Prefers to be called: _____ Gender: ☐ M ☐ F ☐ Other: _____

Marital Status: ☐ Single ☐ Married ☐ Other_____

DOB: _____ SSN: _____

Email: _____

Street Address: _____P.O. Box: _____

City: _____ State: _____Zip Code: _____

Emergency Contact: _____ Emergency Phone: _____

Preferred Pharmacy: _____

How Did You Hear About Us: _____

Employer Information

Name: _____

Phone: _____

Address: _____

City _____ State _____ Zip_____

Dr Aaron Sasaki
1355 Exchange Street Suite 3
Astoria, OR 97103

Primary Insurance

Insurance Company: _____ Phone Number: _____

Insurance ID: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber Employer: _____

Relationship to Subscriber (if not patient): _____

Secondary Insurance

Insurance Company: _____ Phone Number: _____

Insurance ID: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber Employer: _____

Relationship to Subscriber (if not patient): _____

Assignment and Release

I hereby certify that I have insurance coverage with the above listed companies and that I assign Aaron T Sasaki MD any benefits otherwise payable to me for services rendered during treatment by him. I understand that I am liable for payment of services whether paid by insurance or not. I authorize my signature on all insurance claims. I authorize Aaron T Sasaki MD to use my above listed health information and disclose such information to obtain legal payment form insurance carriers for his services. **This assignment and release is a permanent agreement to bill for services rendered by Aaron T Sasaki MD.**

Patient Signature: _____ Date: _____

Print Name, Guardian or Legal Representative: _____

Relationship to Patient: _____

Dr Aaron Sasaki
1355 Exchange Street Suite 3
Astoria, OR 97103

OFFICE POLICIES

Office Hours:

Our office is open by appointment Monday through Friday from 8am-12pm and 1:20pm to 5pm except for 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 these hours, you will reach our voicemail with instructions on how to reach the after-hours provider. You may leave a voice message, but your message will not be addressed until the next business day during operating hours.

When you schedule an appointment with Ohana Medical and Spa we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, no later than 24 hours prior to your scheduled appointment. This allows us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours' notice** will be considered a No Show. For the **FIRST** missed appointment, a **warning letter** will be sent to the patient notifying them of missed appointment. **No fee will be assessed for this missed appointment.**

- Any established patient who fails to show or cancels/reschedule an appointment witho**ut a 24-hour** notice **a SECOND** time will receive a letter and will be charged **a fee of $100.00.**

- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit.**

- If a **THIRD** No Show or cancellation/reschedule **without a 24-hour notice** should occur the patient may be **TERMINATED from care at Ohana Medical and Spa and will be charged a $100.00 fee.**

Dr Aaron Sasaki
1355 Exchange Street Suite 3
Astoria, OR 97103

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee. You may contact Ohana Medical and Spa 24 hours a day, 7 days a week at 503-338-4325. Should it be after regular business hours, Monday through Friday, or a weekend, you may leave a message on our voicemail.

Prescription Refills:

Due to the volume of refills, we do not accept phone requests 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 send us a request. Please allow up to 3 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 service prior to being seen by the provider. We will bill your insurance for the services rendered. If a balance is owed, we will send monthly statements on the 1st of the month. Please pay any balance promptly. We accept cash, check, credit, and debit cards.

By signing below, you agree to the above terms of our Office Policies.

Signature: _____

Date: _____

Dr Aaron Sasaki
1355 Exchange Street Suite 3
Astoria, OR 97103

Services Consent Form

I, _____, understand that as part of my health care, Aaron T Sasaki MD, originates and maintains 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 on my bill.
- A means by which a third-party payer can verify that services billed were 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 MD** 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 acted in reliance thereon. I also understand that by refusing to sign consent or revoking this consent, this organization may refuse to treat me as permitted by Section164.506 of the Code of Federal Regulations.

I further understand that **Aaron T Sasaki MD** reserves the right to change their notice and practices and prior to implementation, 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 restrictions on the use and 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 Signature: _____

Date of Birth: _____ Date Signed: _____

Dr Aaron Sasaki
1355 Exchange Street Suite 3
Astoria, OR 97103

Notice of Privacy Practices

This notice will describe to you how your personal information may be used to disclose 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, MD is committed to comply with all legal and ethical guidelines outlined by state and federal agencies regarding your protected health information (PHI). 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 PHI.

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, exams and tests, 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. 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 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 MD; however, you have the right to the following:

- Obtain a paper copy of this notice upon request (fees apply)
- Inspect and copy your health record as provided for in 45 CFR 164.528 (fees apply)
- 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 extent that action has already been taken.

Dr Aaron Sasaki
1355 Exchange Street Suite 3
Astoria, OR 97103

Our Responsibilities

AARON T SASAKI MD 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 the 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 ne policies effective for all protected health information. Should our practices change, we will issue 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 Office Manager at 503-338-4325. If you believe that your rights have been violated, you may file a complaint with the Office Manager or with the Office for Civil Rights, US 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, Us Department of Health and Human Services, 200 Independence Ave SW Room 509F, HHH Building, Washington DC 20201.

Examples of Disclosure 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 for you. We will also disclose personal information to any physician 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 diagnosis and treat you. We may also disclose your personal health information to another physician or health care provider such as a specialist or laboratory who at the request of your physician becomes involved in your care by aiding 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 Example:

Your personal health information may be used to support the business activities of your physician's practice. These activities include but 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 in the emergency department and radiology and certain lab tests. When we contract for these services, we may disclose

Dr Aaron Sasaki
1355 Exchange Street Suite 3
Astoria, OR 97103

your health information to our associates so that they can perform the services contracted for and bill the appropriate party. To protect your privacy, we do not 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 person's 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 information related 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 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 Institutions: Should you become an inmate of a correctional facility, we may disclose to that facility 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 and potentially endangering one or more patients, workers, or the public.

Signature: _____ Date:_____

Dr Aaron Sasaki
1355 Exchange Street Suite 3
Astoria, OR 97103

HEALTH HISTORY - CONFIDENTIAL

Patient Name: _____ DOB: _____

Date of last Physical Examination: _____

What is your reason for this visit: _____

Health Care Providers in last 5 years:

Name	Physician Specialist	Are you still seeing?
_____	_____	_____
_____	_____	_____

Personal Medical History:

Condition	Yes	No	Condition	Yes	No
Angina			Sleep Apnea		
High Blood Pressure			Seasonal Allergies		
Heart Failure			Bleeding Disorder		
Heart Attack			Blood Clots		
High Cholesterol			Anemia		
Heart Disease			Diabetes		
Pacemaker			Arthritis		
Peripheral Vascular Disease			Lupus		
Migraines			Fibromyalgia		
Kidney Stones			Liver Disease		
Kidney Disease			Chronic Constipation		
Hepatitis B			Acid Reflux/GERD		
Hepatitis C			Colon Polyps		
Cancer Type:			Depression		
Osteoporosis			Anxiety		
Asthma			Drug Abuse		
COPD			Thyroid Disease		
Emphysema			Alzheimer's/Dementia		
Stroke/TIA			Genetic Disorder		
Seizure			Other: _____		

Dr Aaron Sasaki
1355 Exchange Street Suite 3
Astoria, OR 97103

Allergies: (please list type of allergies and describe reaction)

Medication	Reaction

Surgeries: (Please include date)

1._____ **Date:** _____

2. _____ **Date:** _____

3. _____ **Date:** _____

Hospitalizations:

1. _____
2. _____
3. _____
4. _____

Vaccination History: (Please provide date of last vaccination)

Tetanus: _____ Pneumonia: _____ Influenza: _____ Shingles: _____

Medications: (Please list all medications currently taking)

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Dr Aaron Sasaki
1355 Exchange Street Suite 3
Astoria, OR 97103

Health Maintenance:

	Yes	No	Date	Abnormal Yes or No
Colonoscopy				
Mammogram				
Pap Smear				
Dexa Scan				
PSA				

Women's Health

Date of Last Period: _____

Age of Menopause: _____

Pregnancies:

How Many: _____

Live Births: _____

Abortions: _____

Stillbirths: _____

Miscarriages: _____

Social History:

Tobacco Use

- ☐ Non- Smoker
- ☐ Ex-Smoker (Year Quit: ____)
- ☐ Current Smoker (Packs per day _____)
- ☐ E-Cigarettes/Vape
- ☐ Smokeless Tobacco, Current
- ☐ Ex-Smokeless Tobacco

Alcohol Use:

- ☐ Never
- ☐ Occasionally
- ☐ Frequent

Family History

☐ **Adopted, unknown family history**

Disease	Mother	Father	Sister(s)	Brother(s)	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa
High Blood Pressure								
Heart Disease								
Diabetes								
Cancer								
Arthritis								
Colon Polyp								
Depression								
Alcoholism								
Kidney Disease								

Dr Aaron Sasaki
1355 Exchange Street Suite 3
Astoria, OR 97103

Review of Symptoms: (Please check any symptoms you are currently experiencing)

Constitutional

- ☐ Recent Fevers
- ☐ Night Sweats
- ☐ Unexplained weight loss
- ☐ Unexplained weight gain
- ☐ Unexplained fatigue
- ☐ Unexplained weakness

Eyes

- ☐ Change in Vision

Ears/Nose/Throat/Mouth

- ☐ Difficulty Hearing
- ☐ Ringing in Ears
- ☐ Hay Fever
- ☐ Allergies
- ☐ Persistent congestion
- ☐ Trouble Swallowing

Cardiovascular

- ☐ Chest Pain
- ☐ Chest Pressure
- ☐ Palpitations
- ☐ Short of breath w/exertion

Respiratory

- ☐ Cough
- ☐ Wheeze
- ☐ Coughing up blood
- ☐ Coughing up mucus

Musculoskeletal

- ☐ Muscle Pain
- ☐ Joint Pain
- ☐ Recent Back Pain

Skin

- ☐ Rash
- ☐ New Mole
- ☐ Change in Mole

Breast

- ☐ Breast Lump
- ☐ Nipple Discharge

Gastrointestinal

- ☐ Recent Heartburn/reflux
- ☐ Blood in Stool
- ☐ Change in Bowel Movements
- ☐ Nausea
- ☐ Diarrhea
- ☐ Frequent Constipation

Genitourinary

- ☐ Painful Urination
- ☐ Bloody Urination
- ☐ Leaking Urine
- ☐ Frequent nighttime Urination
- ☐ Discharge from penis or vagina
- ☐ Sexual Function Concerns

Neurological

- ☐ Headaches
- ☐ Memory Loss
- ☐ Fainting

Psychiatric

- ☐ Anxiety
- ☐ Stress
- ☐ Sleeping Problems
- ☐ Unusual Sadness

Endocrine

- ☐ Increased Thirst
- ☐ IncreasedAppetite
- ☐ Cold Intolerance
- ☐ Heat Intolerance

I verify that the above information is correct to the best of my knowledge and truthful.

Patient Signature: _____Date: _____

Dr Aaron Sasaki
1355 Exchange Street Suite 3
Astoria, OR 97103

Authorization to Receive and Disclose Protected Health Information

Patient Name: _____ Date of Birth: _____

Patient's Address: _____

City: _____ State: _____ Zip: _____

I give permission for Aaron T Sasaki MD to☐ receive ☐disclose (please mark 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 items 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 of 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	___ Visit/ Encounter notes	___ Billing Records
___ HIV or AIDS Information	___ Radiology Reports	___ Other

Dr Aaron Sasaki
1355 Exchange Street Suite 3
Astoria, OR 97103

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 of 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 for payment for healthcare to be made. However, if the healthcare 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 the 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 will need to send a letter to the person or organization 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 reason that would cancel the authorization)

_____ _____

Signature of Patient or legal representative Date

Printed Name of Patient or patients' legal representative

_____

Legal representative's relationship to the patient

Dr Aaron Sasaki
1355 Exchange Street Suite 3
Astoria, OR 97103