### Yale M. Kadesky, M. D.

# REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| (Please Print) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Today’s date: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PCP: | | | | | | | | | | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s last name: | | | | | | | | | | | | | | | | | | First: | | | | | | | | | Middle: | | | | | | | | | ❑ Mr.  ❑ Mrs. | | | | | ❑ Miss  ❑ Ms. | | | | | | | Marital status (circle one) | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Single / Mar / Div / Sep / Wid | | | | | | | | | | |
| Is this your legal name? | | | | | | If not, what is your legal name? | | | | | | | | | | | | | | | | | | | | (Former name): | | | | | | | | | | | | | | | | | | | Birth date: | | | | | | | Age: | | Sex: | | | | |
| ❑ Yes | | ❑ No | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | / / | | | | | | |  | | ❑ M | | | ❑ F | |
| Street address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Social Security no.: | | | | | | | | | | | | | | | | | | Home phone no.: | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | ( ) | | | | | | | | | | |
| City: | | | | | | | | | | State: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ZIP Code: | | | | | | | | | | | Cell phone no.: | | | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | |
| Occupation: | | | | | | | | | | Employer: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Employer phone no.: | | | | | | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ( ) | | | | | | | | | | | |
| Who referred you to Dr. Kadesky? Please 🗸 one | | | | | | | | | | | | | | | | | | | | | | | | | | | ❑ Dr. | | | | |  | | | | | | | | | | | | | | | | | ❑ Insurance Plan | | | | | | | ❑ Hospital | | |
| ❑ Family/ Friend | | |  | | | | ❑ Internet (where?) | | | | | | | | | | | | | | | | ❑ | | | | | | | | | | | | | | | | ❑ Other | | | | | | |  | | | | | | | | | | | | |
| **\*Email Address**: | | | | | | | | | | | **PHARMACY YOU USE: PHONE #:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| INSURANCE INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (**Please give your insurance card to the receptionist**.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Person responsible for bill: | | | | | | | | Birth date: | | | | | | | | | | | | | Address (if different): | | | | | | | | | | | | | | | | | | | | | | | | | | Home phone no.: | | | | | | | | | | | |
|  | | | | | | | | / / | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | ( ) | | | | | | | | | | | |
| Is this person a patient here? | | | | | | | | ❑ Yes | | | | | | | | ❑ No | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |
| Occupation: | | | | Employer: | | | | | | | | | | | Employer address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Employer phone no.: | | | | | | | | | | | |
|  | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ( ) | | | | | | | | | | | |
| Is this patient covered by insurance? | | | | | | | | | | | | ❑ Yes | | | | | | | | ❑ No | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Please indicate primary insurance** | | | | | | | | | ❑ | | | | | | | | | | | | | | | | | | | | | |  | |  |  | | | |  | | | | | | | | | | | | | | | | | | | | |
|  | | | | |  | | | | | | | | | | | |  | | | | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |
| Subscriber’s name: | | | | | | | | | Subscriber’s S.S. no.: | | | | | | | | | | | | | | | Birth date: | | | | | | | | | | | Group no.: | | | | | | | | | | | | Policy no.: | | | | | | | | Co-payment: | | | |
|  | | | | | | | | |  | | | | | | | | | | | | | | | / / | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | $ | | | |
| Patient’s relationship to subscriber: | | | | | | | | | | | | | ❑ Self | | | | | | | | | ❑ Spouse | | | | | ❑ Child | | | | | | | | ❑ Other | | | | | | | |  | | | | | | | | | | | | | | | |
| Name of secondary insurance (if applicable): | | | | | | | | | | | | | | | | | | | Subscriber’s name: | | | | | | | | | | | | | | | | | | | | | | | | Group no.: | | | | | | | | | | Policy no.: | | | | | |
|  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | |
| Patient’s relationship to subscriber: | | | | | | | | | | | | | | ❑ Self | | | | | | | | ❑ Spouse | | | | | ❑ Child | | | | | | | | ❑ Other | | | | | | | |  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IN CASE OF EMERGENCY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of local friend or relative: | | | | | | | | | | | | | | | | | | | | | | | | | | | | Relationship to patient: | | | | | | | | | | | | | | Home phone no.: | | | | | | | | | | Work phone no.: | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | ( ) | | | | | | | | | | ( ) | | | | | | |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize or insurance company to release any information required to process my claims. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | |  |
|  | **Patient/Guardian signature** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | **Date** | | | | | | | | | | | | | |  |

MEDICAL HISTORY

**NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **TODAY’S DATE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DATE OF BIRTH**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES TO MEDICATIONS**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIST ANY OPERATIONS YOU HAVE HAD:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIST ANY SERIOUS ILLNESS YOU HAVE HAD:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIST YOUR CURRENT MEDICATIONS WITH DOSAGES:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF YOU or ANY FAMILY MEMBERS HAVE HAD ANY OF THE FOLLOWING HEALTH ISSUES**

**PLEASE CIRCLE: YES or NO (***IF YES PLEASE GIVE YOU OR YOUR FAMILY MEMBERS DIAGNOSIS)*

NEUROLOGIC (Seizures, paralysis): YES / NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIGH / LOW BLOOD PRESSURE: YES / NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

KIDNEY/LIVER/UTERIN: YES / NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DIGESTIVE (GERD, Ulcers): YES / NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BONE / JOINT (Arthritis, Osteoporosis): YES /NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MUSCULAR WEAKNESS: YES /NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SKIN (Eczema, Psoriasis, Keloids): YES / NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DIABETES: YES / NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CANCER: YES / NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BLOOD DISORDERS: YES / NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STROKE / HEART CONDITION: YES / NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DRUG / ALCOHOL ADDICTON: YES/ NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIV/AIDS: YES / NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THYROID: YES / NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DO YOU SMOKE TOBACCO: YES / NO IF SO HOW MUCH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WARNING: CIGARETTE SMOKING OR USE OF TOBACCO IS DETRIMENTAL TO WOUND HEALING AND CAN CAUSE THE FOLLOWING: SKIN TO TURN BLACK OR DIE, WOUND TO OPEN UP, INCREASES THE RISK OF INFECTION, AND DRASTICALLY SLOWS WOUND HEALING.**

**DR. KADESKY RECOMMENDS THAT YOU STOP SMOKING OR ANY USE OF TOBACCO. IF YOU CHOOSE TO CONTINUE THE USE OF TOBACCO YOU ARE ACCEPTING ALL RESPONSIBILITY FOR ALL THE ABOVE COMPLICATIONS. (PLEASE INITIAL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)**

**PATIENT SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Yale M. Kadesky, M.D.***

***Statement of Patient Financial Responsibility***

Dr. Kadesky appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

As the patient, you are ultimately financially responsible for the medical services you receive. You are responsible to furnish us with accurate and up to date insurance information. In addition, it is your responsibility to know your insurance benefits, including coverage for the office visits and surgery if applicable.

If you do not have insurance coverage on the date of services:

* The entire cost will be collected at the time the service is provided.

If you have medical insurance:

* You are responsible for co-pays, co-insurance as well as the deductible.
* If your insurance requires referral and/or preauthorization, it is your responsibility to obtain it. If it has not been received before your appointment you will be charged as a cash pay patient or your appointment may be cancelled.
* Co-payments and deductibles are due on the day of service.
* Failure of your insurance carrier to pay claims within 90 days of filling is viewed as a refusal to pay; therefore, you become financially responsible. This usually results when the insurance carrier is holding the claim for review of pre-existing conditions and other insurance information requested from the patient.
* It is our policy to send 2 statements for past due. If payment is not made, a courtesy call will be made to try to make payment arrangements. If it is not resolved, the account will be sent to the collection agency.

**Consent for Treatment and Authorization to Release Information**

I hereby authorize Yale M. Kadesky, M.D., through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessments and treatment procedures.

I further authorize Yale M. Kadesky, M.D., to release to appropriate agencies, any information acquired in the course of my or the above named patient’s examination and treatment.

Patient/Guarantor Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***A MESSAGE TO PATIENTS ABOUT***

***MEDICAL/SURGICAL RISKS***

Medicine and surgery are generally safe, helpful and often lifesaving. However, medical or surgical procedures of any type involve the taking of risks, ranging from minor to serious (including the risk of death.) It is important to be aware of the following possible risks before receiving the treatment you and your physician are planning. The following may be the reactions of your body to medical/surgical operations or procedures:

**1. INFECTION:** Invasion of tissue by bacteria or any other germs occurs to some degree whenever a cut, incision or puncture is made. In most instances, through the natural defense mechanisms of the body, healing of the affected area occurs without difficulty. In some instances antibiotic medicines are prescribed and at times additional surgical measures may be necessary to combat infection.

**2. HEMORRAGE:** The cutting of blood vessels causes bleeding and this occurs in every surgical incision. The bleeding is usually controlled without difficulty. At times, blood transfusions are required to replace blood loss. If blood transfusions are given, there are additional risks of liver inflammation, hepatitis, and the possibility of receiving Acquired Immune Deficiency Syndrome (AIDS). There is no absolutely reliable way to predict these unwanted reactions, some of which may be quite serious and even lead to death.

**3. DRUG REACTIONS:** Unexpected allergies, lack of proper response to mediations or illness caused by the prescribed drugs are possibilities. It is important for you to inform your physician and your anesthesiologist or certified registered nurse anesthetist of any problem you or your family have had with reactions to drugs and which medications you have taken in the past six months, including over-the-counter drugs, **especially** aspirin.

**4. ANESTHESIA REACTIONS:** There may be unusual or unexpected responses to the gases, drugs or methods used to anesthetize you which can lead to difficulties with lung, heart, or nerve function. Eating or drinking before anesthesia increase the risk of vomiting which may cause significant complications. Inform your anesthesiologist or certified nurse anesthetist of problems you and your family have had to anesthesia.

**5. BLOOD VESSEL INFLAMMATION AND BLOOD CLOTTING:** It is impossible to predict the occurrence of blood vessel inflammation and clotting problems. If blood clots form, they can move from where they formed to other areas of the body and cause injury.

**6. INJURY TO OTHER ORGANS:** Because of the closeness of other organs to the area being operated on, there may be injury to other organs. The stress of surgery or the procedure may also harm other organ systems of the body.

**7. OTHER RISKS:** It is not possible to list all the possible risks and complications, and their variations that may arise in any surgical operation or medical procedure. Each situation depends upon the purpose and nature of the operation or procedures. Your physician is willing to discuss further you various details about the risks.

***ALTERNATIVES TO TREATMENT***

Although you and your doctor have decided upon this procedure, do not hesitate to discuss the reasons for the choice and the alternatives available for treatment of your condition, in addition, be sure to ask your doctor any other questions that you may have about your treatment.



**This accredited ambulatory surgery facility presents a Patient Bill of Rights with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his/her physician and the group organization. It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes a new dimension when care is rendered within an organizational structure. Legal precedent has established that the facility itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed.**

*1.* **The patient has the right** to considerate and respectful care.  
2. **The patient has the right** to obtain from his/her physician complete current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information the patient, the information should be made available to an appropriate person in his/her behalf. He/she has the right to know by name the physician responsible for coordinating his/her care.  
3. **The patient has the right** to receive from his/her physician the information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved and the probably duration in incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to know the name of the person responsible for the procedures and/or treatment.  
4. **The patient has the right** to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his/her action.  
5. **The patient has the right** to every consideration of his/her privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. Those not directly involved in his/her care must have the permission of the patient to be present.  
6. **The patient has the right** to expect that all communications and records pertaining to his/her care will be treated as confidential.  
7. **The patient has the right** to expect that within its capacity this accredited ambulatory surgery facility must provide evaluation, service and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he/she has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.  
8. **The patient has the right** to obtain information as to any relationship of this facility with other health care and educational institutions insofar as his/her care is concerned. The patient has the right to obtain formation as the existence of any professional relationships among individuals by name that is treating him/her.  
9. **The patient has the right** to be advised if this accredited ambulatory surgery facility proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects.  
10 **The patient has the right** to expect reasonable continuity of care. He/she has the right to know in advance what appointment times and physicians are available and where.   
11. **The patient has the right** to expect that this facility will provide a mechanism whereby he/she is informed by his/her physician of the patient’s continuing health care requirements following discharge.12. The patient has the right to examine and receive an explanation of his/her bill regardless of the source of payment. The patient has the right to know what facility rules and regulations apply to his/her conduct as a patient.   
No catalog of rights can guarantee for the patient the kind of treatment he/she has a right to expect. This facility has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patients and the conduct of clinical research. All these activities must be conducted with an overriding concern for the patient and above all the recognition of his/her dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient.

**The Patient’s Responsibilities**

It is the patient’s responsibility to fully participate in decisions involving his/her own health care and to accept the consequences of these decisions if complications occur. The patient is expected to follow up on his/her physician’s instructions, take medication when prescribed and ask questions concerning his/her own health care that he/she feels is necessary.