

Brian J. Supple, M.D., F.A.C.S.

Diplomate of the American Board of Surgery
Fellow of the American College of Surgeons
General, Laparoscopic, and Oncologic Surgery

1000 Newbury Road, Suite 285
Newbury Park, CA 91320
(805) 499-7971- phone
(805) 498-4192- fax



COMMITTED TO EXCELLENCE

Privacy Policy for the Office of Brian J Supple, M.D., FACS

Purpose of this policy:

We are required by law to maintain the privacy of your medical information and to provide you with notice of our legal duties, privacy practices and your rights with respect to your medical information. The policy is called the Health Insurance Portability and Accountability Act (HIPAA). Medical information includes medical, insurance, and medical payment information such as your diagnosis, medications, or medical payment history that identifies you.

Who will follow this notice:

This notice pertains to Dr. Supple as well as all office staff.

Uses and disclosures of information without your authorization:

The following are types of uses and disclosures of medical information that includes medical, insurance, and medical payment information such as your diagnosis, medications, or medical payment history.

Treatment

We will use and disclose your medical information for treatment. This includes medical information used by nurses, physicians and others who are involved in your care at this office as well as any hospital or surgery center.

Payment

We will use your medical information for payment purposes. An example would be billing your insurance company; this will include a diagnosis as well as coding for any procedures performed.

Family and friends

Information regarding your medical care may be provided to family and friends with your permission or where it is in your best interest to supply information on

your behalf. An example would be discussing needed care if you are incapacitated due to your condition.

Public health

We may provide the information regarding a medical diagnosis, disease, or treatment for the purpose of preventing or controlling disease, injury, or disabilities.

Health oversight activities

We made disclose medical information for any health oversight agencies authorized by law. These include audits, investigations, inspections, and government agencies/programs.

Judicial, law enforcement, and administrative proceedings

If you are involved in a lawsuit we may disclose medical information about you in response to a court or administrative order.

Workers' compensation

We may release medical information as required and authorized by law for workers' compensation programs.

Individual rights:

You have the right to request a restriction on how we use and disclose medical information for treatment, payment, to certain family members, friends.

Complaints:

If you have concerns about our privacy practices or believe that your privacy rights have been violated, please file a complaint to Dr. Supple directly at the above address. Furthermore, a complaint can be made to the US department of Health and Human services. There will be no retaliation for filing a complaint.

**For more information and summary of the HIPAA Policy Rule, please refer to:
<http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html>**

A handwritten signature in blue ink, appearing to read 'B. Supple', with a long horizontal line extending to the right.

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Please read the following. If you agree to the below statements, please sign and return to the office.

Notice to consumers:

I understand that medical doctors are licensed and regulated by the Medical Board of California. The board can be contacted at 1-800-633-2322. The website is www.mbc.ca.gov.

Assignment of benefits:

I hereby assign Brian J. Supple, MD, FACS any insurance or other third-party benefits available for health care services provided to me. I understand that Dr. Supple has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Dr. Supple, I agree to forward all health insurance and other third-party payments that I receive for services rendered immediately upon receipt to Dr. Supple.

If I do not have insurance, I understand that I am responsible for all bills from the office of Brian J. Supple, MD, FACS for services.

HIPAA Policy

I have been provided a copy of the HIPAA Policy for Dr. Supple.

Signature of Patient/Legal Guardian

Date: _____

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Patient Information

Patient Information

Name (first , middle, last) _____

Address _____

City, State _____ Zip code _____

Date of Birth _____ Age _____ Sex _____ Social Security # _____

Marital Status _____

Home phone _____

Work phone _____ Cell phone _____

Referring physician _____

Nearest Relative _____ Relative's phone _____

Nearest relative's address _____ Zip code _____

If applicable

Employer _____ Employer phone _____

Employer's Address _____

Employer City, State _____ Zip code _____

Occupation _____

Insurance Information

Name of Policyholder- primary insurance _____

Address _____

City, State _____ Zip code _____

Policy number _____ Group number _____ DOB of Policyholder _____

Name of Policyholder- secondary insurance _____

Address _____

City, State _____ Zip code _____

Policy number _____ Group number _____ DOB of Policyholder _____

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Pertinent Medical Information

Reason for Seeing Dr. Supple	<hr/> <hr/> <hr/>
Medications (list all medications, how much, and how often they are taken)	<hr/> <hr/> <hr/> <hr/> <hr/>
Allergies (list all medications that you are allergic to, and the reaction you had to it)	<hr/> <hr/> <hr/>
Medical problems (list all problems with your heart, lungs, kidneys, GI tract, etc.)	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
Past Surgeries (list all surgeries you have had in the past)	<hr/> <hr/> <hr/> <hr/> <hr/>

Smoking & Alcohol use

(list how long you have used either and how much-daily, weekly)

Tobacco Never Smoked _____ years smoking _____ packs per day _____

Alcohol Never used Alcohol _____ Occasionally _____
(whichever applies) Drinks weekly _____ Drinks daily _____

Family History

(list their medical problems, especially cancer and heart disease)

Mother _____
Father _____
Sisters _____
Brothers _____
Daughters _____
Sons _____

Review of Systems

(circle all that apply)

General weight loss/gain fever tiredness night sweats
Eyes recent change in vision temporary blindness
HENT recent head trauma / nasal discharge / throat pain / difficulty swallowing
Cardiac heart attack in past / irregular heart beat / heart valve problems
Pulmonary recent pneumonia / asthma / COPD / emphysema / smoker / steroid use
Gastrointestinal nausea / vomiting / diarrhea / constipation
Genitourinary burning with urination / blood in urine / difficulty voiding
Neurologic stroke / seizures / paralysis
Hematologic anemia / anticoagulant use (Coumadin, Aspirin, Plavix)
Musculoskeletal arthritis / broken bones
Endocrine diabetes / thyroid / steroid use
Integumentary skin cancer / keloid formation / skin infections

Concerns

(Please list any concerns not covered above)

