

***Platinum Surgical Care***  
***Gregg A. Ginsburg, M.D., F.A.C.S.***  
*1455 Highway 61, Suite B, Festus, MO 63028*  
*13303 Tesson Ferry Road, Suite 150, St. Louis, MO 63128*  
*5034 Griffin Road, St. Louis, MO 63128*  
*507 West Pine St., Farmington, MO 63640*  
*Phone number (636)931-4744 or Toll free 877-931-4744*  
*Fax number (636)931-4739*

Welcome to Platinum Surgical Care. You are scheduled for an appointment with

Dr. Ginsburg on \_\_\_\_\_

You will be seen at the following office location:

- 1455 Highway 61, Suite B; Festus, MO 63028
- 13303 Tesson Ferry Rd., Suite 150; St. Louis, MO 63128
- 5034 Griffin Road; St. Louis, MO 63128
- 507 West Pine Street; Farmington , MO 63640

Please complete the enclosed forms and bring them with you to the appointment. For the appointment you will need the following:

- Your insurance card
- A referral if you participate in an HMO.  
If the referral is to be faxed by your Primary Care Provider, please call our office to confirm the referral has been received.
- Please bring a list of your medications for the doctor.
- If you are being seen for a breast mass or lump you will need to pick up your films for the appointment. Please contact the facility 24 hours prior to picking them up.
- Reports of any diagnostic studies and evaluations by another specialist can be brought with you to the appointment or faxed to our office at (636)931-4739
- If you are seeing the physician for a problem that resulted from an injury sustained at work, a motor vehicle accident, or other event, please provide us with the information so that we may obtain authorization for treatment.
- If you have any questions or concerns, please call the office at (636)931-4744 or toll free at 877-931-4744.

Please visit our website at [www.platinumsurgicalcare.com](http://www.platinumsurgicalcare.com)

**PLATINUM SURGICAL CARE**  
**Gregg A. Ginsburg, MD, F.A.C.S.**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:   M     F  

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Social Security # \_\_\_\_\_ Marital Status: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Address of Emergency Contact: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ ID Number: \_\_\_\_\_

Cardholder's name: \_\_\_\_\_ Cardholder's SSN: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Cardholder's date of birth: \_\_\_\_\_

Cardholder's Employer: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID Number: \_\_\_\_\_

Cardholder's name: \_\_\_\_\_ Cardholder's SSN: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Cardholder's date of birth: \_\_\_\_\_

Cardholder's Employer: \_\_\_\_\_

I hereby authorize my insurance benefits, including Medicare & Medicaid, to be paid directly to Gregg A. Ginsburg, MD. This assignment will remain in effect until revoked by me in writing. **I understand that I am financially responsible for all charges, whether or not paid by said insurance. I also understand that failure to provide the proper insurance information or obtain any required insurance plan referrals will result in my acceptance of full financial responsibility for these services.** I hereby authorize said assignee to release all information necessary to secure that payment. In the event this account is assigned to collections, I agree to pay all cost of collection including reasonable attorney fees. It is the policy of Platinum Surgical Care to provide services to all persons without regard to race, color, national origin, religion, sex, age or disability. No person shall be denied the benefits of any service, or to be subject to discrimination because of race, color, national origin, religion, sex, age or disability. If you believe you have been denied a benefit of service because of your race, color, national origin, religion, sex, age or disability, you may file a Complaint of Discrimination with our office, either verbally or in writing

**Signature of Patient or Parent/Guardian** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

MEDICATION NAME	DOSAGE	MEDICATION NAME	DOSAGE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**ANY MEDICATION ALLERGIES?**    **Yes**    **No**    If yes, be specific \_\_\_\_\_

**MEDICAL HISTORY, REASON FOR MEDICATIONS**

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

**PLEASE LIST ANY PREVIOUS SURGERIES, SERIOUS INJURIES, HOSPITALIZATIONS**

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

**PATIENT SOCIAL HISTORY:**

Alcohol use?            Never    Rarely    Moderately    Daily  
Recreational Drug Use?    No    Yes  
Tobacco Use?            No    Yes    Packs per Day \_\_\_\_\_    Do you smoke:    \_\_\_ everyday    \_\_\_ some days, but not everyday  
Are you a:    \_\_\_ Current Smoker    \_\_\_ Former Smoker    \_\_\_ Never a Smoker    Are you interested in quitting?    \_\_\_ Yes    \_\_\_ No  
Caffeine Consumption: \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

	Age	Please list diseases and health history	If deceased, cause of death
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____
Children:	_____	_____	_____

**Authorization to Access Rx History Information: I hereby authorize Platinum Surgical Care to access my historical prescription drug information. Without this authorization we will not be able to prescribe any controlled substances to you.**

**Patient Name** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Preferred Pharmacy** \_\_\_\_\_ **Phone Number** \_\_\_\_\_  
**Location or Address of Pharmacy** \_\_\_\_\_  
**Mail Order Pharmacy** \_\_\_\_\_ **Location** \_\_\_\_\_

**The following information is now being required for Government Reporting purposes. Please complete ALL sections.**

**Race:**            White    Black or African American    Hispanic    American Indian or Alaskan Native    Asian    Other  
\_\_\_\_\_  
**Language:**    English            Spanish            Indian            Other \_\_\_\_\_  
**Ethnicity:**    Non-Hispanic            Hispanic            Other \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**\*CONSTITUTIONAL SYMPTOMS**

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

**\*EYES**

Eye disease or injury	No	Yes
Wear glasses/contact lens	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

**\*EARS\*NOSE\*THROAT**

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

**\*CARDIOVASCULAR**

Heart disease	No	Yes
Shortness of breath with walking or lying flat	No	Yes
Hypertension	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitations	No	Yes

**\*RESPIRATORY**

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

**\*GASTROINTESTINAL**

Loss of appetite	No	Yes
Change in bowel movement	No	Yes
Nausea or vomiting	No	Yes
Rectal Bleeding or blood in stool	No	Yes
Abdominal Pain	No	Yes

**\*BREAST**

Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

**\*NEUROLOGICAL**

Frequent headaches	No	Yes
Lightheaded or dizzy	No	Yes
Convulsions/seizures	No	Yes
Numbness/tingling sensation	No	Yes
Stroke	No	Yes
Head injury	No	Yes

**\*ENDOCRINE**

Glandular/Hormone problems	No	Yes
Thyroid disease	No	Yes
Diabetes	No	Yes

**\*HEMATOLOGIC/LYMPHATIC**

Slow to heal after cuts	No	Yes
Bleeding/bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged Glands	No	Yes

**\*GENITOURINARY**

Frequent urination	No	Yes
Burning/painful urination	No	Yes
Blood in urine	No	Yes
Kidney stones	No	Yes

CURRENT WEIGHT \_\_\_\_\_ HEIGHT \_\_\_\_\_

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**Notice of Privacy Practices Acknowledgement**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices*. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

**Printed Patient Name** \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

To address any special needs you may have and to assure your patient information is kept confidential please answer the following questions:

Other than yourself, do you authorize our office to discuss your health information with another family member or spouse? Circle one      YES      NO

If so, please list names below for our record.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Do you authorize our office to call your home and leave a message about test results or other information on your answering machine?      YES      NO      I don't have a machine

Do you authorize our office to call you at work?      YES      NO      NA

Comments: \_\_\_\_\_

**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Reason: \_\_\_\_\_

Staff Initials: \_\_\_\_\_ Date: \_\_\_\_\_

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**This form will be used to obtain or release medical records when required for treatment or medical care for the below named patient. Please sign and date.**

AUTHORIZATION FORM FOR USE AND/OR DISCLOSURE OF  
PROTECTED HEALTH INFORMATION

**Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to obtain or release protected health information for the purposes described below.

Description of the specific information to be obtained or released: \_\_\_\_\_

\_\_\_\_\_

The persons in our workforce authorized to make the disclosure is: Medical Records Dept.

The person or entity to whom we will disclose the information, and who may use it are:

\_\_\_\_\_.

The purpose for which the use/disclosed information will be used:

\_\_\_\_\_.

- You may refuse to sign this authorization. Your refusal will NOT affect your ability to obtain treatment, payment or eligibility for benefits.
- If the persons who are authorized to receive the information above are NOT health care providers or health plans covered by federal health privacy laws, they may re-disclose that information and those laws would no longer protect it.
- You may inspect or copy the protected health information to be used or disclosed under this authorization. Please send your request to the above address.
- Once you give us this authorization, we can rely on it until you revoke it or, if you have not revoked it, until it expires. You can revoke this authorization by delivering a dated and signed letter to our office at the above location. However, your revocation will not prohibit us from
  - a. any acts we have already taken in reliance of the authorization, or
  - b. any right associated with an insurer's contest of a claim under its policy, if the authorization was obtained in order to obtain insurance coverage. If not revoked, this authorization will expire one year from the date of the signature below.

X \_\_\_\_\_ **Date:** \_\_\_\_\_

Signature (Patient or Legal Representative)

Capacity of Legal Rep. \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES  
For  
Platinum Surgical Care**

**Gregg A. Ginsburg, M.D., F.A.C.S**

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

The Health and Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example would include a physical exam.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree to a requested restriction.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.

- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a copy of the notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 1, 2009, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice or Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

U.S. Dept. of Health and Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
(202)619-0257  
Toll free 1-877-696-6775