

**MARK A. BARTOLOZZI, M.D., F.A.C.S.**  
**JOSEPH J. MAGALSKI, JR., M.D., F.A.C.S.**  
**JOHN A. HARRISON, D.O.**  
**General Laparoscopic & Oncologic Surgery**  
**Certified American Board of Surgeons**

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_ Social Security \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Marital Status: M S W D Sep

If Married Spouse's Name \_\_\_\_\_ Spouse's SSN# \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Relationship \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_

Policy Holder Name \_\_\_\_\_

Employer's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_

Primary Insurance \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Secondary Insurance \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

**Primary Doctor** \_\_\_\_\_ **Phone Number** (\_\_\_\_) \_\_\_\_\_

**Referring Physician** \_\_\_\_\_ **Phone Number** (\_\_\_\_) \_\_\_\_\_

**Medical Reason For your Visit** \_\_\_\_\_

*I CERTIFY THAT ALL OF THE INFORMATION PROVIDED HEREIN IS TRUE AND CORRECT.*

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

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**Do you have any of the following health problems? Please check all that apply to you:**

**Last Name:** \_\_\_\_\_ **First Name** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**HEIGHT** \_\_\_\_\_ **WEIGHT** \_\_\_\_\_

<b><i>Have you had any of the following: (if yes, please circle all that apply)</i></b>	<b>YES</b>	<b>NO</b>	<b>YEAR</b>
Anemia			
Arthritis			
Bleeding problems/Blood Clots			
Cancer (Breast/Colon/Other)			
Diabetes (Insulin or Non-Insulin Dependent)			
Epilepsy or Seizures			
Female problems (ovarian cysts, PID, endometriosis, etc)			
Gallbladder disease (stones, dysfunction, etc.)			
Heart Disease, please specify			
Hepatitis/HIV/Rheumatic Fever			
Hypertension (High Blood Pressure)			
Kidney problems (renal failure, stones or urinary problems)			
Liver problems (cirrhosis)			
Migraine Headaches			
Peripheral Vascular Disease			
Prostate			
Pulmonary Disease (COPD/Emphysema/Asthma)			
Seasonal Allergies, Hay Fever			
Skin Problems (psoriasis, eczema, etc.)			
Stomach problems ( ulcers, GERD, etc.)			
Stroke			
Thyroid Disease/Goiter			
List any other medical problems:			

**Family History (medical problems: cancer, heart disease, diabetes etc.)**

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**SURGICAL HISTORY** If none please indicate: \_\_\_\_\_ Date \_\_\_\_\_


**General Laparoscopic & Oncologic Surgery**

**Last Name:** \_\_\_\_\_ **First Name** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**List all medications that you are currently taking (include over -the-counter and alternative medications), If none please indicate:**

MEDICATION NAME	Dose/How Taken	MEDICATION NAME	Dose/How Taken

**ALLERGIES (to medication, dyes, food etc): If none please indicate:**

Name of Drug/Item	Reaction	Name of Drug/Item	Reaction

Are you currently taking any blood thinners (Coumadin, Plavix, ASA)?    YES    NO  
 If yes, please elaborate: \_\_\_\_\_

**SOCIAL HISTORY**

**YES      NO**

Do you smoke?			# Pack/day:
Have you ever smoked in the past?			Stop date:
Do you drink?			
Number of alcoholic drinks/week?			

**If there are any special concerns you would like to discuss with the doctor, please continue below. Thank you for providing us with this important information.**

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*Patient Signature* \_\_\_\_\_ *Date* \_\_\_\_/\_\_\_\_/\_\_\_\_

**BLOOD THINNERS MUST BE STOPPED 7 DAYS PRIOR TO SURGERY!!!!**

**MARK A. BARTOLOZZI, M.D., F.A.C.S.**  
**JOSEPH J. MAGALSKI, JR., M.D., F.A.C.S.**  
**JOHN A. HARRISON, D.O.**

I understand that I am *financially responsible* for all charges for services to me, provided by Mark A. Bartolozzi, M.D. or Joseph J. Magalski, Jr., M.D., or John A. Harrison, D.O. including the balance remaining after payment of insurance benefits and all costs of collection, including attorney fees and costs.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Signature of patient or Responsible Party* *Date*

I understand that my insurance plan requires a referral for special office visits. I also understand that if I do not have a valid referral in hand, at the time of service, my appointment will be rescheduled or I will be subject to the total cost of my office visit - NO EXCEPTIONS - and I will be considered out of network. I further understand that it is **NOT** the responsibility of General, Laparoscopic & Oncologic Surgery's staff to obtain referrals by telephone, fax or any other method from my PCP.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Signature of patient or Responsible Party* *Date*  
*(If applicable)*

I hereby consent to treatment by Mark A. Bartolozzi, M.D. or Joseph J. Magalski, Jr., M.D. or John A. Harrison, O.D. Treatment would include any office procedures, including injections, excisions and biopsies.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Signature of patient or Responsible Party* *Date*

I authorize the release of information necessary for the filing of any insurance and the direct payment of amounts due, from any insurance claim, to Mark A. Bartolozzi, M.D. or Joseph J. Magalski, Jr., M.D. or John A. Harrison, D.O. This release is applicable to any insurance I now have, and any that I may have in the future.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Signature of patient or Responsible Party* *Date*

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**JOSEPH J. MAGALSKI, JR., M.D., F.A.C.S.**  
**JOHN A. HARRISON, D.O.**  
**2280 Opitz Boulevard, Suite 310**  
**Woodbridge, VA 22191**

**PRIVACY NOTICE**

The Department of Health and Human Services, Office of Civil Rights, under the Public Law 104-191, (The Health Insurance Portability and Accountability Act of 1996) (HIPPA), MANDATE THAT WE ISSUE THIS NEW REVISED Privacy Notice to our patients. This notice to our patients meets all current requirements as it relates to Standards for Privacy of Individually Identifiable Health Information (IIHI); affecting our patients. You are urged to read this notice.

Our Privacy Notice informs you of our use and disclosure of your Protected Health Information (PHI), defined as: “any information, whether oral or recorded in any form or medium, that is, created or received by a covered entity, that relates to the past, present or future physical or mental health condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual that identifies the individual or, with respect to which there is reasonable basis to believe that the information can be used to identify the individual”.

Our office will use or disclose your PHI for purposes of treatment, payment and other healthcare operations. It is our policy to control access to your PHI to only those who have a need to know; and even in cases where access is permitted, we exercise a “minimum necessary information” restriction to that access.

An Authorization differs from a Privacy Notice in that it is very specific with respect to the information allowed to be disclosed, or used, the entity to which the information may be disclosed, the intent for which it may be disclosed, and the time frame of the authorization and used only for one specific request for information. In the event of a non-healthcare related request for personal health information this office will insist that the requestor have you complete an Authorization form.

You, as our patient, may restrict the use or disclosure of an Authorization at any time and all use and disclosure and administration of related healthcare services will be revised accordingly, with the exception of matters already in process as a result of prior use of your PHI. To revoke an Authorization you must provide this office with a written request with your signature and date and provide instructions regarding existing Authorization or consent. Any revocation will not apply to information already used or disclosed. If you had a “personal representative” initiate an Authorization you may revoke that authorization at any time.

You may request to examine your healthcare information, may request copies of your information, and may request amendments to your information. The physician or principal will exercise professional judgement with regard to requests for amendments and by law may reject the request. If we agree with the request to amend the information, we will abide by the changes.



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To all patients with secondary insurance coverage:

We are having increasing problems getting claims paid by patients' secondary insurance companies. Often they do not even respond to our claims or they pay the patient directly. Because of this situation, we have instituted the following policy.

We will file all secondary insurance claims once only. All follow-up on secondary claims will be the patient's responsibility. Keep the explanation of benefits from your primary insurance company (including Medicare) and you can use these to refile your claims.

After one claim is submitted, the balance becomes the patient's responsibility.

Please sign below to indicate that you have read and accepted this policy.

***Patient Signature*** \_\_\_\_\_ ***Date*** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Refusal to sign this agreement mean that we will not file any secondary claims for you.**