JAMES A. TOTORO, M.D.

FINANCIAL POLICY

Thank you for choosing us as your health care provider. The physicians and staff are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. This statement of Financial Policy must be read and signed by you prior to any treatment. Furthermore, all patients must complete the Patient Information Form before seeing the physician.

All co-pays, deductibles and co-insurance are due at the time services are rendered.

If you have a past due balance that is sent to an outside source for collections, an additional 35% of the past due balance will be your responsibility to pay along with any court costs or legal fees. This may be a collection agency, small claims court, or civil court, dependent upon the decision of Dr. Totoro's office.

We accept cash, checks, Visa or Mastercard.

Regarding Insurance:
The balance on your account is still your responsibility whether your Insurance company pays or not. We cannot bill your Insurance Company unless you give us your Insurance information.
Your Insurance policy is a contract between you and your insurance company. In some cases, if you fail to pay the provider your co-pay, deductible, and co-insurance, your Insurance Company can terminate your coverage.
If your Insurance Company has not paid your account in full within 90 days from the date services are rendered, the balance will automatically be transferred to your responsibility.
Please be aware that some, and perhaps all, of the services provided by the physician may be non-covered services and not considered reasonable and necessary under your medical insurance.

Due to recent problems with Insurance coverages, you must inform us if your Insurance or your Primary Care Provider changes. If you fail to notify us about any changes, you will be responsible for all charges incurred.

I, _____, have read the above information and agree with the terms of the Financial Policy.

Signature: _____ ***Date:*** _____

Hernia Questionnaire

Name: _____ Date: _____

1. When did you first notice this hernia or pain? _____
   _____

2. Did this occur on the job? Yes___ No___
   If yes, did you notify your supervisor? Yes___ No___
   What were you doing when the pain happened?_____
   _____

3. Bulge? Yes___ No___
   If yes, Left___ Right___

4. Pain? Yes___ No___
   if yes, burning___ stinging___

5.

Does pain:	Increase	Decrease	Doesn't change
with exercise	_____	_____	_____
with lifting	_____	_____	_____
with bowel movement	_____	_____	_____
with coughing/sneezing	_____	_____	_____

6. Previous hernia repair? Yes ___ No ___
   If yes, Left___ Right___
   Dates including year_____

7. Bowels regular? Yes ___ No ___

8. Blood in stools? Yes ___ No ___

8. Black tarry stools? Yes ___ No ___

10. Pain going down your leg? Yes ___ No ___

YOUR NAME:_____

DOB:_____

WHO REFERRED YOU TO OUR OFFICE:_____

PHARMACY NAME:_____

PHARMACY ADDRESS:_____

PHARMACY PHONE NUMBER:_____

PLEASE LIST ALL MEDICATIONS PRESCRIBED OR OVER-THE-COUNTER INCLUDING <u>DOSAGE</u> AND FREQUENCY: _____

_____

_____

_____

_____

_____

_____

DO WE HAVE YOUR CONSENT TO PULL YOUR MEDICATION HISTORY FROM SURESCRIPTS? _____YES OR _____NO

PLEASE LIST ANY DRUG ALLERGIES AND <u>REACTION</u>:

_____

_____

_____

PLEASE LIST ANY PAST SURGERY AND DATE:

_____

_____

_____

_____

_____

_____

_____

HEIGHT:_____ **WEIGHT:**_____

Patient Information Sheet

JAMES A. TOTORO, M.D.

Date: ____ - __ - ____ **Please Print**

Patient Name: _____ Sex: M F

Date of Birth: ____ - __ - ____ Age: ____ SSN: _____

Marital Status (Circle One) M S D W Race: _____

Patient Address: _____

City: _____ ST: _____ Zip: _____

Home Ph: ( ) _____ Work Ph: _____ Cell/Pgr: _____

Referring Physician: _____ Phone: ( ) _____

Employer: _____

Work Address: _____

City: _____ ST: _____ Zip: _____

Spouse Name: _____ SSN: _____

Date of Birth: ____ - __ - ____ Work Ph: ( ) _____

Spouse Employer: _____

Work Address: _____ City/ST/Zip: _____

Emergency Contact (Outside home) _____ Phone: ( ) _____

Do you have insurance? (Check One) Yes____ No____ *** Please present insurance card to receptionist. ***

Name of Primary Insurance _____ Secondary: _____

Policy Holder Name _____ Policy Holder Name _____

Answer the following if patient is under the age of 21

Mother's Name: _____ SSN: _____

Mother's DOB ____ - __ - ____ Work Phone: _____

Employer: _____ Address: _____

Father's Name: _____ SSN: _____

Father's DOB ____ - __ - ____ Work Phone: _____

Employer: _____ Address: _____

Authorization for services / Please read the following and sign at the bottom of this form.

I hereby authorize payments directly to the Physician, staff, or facility for medical services rendered. I understand I am responsible for any portion of my bill not covered by my insurance company, whether as a co-pay, co-insurance, deductible, or a non-covered service. I understand office co-pays are due at the time services are rendered. I also understand all the above and state that the information provided herein is true and correct to the best of my knowledge.

Signature: _____ ***Date:*** _____

Acknowledgement of Receipt of Notice of Privacy Practices.

This acknowledges I have received the Notice of Privacy Practices from my provider

Signature: _____ ***Date:*** _____

James A. Totoro, M.D.

13321 North Meridian, #400
Oklahoma City, Oklahoma 73120
405-608-6868 405-463-3326 FAX

HISTORY AND PHYSICAL

PATIENT NAME :_____ Age: _____

CC:_____

_____

HPI: _____

_____

_____

_____

Doctor's Initials _____

All **medicines** patient is currently taking (including nonprescription drugs) and the dosage: ☐None

_____

_____

_____

_____

_____

All **allergies** (foods, drugs, environment): ☐ None

_____

_____

_____

All previous **operations** and the year they occurred: ☐ None

_____

_____

_____

_____

_____

PMH Comments:

_____

_____

_____

Doctor's Initials _____

Referring Doctor _____

Patient Name_____

HISTORY AND PHYSICAL

PAST MEDICAL HISTORY: Have you ever had the following: (Circle "no" or "yes")

HABITS:

Do you smoke now? ☐no ☐yes Number of packages per day? _____ Number of years you have smoked? _____
Have you ever smoked? ☐no ☐yes I quit ___ yrs ago, # of packs per day___ #yrs smoked___
Do you drink alcohol? ☐no ☐yes Amount per week? _____ I quit _____ years ago.

Have you ever had the following: (Circle "no" or "yes")

Arthritis	no yes	Heart disease	no yes	Epilepsy	no yes
Diabetes	no yes	Tuberculosis	no yes	Hemorrhoids	no yes
Cancer	no yes	Venereal disease	no yes	Glaucoma	no yes
Blood or plasma transfusion	no yes	Migraine headaches	no yes	Bladder infections	no yes
Hernia	no yes	Asthma	no yes	Back trouble	no yes
AIDS or HIV+	no yes	High or low blood pressure	no yes	Bronchitis	no yes
Hives or eczema	no yes	Stroke	no yes	Mitral valve prolapse	no yes
Ulcer	no yes	Hepatitis	no yes	Thyroid disease	no yes
Kidney disease	no yes	Pneumonia	no yes	Bleeding tendency	no yes

Date of last chest x-ray: _____
Date of last EKG: _____
Please list any other diseases not included above:_____
_____

FAMILY HISTORY: Has any member of your immediate family had any of the following:

(Circle "no" or "yes")

		Relationship			Relationship
Cancer	no yes	_____	Stroke	no yes	_____
Tuberculosis	no yes	_____	Epilepsy	no yes	_____
Diabetes	no yes	_____	Allergies	no yes	_____
Heart disease	no yes	_____	Anemia	no yes	_____
High blood Pressure	no yes	_____	Bleeding tendency	no yes	_____
Asthma	no yes	_____	Chronic lung disease	no yes	_____
Drug abuse	no yes	_____	Alcohol abuse	no yes	_____
Mental illness	no yes	_____	Leukemia	no yes	_____
Migraines	no yes	_____	Obesity	no yes	_____
Thyroid disease	no yes	_____	Ulcer	no yes	_____
Depression	no yes	_____	High cholesterol	no yes	_____
Kidney disease	no yes	_____	Glaucoma	no yes	_____
Gout	no yes	_____			

List family members below with age, or age at death. If living, list present state of health. If deceased, list the cause of death:

Father _____
Mother _____
Brothers and Sisters_____
Spouse_____
Children_____

REVIEW OF SYSTEMS: Do you have now or have you had within the past month any of the following: (Circle "no" or "yes")

Weakness or paralysis	no yes	Muscle cramps or spasms	no yes	Tire easily or weak	no yes	Backaches	no yes
Recent weight change	no yes	Swollen joints	no yes	Change in appetite	no yes	Chest pains	no yes
Sensitivity to cold	no yes	Palpitations/fluttering heart	no yes	Persistent fever	no yes	Leg cramps	no yes
Night sweats	no yes	Enlarged veins	no yes	Skin rash	no yes	Heartburn	no yes
Skin trouble or changes	no yes	Frequent belching	no yes	Headaches	no yes	Nausea	no yes
Change in nails or hair	no yes	Abdominal cramping	no yes	Vomiting	no yes	Eye pain	no yes
Easy bleeding	no yes	Double vision	no yes	Blurred vision	no yes	Vomited blood	no yes
Chronic diarrhea	no yes	Infected eyes	no yes	Chronic constipation	no yes	Glasses/contacts	no yes
Rectal bleeding	no yes	Black tarry stools	no yes	Ringing in the ears	no yes	Dark urine	no yes
Yellow jaundice	no yes	Ear pain	no yes	Hemorrhoids	no yes	Seizures	no yes
Decrease in hearing	no yes	Frequent nosebleeds	no yes	Memory loss	no yes	Frequent colds	no yes
Dizziness	no yes	Sinus trouble	no yes	Sleeplessness	no yes	Loss of Smell	no yes
Depression	no yes	Persistent hoarseness	no yes	Poor coordination	no yes	Sore throat	no yes
Frequent urination (day)	no yes	Sore tongue and gums	no yes	Frequent urination	no yes	Chronic cough	no yes
Increase in thirst	no yes	Shortness of breath	no yes	Painful urination	no yes	Bloody sputum	no yes

Drug Allergies:_____
_____

PATIENT PORTAL

If you would like the ability to view online your health information within four business days of being seen, please supply us with your e-mail address and we will send you an invitation to our patient portal.

NAME: _____

DOB: _____

E-MAIL ADDRESS: _____

YOUR EVALUATION IS IMPORTANT TO US!

Dear Patient,

It is the goal of Dr. Totoro to make your experience with us the best it can be. Would you help us by completing and returning this evaluation at the time of your post-op visit? Please, feel free to comment as you feel necessary. **THANK YOU!!**

Name of Patient:

_____

APPOINTMENT SCHEDULING

Did you receive appointment instructions?	___Y ___N
Were they given in a manner in which you understood?	___Y ___N
Were all of your questions answered?	___Y ___N
Were you notified of your financial responsibility prior to the appointment?	___Y ___N
Was the scheduler courteous and efficient?	___Y ___N

DAY OF APPOINTMENT

Was the staff responsive to all of your needs?	___Y ___N
Was the atmosphere comfortable and pleasing?	___Y ___N
Were all of your questions answered?	___Y ___N
Was the receptionist courteous and efficient?	___Y ___N
Did you feel that you were made to wait too long, at any time?	___Y ___N

Comments:

_____

_____

_____

SURGERY SCHEDULING

Did you receive pre-operative instructions?	___Y ___N
Were they given in a manner in which you understood?	___Y ___N
Were all of your pre-surgical questions answered?	___Y ___N
Were you notified of your financial responsibility prior to the day of surgery?	___Y ___N
Were your financial arrangements discussed courteously?	___Y ___N
Were you satisfied with the arrangements?	___Y ___N

GENERAL

Is there anything you feel we could have done to make your visit with us more comfortable?

If you required surgery in the future, would you choose Dr. Totoro? ___Y ___N

If no, why?

THANK YOU! YOUR COMMENTS AND SUGGESTIONS FOR IMPROVEMENT ARE MOST WELCOME. WE WOULD LIKE FOR YOU TO WRITE A REVIEW ON ONE OF THE DOCTORS' WEBSITES SUCH AS HEALTHGRADES, ETC.

James A. Totoro, M.D.
13321 N. MERIDIAN #400
OKC, OK 73120
(405) 608-6868
Fax: (405) 463-3326