

**PATIENT INFORMATION FORM**

ACCT # \_\_\_\_\_  
DOCTOR \_\_\_\_\_ LOC \_\_\_\_\_  
PATIENT LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: ( ) \_\_\_\_\_ CELL PHONE: ( ) \_\_\_\_\_

DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: M F SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

MARITAL STATUS: SINGLE/MARRIED

REFERRING DR.: \_\_\_\_\_ PRIMARY CARE DR.: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK # \_\_\_\_\_ EXT. \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

NAME OF INSURANCE \_\_\_\_\_

NAME OF POLICYHOLDER \_\_\_\_\_ DOB \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

INSURED'S SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ EMPLOYER \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

NAME OF INSURANCE \_\_\_\_\_

NAME OF POLICYHOLDER \_\_\_\_\_ DOB \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

INSURED'S SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ EMPLOYER \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMERGENCY CONTACT: NAME \_\_\_\_\_

PHONE NUMBER ( ) \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

If you have had prior uninterrupted insurance coverage, please give us the name of the insurance company. \_\_\_\_\_

Job related injury (Y/N) Automobile related injury (Y/N)

- \* I authorize the release of medical information to other physicians participating in my care.
- \* I authorize the release of medical information to the insurance companies listed above for the purpose of processing my insurance claims.
- \* I authorize that any benefits due be made payable to Surgical Associates of the Mid-Cities.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Surgical Associates of the Mid-Cities  
**HEALTH HISTORY**

(please print / all answers are confidential)

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Cell: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F Ht: \_\_\_\_\_ Wt: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Dr's Phone #: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Dr's Phone #: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_  
\_\_\_\_\_

When did your problem start? \_\_\_\_\_ Work related injury? yes / no

Symptoms: (check if you have any of the following)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> weight loss / gain - _____ lbs | <input type="checkbox"/> nausea / vomiting          | <input type="checkbox"/> fainting                   |
| <input type="checkbox"/> fevers / night sweats          | <input type="checkbox"/> change in bowel habits     | <input type="checkbox"/> leg pain with exertion     |
| <input type="checkbox"/> fatigue                        | <input type="checkbox"/> black / bloody stool       | <input type="checkbox"/> leg swelling               |
| <input type="checkbox"/> enlarged lymph glands          | <input type="checkbox"/> difficulty urinating       | <input type="checkbox"/> short of breath / wheezing |
| <input type="checkbox"/> swallowing difficulty          | <input type="checkbox"/> breast lump                | <input type="checkbox"/> numbness / weakness        |
| <input type="checkbox"/> heartburn                      | <input type="checkbox"/> change in mole/skin lesion | <input type="checkbox"/> anxiety / nervousness      |
| <input type="checkbox"/> indigestion                    | <input type="checkbox"/> chest pain with activity   | <input type="checkbox"/> snoring                    |
| <input type="checkbox"/> abdominal pain                 | <input type="checkbox"/> palpitations               | <input type="checkbox"/> daytime sleepiness         |
| <input type="checkbox"/> other (please describe) _____  |   |   |

Medical History: (check if you currently have or if you have had any of the following in the past)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> anemia                    | <input type="checkbox"/> heart surgery / stints | <input type="checkbox"/> pacemaker                   |
| <input type="checkbox"/> arthritis                 | <input type="checkbox"/> hepatitis              | <input type="checkbox"/> peripheral vascular disease |
| <input type="checkbox"/> arrhythmias               | <input type="checkbox"/> hernia                 | <input type="checkbox"/> pneumonia                   |
| <input type="checkbox"/> asthma                    | <input type="checkbox"/> hiatal hernia          | <input type="checkbox"/> polio                       |
| <input type="checkbox"/> bleeding disorders        | <input type="checkbox"/> high cholesterol       | <input type="checkbox"/> prostate problems           |
| <input type="checkbox"/> circulation problems      | <input type="checkbox"/> HIV                    | <input type="checkbox"/> psychiatric care            |
| <input type="checkbox"/> diabetes                  | <input type="checkbox"/> high blood pressure    | <input type="checkbox"/> rheumatic / scarlet fever   |
| <input type="checkbox"/> dialysis                  | <input type="checkbox"/> kidney disease         | <input type="checkbox"/> stroke                      |
| <input type="checkbox"/> emphysema / COPD          | <input type="checkbox"/> liver disease          | <input type="checkbox"/> thyroid problems / goiter   |
| <input type="checkbox"/> gout                      | <input type="checkbox"/> migraine headaches     | <input type="checkbox"/> tuberculosis                |
| <input type="checkbox"/> heart disease             | <input type="checkbox"/> multiple sclerosis     | <input type="checkbox"/> ulcers                      |
| <input type="checkbox"/> other (please list) _____ |   |  |

Surgical History: (Please list all previous operations) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Please Turn Over to Complete Other Side)

Family History:

(which members of your family have had any of the following : cancer / heart disease / diabetes / high blood pressure / stroke / other)

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Marital Status:    single    stable relationship    married    widowed    separated    divorced

Are you Pregnant?    yes / no (# weeks) \_\_\_\_\_    LMP \_\_\_\_\_    Children: (# /ages) \_\_\_\_\_

Occupation: \_\_\_\_\_

Exercise: type: \_\_\_\_\_    minutes/day \_\_\_\_\_    days/week: \_\_\_\_\_

Habits:

Tobacco:    yes / no    # of packs/day \_\_\_\_\_    # of years used: \_\_\_\_\_    date quit: \_\_\_\_\_

Alcohol:    none    drinks/day \_\_\_\_\_    drinks/week \_\_\_\_\_    drinks/year \_\_\_\_\_

Drugs:    yes / no    type: \_\_\_\_\_    date quit: \_\_\_\_\_

Allergies / Reactions to Medications: \_\_\_\_\_

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Medications: (prescription / over the counter / vitamins / supplements)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

# Surgical Associates of the Mid-Cities

## FINANCIAL POLICY

SURGICAL ASSOCIATES OF THE MID-CITIES recognizes the need for a clear understanding between patient and surgeon regarding payment for surgical care. The following information is provided to avoid any misunderstanding concerning payment for professional services.

- **Payment:** If your deductible or out of pocket expense that is your responsibility has not been met, we expect payment when services are rendered. You are exempt from this policy if your primary insurance carrier is Medicare or a managed care insurance that requires only a co-payment at the time of service. **EVEN THOUGH INSURANCE WILL BE FILED, YOU ARE RESPONSIBLE FOR ANY BALANCE AFTER INSURANCE PAYMENTS HAVE BEEN MADE.** All charges for treatment become due and payable (90) days after the date of service. This period allows sufficient time to process the insurance claim and allows you time to make payment in full of any remaining balance.
- **Nurse/ Surgical Assistant Fees:** Your surgeon may have his nurse, or one of his partners in the operating room, acting as a first assistant. The first assistant's presence helps your operation proceed in a safe and timely manner. Your insurance will be billed for the assistant's services and you may be financially responsible for a portion of the assistant's charges after the insurance company has paid your allowable.
- **Self-payment (Private, Cash payment):** If you have no insurance coverage, we ask that you coordinate your care with our business office prior to your surgery. We require an advance payment for professional services.
- **Managed Care:** All Managed Care co-payment amounts are due at the time of service.
- **Medicare:** We are participating providers with the Medicare program and accept as payment. If you have secondary insurance to cover the 20% portion of charges, please provide us with a copy of both insurance cards.
- **Children of Divorced Parents:** Responsibility of payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of Surgical Associates of the Mid-Cities.
- **IT IS YOUR RESPONSIBILITY TO ENSURE THAT THE PHYSICIAN YOU ARE SEEING IS PART OF YOUR INSURANCE NETWORK. It is also required that you OBTAIN AND HAVE AT THE TIME OF YOUR VISIT ANY REFERRAL REQUIRED BY YOUR PLAN.** Failure to obtain this referral may deem your medical treatment as "Out of Network" by your insurance company and you will be responsible for a larger amount of the charges. We will obtain pre-certifications required for your office procedures and surgeries.
- **Collections:** I understand that I am financially and legally responsible for all charges. I further agree that should I not pay the balance within thirty (30) days after the statement due date, my account will be considered delinquent. I agree to pay the costs, collection agency fees and interest, which shall accrue at the maximum rate allowed by law.
- **General Consent for Treatment:** I consent to and authorize Surgical Associates of the Mid-Cities to treat any condition that I might have and seek to have treated.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature  
(If patient is a minor under 18 years of age)

\_\_\_\_\_  
Date

Patient Name: \_\_\_\_\_  
Please PRINT

Acct. # \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), 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 acknowledge that I have received 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* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *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.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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### 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:

Date:	Initials:	Reason:
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# SURGICAL ASSOCIATES OF THE MID-CITIES

## Pre-existing Condition Responsibility Acceptance Form

Surgical Associates of the Mid-Cities accepts and files insurance as a courtesy to our patients. If it is determined that a patient requires surgery to improve their condition, it is the patient's responsibility to make sure that their diagnosis is not considered pre-existing. Verifying this prior to your surgery is most beneficial to you, the patient. If a surgical procedure is performed and your insurance company denies the claim due to the diagnosis being a pre-existing condition, the patient automatically becomes responsible for the balance of the account. The patient and this office must work together to attain correct insurance information for the benefit of all parties involved.

I, \_\_\_\_\_, understand that if my insurance carrier deems my illness pre-existing that I, \_\_\_\_\_, will be solely responsible for the balance due to Surgical Associates of the Mid-Cities.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

# SURGICAL ASSOCIATES OF THE MID-CITIES

Date \_\_\_\_\_

Dear Patient:

Your surgeon, \_\_\_\_\_, may have a nurse, physician's assistant, or one of his partners in the operating room, acting as a first assistant. The first assistant's presence helps your operation proceed in a safe and timely manner. Your insurance will be billed for the assistant's services and your insurance may determine that you may be financially responsible for a portion of the assistant's charge after the insurance company has paid your allowable.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

SURGICAL ASSOCIATES  
OF THE MID-CITIES

**AUTHORIZATION FOR RELEASE  
OF  
PATIENT HEALTH CARE INFORMATION**

**PATIENT NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **DATE OF REQUEST:** \_\_\_\_\_

**I hereby request this practice is authorized to release and disclose the following healthcare information contained in my medical records:**

- **History of illness, injury or condition for which I am being treated**
- **Previous history unrelated to the condition for which I am being treated**
- **Examination findings, diagnosis, test results, medication**
- **Treatment plan**
- **Medical recommendation**
- **Other** \_\_\_\_\_

**I authorize the information be released to** \_\_\_\_\_  
**when medically necessary.**

**I understand that I have the right to terminate this authorization at any time in writing or verbal instruction.**

**I also understand that this practice has the right to override my decision when it is medically necessary.**

\_\_\_\_\_  
**Signature of Patient**

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