MEDICAL HISTORY: Today's Date:____________ Updated:__________

Patient Name:_________________ DOB:______ Age:___ Weight:___ Height:____

Referring Physician:____________________ Primary Care Physician:________________

Reason for Visit (Chief Complaint):____

Significant Medical Problems:	Medications: Please list dose and frequency:
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.

Non-Prescribed Meds/Supplements/Vitamins:_________________________________

____

List ALL Past Surgeries you have had and approximate date

1.	2.
3.	4.
5.	6.
7.	8.

ALLERGIES: Are you allergic to any medicines, tape, latex, etc.? (please list)

____

SOCIAL HISTORY:

Do you Smoke?___ If so, how many per day?_____ Quit smoking, when?__________

Do you drink alcohol?____ If so, how often?_________ Marijuana use: Y of N

Are you on any type of special diet, if so please describe:_______________________

FAMILY HISTORY: Please indicate if any family members had/has any of the following:

Gallbladder Problems:________________ Reaction to Anesthesia:______________
Bleeding or Clotting Problems:_____________ Breast Cancer:________________
Heart Attacks:___________________________ Ovarian Cancer:_______________
Diabetes:_______________________________ Colon Cancer:_________________
Hypertension:___________________ Any other Cancer:____________________

Please list anything else your physician should know about your family's health:

____

MEDICAL HISTORY/REVIEW OF SYSTEMS:

Name:____________________

Date:______Updated:______

****PLEASE FLIP PAGE TO COMPLETE****

Are you currently or have you in the past been Diagnosed and/or treated for any of the Following?

Neurological/Head/Eyes/Ears/Nose:

- ☐ **Numbness or Tingling**
- ☐ **Decrease in strength**
- ☐ **Stroke**
- ☐ **Headache**
- ☐ **Eye Symptoms**
- ☐ **Ear Symptoms**
- ☐ **Nasal Symptoms**

Musculoskeletal/Skin:

- ☐ **Back Pain**
- ☐ **Neck Pain**
- ☐ **Joint Pain, localized**
- ☐ **No feeling or sensation**
- ☐ **Rashes**
- ☐ **Arthritis**
- ☐ **Fracture**
- ☐ **Osteoporosis**
- ☐ **Joint Replacement**

Endocrine:

- ☐ **Feeling tired or poorly**
- ☐ **Excessive Thirst (Polydipsia)**
- ☐ **Diabetes**
- ☐ **Thyroid Disorders**
- ☐ **Hyperparathyroidism**

Pulmonary:

- ☐ **Wheezing**
- ☐ **Shortness of Breath**
- ☐ **Coughing up Blood (hemoptysis)**
- ☐ **Bronchitis**
- ☐ **Pneumonia**
- ☐ **Pulmonary Embolism**
- ☐ **Tuberculosis**

Cardiovascular:

- ☐ **Heart Murmur**
- ☐ **Chest Pain or Discomfort**
- ☐ **Palpitations**
- ☐ **CHF**
- ☐ **Heart Attack**
- ☐ **Hypertension**
- ☐ **Pacemaker/Defibrillator**
- ☐ **Heart Valve Replacement**
- ☐ **Rheumatic Fever**

Communicable Diseases:

- ☐ **Malaria**
- ☐ **HIV/AIDS**
- ☐ **Hepatitis**
- ☐ **Sexually Transmitted Disease**
- ☐ **Tuberculous**

Name:______________________

Genitourinary:

- ☐ Kidney Disorders
- ☐ UTI
- ☐ Kidney Failure
- ☐ Prostate Problems
- ☐ Uterine Disorders
- ☐ Ovarian Disorders
- ☐ Other Genitourinary Symptoms

Gastrointestinal:

- ☐ Abdominal Pain
- ☐ Nausea and/or Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colitis
- ☐ Diverticulitis
- ☐ Hiatal Hernia
- ☐ Esophageal Reflux
- ☐ Irritable Bowel
- ☐ Ulcer
- ☐ Pancreatitis
- ☐ Hemorrhoids/Rectal Pain/Bleeding
- ☐ Cirrhosis
- ☐ Jaundice
- ☐ Bowel/Bladder Changes
- ☐ Gallstones
- ☐ Other Gastrointestinal Symptoms

Breast:

- ☐ Nipple Discharge
- ☐ Breast Lump
- ☐ Breast Pain
- ☐ Other Breast Symptoms

Blood Immune:

- ☐ Swollen Glands in the neck
- ☐ Anemia
- ☐ DVT
- ☐ Lupus

Cancer:

Type:______________________

Treatment:______________________

Location:______________________

Psychological Symptoms:

- ☐ Feeling Nervous
- ☐ Anxiety
- ☐ Depression
- ☐ Other Psychological Symptoms

Constitutional:

- ☐ Fever
- ☐ Chills
- ☐ Weight Change
- ☐ Night Sweats

SurgOne, P.C.

PATIENT INFORMATION

Requesting/Referring Physician________________ **Primary Care Physician**________________

Name (Legal): *Last*:__________ *First*:__________ *M.I.*____ Nickname:__________

Address:________________ *City*:__________ *State*:____ *Zip*:______

Sex: M / F *Martial Status*: S / M / W / D *Date of Birth*: ____ ____ ____ (MM DD YYYY) *Age*:______

Race: __________ ***Ethnicity:*** __________ ***Language Spoken at Home*** __________

Phone*: *Home ( ) __________ ***Work*** ( ) __________ ***Cell/Pager*** ( ) __________

Patient's Employer:________________ ***Patient's Occupation***:________________

Employer's Address:____________________ Employer's Phone #:__________

Person Responsible for Payment of Services (If different from Patient):________________

Emergency Contact: Relative/Friend, **not living with you** (In case we are unable to contact you, or need to contact someone regarding your care in an emergency).

Contact:________________ Phone #:__________ Relationship to Patient:__________

Address:____________________ City:__________ State:____ Zip:______

INSURANCE INFORMATION

Legible Copy of Ins. Card **Copy of Driver's License**

PRIMARY Insurance:____________________ ***Subscriber ID#***:__________

Group#__________ ***Mailing Address (for claims)***:____________________

Policy Holder Name____________________ ***Relationship***: Self / Spouse / Child / Other______

Policy Holder DOB:________ ***Ins. Phone #:*** ( )__________ ***Employer carrying insurance***:__________

If Accident:☐ WorkComp or ☐ Auto: Date of Injury __________ Claim No.________________

SECONDARY Insurance:____________________ ***Subscriber ID#***:__________

Group#__________ ***Mailing Address (for claims)***:____________________

Policy Holder Name____________________ ***Relationship***: Self / Spouse / Child / Other______

Policy Holder DOB:__________

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES. I WILL FURNISH THIS OFFICE WITH ALL INFORMATION NECESSARY TO BILL MY INSURANCE. ANY BALANCE AFTER INSURANCE HAS PAID OR DENIED IS DUE BY ME. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE REASONABLE COST OF COLLECTION, TO INCLUDE ATTORNEY FEES. I UNDERSTAND THAT MY INSURANCE BENEFITS AND REFERRAL REQUIREMENTS ARE MY RESPONSIBILITY AND THAT ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE.

I HEREBY ASSIGN MY RIGHT AND AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO SURGONE FOR THESE SERVICES AND ALL FUTURE CLAIMS AND I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ALL FUTURE CLAIMS.

X______________________________(Signed) Date:________________

SurgOne, P.C.

Protected Health Information and Communication Consent

Your physician and/or the staff may at times need to contact you and/or discuss your care with those persons whom you give us consent to do so. By completing the information below, we will be better able to serve you.

In an effort to protect your privacy and follow new federal guidelines, we have developed a policy regarding leaving medical care messages and/or discussing your care with others:

- We will ***NOT*** leave messages on voice mail or answering machines ***UNLESS WE HAVE WRITTEN PERMISSION TO DO SO.***
- We will ***NOT*** discuss your care with others ***UNLESS WE HAVE WRITTEN PERMISSION TO DO SO.***

PATIENT NAME: ______________________________ Birth Date:________________

		May we leave a message?		May we discuss your care?	
HOME PHONE:	____________________	Yes	No	Yes	No
WORK PHONE:	____________________	Yes	No	Yes	No
CELL PHONE:	____________________	Yes	No	Yes	No
EMAIL*:	______________________________			Yes	No

(*Please note that most standard email addresses (yahoo, comcast, hotmail, aol, etc)are not secure/HIPAA compliant. By writing in your email above and circling YES, you are giving us permission to contact you via unsecure email).

Please carefully consider with whom we may leave messages and/or whom you wish to have us communicate with in regards to your medical and/or billing information:

Spouse or Partner	Yes	No	If yes, name:______________________________
Son or Daughter	Yes	No	If yes, name:______________________________
Mother or Father	Yes	No	If yes, name:______________________________
Friend/Neighbor	Yes	No	If yes, name:______________________________
Other	Yes	No	If yes, name:______________________________

Notes:____

Voice mail or answering machine messages may include the following information:

Specific information regarding my surgery/treatment	Yes	No
Scheduling for Lab/Test/Surgery	Yes	No
Results for Lab/Test/Surgery	Yes	No

I fully understand that this consent will remain valid until revoked in writing by me.

SIGNATURE:____ **DATE:**_______________

Revised 03/01/2017

SURGONE, P.C. FINANCIAL POLICY

Thank you for choosing SurgOne, P.C. for your healthcare. In order to achieve our goal of providing and maintaining a good physician-patient relationship, we believe it is important to have solid financial policies in place. We also believe that these policies will allow us to provide our patients with high quality, cost-effective care. We ask that you carefully read and sign the following SurgOne, P.C. Financial Policy prior to your treatment.

- Upon arrival, please sign in at the front desk and present your current health insurance card as well as your driver's license or another acceptable form of ID. You may be asked to present both of these items at each visit for proper identification.
- If you do not have health insurance coverage, choose to bill your own insurance, or if our physicians do not participate in your health insurance plan, payment IN FULL is due at the time of service. Acceptable forms of payment are cash, check, VISA and MasterCard.
- You are responsible to make complete insurance information available to SurgOne, P.C. for accurate filing of claims. Complete insurance information includes current benefit cards (primary and secondary), proper identification, and referrals from other providers if applicable.
- You are responsible for checking with your insurance plan regarding any co-payment, deductible or co-insurance that you may owe at the time of service.
- Co-payments are a contractual obligation with your insurance company. You are required to pay your co-payment, and we are required to collect your co-payment at the time of each visit. Co-payments are collected prior to service.
- If the insurance information that you provide at the time of your visit is incorrect, you will be responsible for payment of your visit and to submit the charges to the correct plan.
- For indemnity-type health insurance plans, insurance payments received by SurgOne, P.C. will be applied to your account and you agree to pay the balance.
- If you have a HMO or PPO health insurance plan and our SurgOne, P.C. physicians participate in your plan, we will accept payment from the carrier for services covered by your benefit plan.
- Not all services provided by our office are covered by every health insurance plan. Any service determined NOT to be covered by your plan will be your responsibility.
- SurgOne, P.C. is committed to providing the best treatment for our patients; however, you are responsible for any unpaid balance regardless of your insurance company's arbitrary determination of usual and customary rates.
- For scheduled appointments, prior balances must be paid prior to the visit.
- We require 48-hour notice for canceling any appointments. A cancelation fee may apply.
- A $20 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
- A $35 fee is required for the completion of patient forms regarding disability insurance, life insurance and FMLA.

- If you undergo a surgical procedure, in addition to a bill from your surgeon, you may also receive bills from the hospital or surgical center, the anesthesiologist, pathology/lab and/or radiology, depending on the procedure.

______ If you have a surgical procedure that requires the use of a surgical assistant, SurgOne, P.C. may not bill for those services. You will receive a separate bill from the surgical assistant. Most insurance companies do not have contracts with surgical assistants, therefore your assistant may be out of network. The surgical assistant may or may not be covered by your health insurance plan. If you have specific questions regarding surgical assistant services or whether an assistant will be required for a specific surgical procedure, please let your provider or the staff know.

Initial

- **It is your responsibility to know your healthcare benefits and coverage limitations.**

We will be happy to address any questions you may have after reading our Financial Policy. Please let our staff know if you would like a copy of this policy.

I have read and understand SurgOne, P.C.'s Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as outlined in the above policy. I agree to pay for all services rendered not covered by my insurance and to notify this office should there be any change to my health insurance coverage.

____
Patient's Printed Name

______________________________ ______________________________
Patient Signature Date

______________________________ ______________________________
Legal Guardian Printed Name Relationship to Patient

______________________________ ______________________________
Legal Guardian Signature Date

SurgOne, P.C. Cancellation Policy

At SurgOne, P.C. ("SurgOne"), we strive to render care in a timely and prompt manner. When a patient misses a scheduled appointment, or cancels an appointment with minimal notice, not only is that time lost, but it negatively impacts our ability to schedule other patients that require medical care. SurgOne has thus adopted the following Cancellation Policy. By signing below, you hereby acknowledge and agree to the following:

- Any patient that fails to show up for a scheduled appointment, or cancels a scheduled appointment with less than 48 hours' notice, will be charged a Cancellation Fee.
- Cancellation Fees can range from $25.00 up to $200.00 depending on the length of the appointment and the specialty of the provider with whom it was scheduled. SurgOne can provide the exact amount of a Cancellation Fee at the time an appointment is scheduled.
- All outstanding Cancellation Fees must be paid in full prior to the scheduling of a patient's next appointment with SurgOne.
- Patients are <u>solely</u> responsible for the payment of Cancellation Fees, not insurance companies, Medicare, or other third-party payers.
- Any patient who, in a given 12-month period, misses three or more scheduled appointments, or cancels three or more scheduled appointments with less than 48 hours' notice, may be dismissed as a patient from SurgOne.

I have read and understand the above SurgOne Cancellation Policy and I agree to be bound by its terms.

____
Patient Signature

____
Patient Name

____
Date

SurgOne, P.C.

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT

I acknowledge that I am in receipt of the Notice of Privacy Practices for SurgOne, P.C.

____
Print Name

________________________________ ____________________
Signature Date