FOREST
General Surgery

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name Last First Middle	Birthdate ___/____/_______	Age Sex

Is this your legal name? □ YES □ NO	Marital Status: Single Married Widow Legally Separated	Home Phone Number ( )	Cell Phone Number ( )

Mailing Address: City State Zip Code	Social Security Number: ______- ___-_______

E-Mail Address	Employer: Fulltime Parttime Unemployed Retired

Student Status: □F – Full-Time Student □P – Part-Time Student □N – Not a Student
School Attended:

Race: □American Indian/Alaska Native □Asian □White □Hispanic □African American □Other □Declined
Ethnicity: □Hispanic or Latino □Not Hispanic or Latino □Declined
Language: □English □Spanish □Indian □Japanese □Chinese □Korean □French □German □Russian

Pharmacy: Cite/State: _____________	Do you have a living will? □ YES □ NO

Referred By (Please check one box)
□ Dr. _____________ □ Insurance □ Hospital □ Family □ Friend □Yellow Pages □ Other ________

PCP Name	Phone #

INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Is this visit for one of the following? □ WORKERS COMPENSATION (WC) □ MOTOR VEHICLE ACCIDENT (MVA)
□ ACCIDENT DATE _________________________

Does the patient have healthcare coverage? □ YES □ NO	Insurance Name

Name of Insured	Social Security Number	Birth Date	Effective Date	Group ID	Subscriber ID (Policy Number)
	- -	/ /	/ /		

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other __________________

Name of Secondary Insurance	Name of Insured	Date of Birth	Group ID	Subscriber ID (Policy Number)
		/ /		

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other __________________

HIPPA Acknowledgement, Patient Consent and Financial Policy

I. ***CONSENT FOR TREATMENT:*** I hereby consent to the performance of such diagnostic procedure and/or medical treatment as deemed necessary or advisable by my physician(S). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis B and C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me because of treatments or examination. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

II. ***NOTICE OF PRIVACY PRACTICES:*** Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing this acknowledgement. The terms of our notice may change; if we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office. The clinic provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPPA).

____________ (Patient Initials) The Patient understands that:

- The practice has a Notice of Privacy Practices and that the patient can review this notice.
- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the notice of privacy practices.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. Please note that this does not allow these individuals to obtain copies of my medical records without a complete and valid authorization from me.

Name	**Relationship**	**Contact Number**

III. ***ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION:*** I authorize the clinic to provide a copy of the medical record of my treatment, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care providers(s) or facility(ies) to facilitate my treatment and continuity of care. I understand that inform/ration disclosed under this paragraph my include among other things, confidential HIV-related information and other information relating to sextually transmitted or communicable disease, information relating to drug or alcohol abuse or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this episode of care, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the clinic, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will automatically expire one year after the date on which my current treatment episode comes to an end.

IV. ***PARTICIPATION IN HEALTH INFORMATION:*** Federal and state laws may permit this clinic to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that my include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I hereby authorize Forest General Surgery to provide a copy of my medical record or portions thereof to any health information exchange or network with which Forest General Surgery participates and to any other participants in such health information exchange or network for purposes of treatment, payment, health care operations, and the purposes discussed above, and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or networks with which Forest General Surgery participates may be found in the Notice of Privacy Practices, which is available on the clinic website, and this list may be updated from times to understand that information disclosed under this paragraph may include, among other things, confidential HIV related information and other information relating to sexually transmitted or mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the privacy officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already. been released under this authorization. This authorization will expire upon revocation.

V. ***EMAIL AND TEXT COMMUNICATION:*** If at any time I provide an email or text address at which I may contracted, I consent to receive calls and text messages, including but not restricted to communications regarding billing and payments for items and services, unless I notify Forest General Surgery to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer-assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication from Forest General Surgery, its affiliates, contractors, servicers, clinical providers, attorneys, or agents, including collection agencies. Practice may contact me via email and/or text messaging to remind me of an appointment, to obtain feedback on my experience with the practice; s healthcare team, and to provide general health reminders/information.

VI. ***FINANCIAL POLICY:***The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fee and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided.

- The clinic will file your insurance as a courtesy to you; however, you are responsible for the entire bill. All co-payments, unmet deductibles, and other patient responsible services must be paid at the time of visit. If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. IF you do not have insurance, payment is full will be expected at the time of visit.
- In the event your insurance company does not pay the claim within a reasonable amount of time (45-60), you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.
- If your insurance plan required a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.
- Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

PATIENTS CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUESTS: If I am covered by Medicare and Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I request that payment of assignment benefits by made on my behalf.

I acknowledge receipt of the HIPAA Acknowledgement and Consent Form. I further Acknowledge that I have been given the opportunity to ask question.

_____________________________________ ____________________

(Signature of Patient or Representative) **(Date)**

Clinic Staff Use Only

○ Check if patient refused to take a copy of the Notice of Privacy Practices

State Reason for refusal, if known:

_____________________________________ ___________________

Staff Signature **(Date)**

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to **Forest General Surgery, PC**. When you schedule an appointment with **Forest General Surgery, PC**, we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective June 1, 2021, any established patient who fails to show/cancel/reschedule an appointment and has not contacted our office with at least 24 hours' notice will be considered a No Show and charged a $25.00 fee.
- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hours' notice a second time will be charged a $50.00 fee.
- If a third, No Show or cancellation/reschedule with no 24-hour notice should occur the patient may be dismissed from **Forest General Surgery, PC**.
- Any new patient who fails to show for their initial visit will not be rescheduled.
- Any patient that is scheduled for a surgical procedure and fails to show/cancel/reschedule within 24 hours will not be reschedule and will be charged a $75.00 fee.
- The fee is charged to the patient, not the insurance company, and is due by patients next scheduled or appointment or when patient receives billing statement.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee with evidence of circumstances. You may contact **Forest General Surgery, PC** at (276) 228-1050 during our regular hours Monday-Thursday 8:30am to 5pm and Friday 8:30am to 12pm, we are closed daily for lunch from 12 pm to 1pm. Should it be after regular business hours Monday through Friday, or a weekend, you may call and leave a message on our nurses' line at 276) 617-2215.

Forest General Surgery, I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

______________________________ ______________________________

Signature (Parent/Legal Guardian) (Date)

______________________________ ______________________________

Staff Signature (Date)

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
Previous or referring doctor:		**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Screening History	☐Colonoscopy Date ____/_____/_____ Were there Biopsies taken: Yes or No	Facility: ________________________
	☐Mammogram Date: _____/____/_____	Facility: __________________________

List any medical problems that other doctors have diagnosed

Surgeries/Hospitalizations

Year	Surgery	Hospital

List your prescribed drugs and over-the-counter drugs (Please inform us if you are on any blood thinners)

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Type of Reaction

HEALTH HABITS AND PERSONAL SAFETY

Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	How many drinks per week?					
	Have you considered stopping?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – ________ pks. /day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit	Are you thinking about quitting?		☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

Do you have a family history of Colon Cancer or Breast Cancer? If so, please state below the relationship of family member, type of cancer, and age of family member when diagnosed. (please be as thorough as possible)	☐ Yes	☐ No

Relationship of Family Member	Age of Family Member at time of Diagnosis	Type of Cancer

WOMEN ONLY

Is your visit today concerning any abnormalities to the breasts? *If so, please continue with questions below. If not, please continue to next section.*		
Age at onset of menstruation:		
Date of last menstruation:		
Have you ever taken birth control medication?	☐ Yes	☐ No
At what age did you start taking birth control medication? _________ Years Old		
Have you ever taken any hormone replacement therapy?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No