Denver Esophageal & Stomach Center

SurgOne, PC

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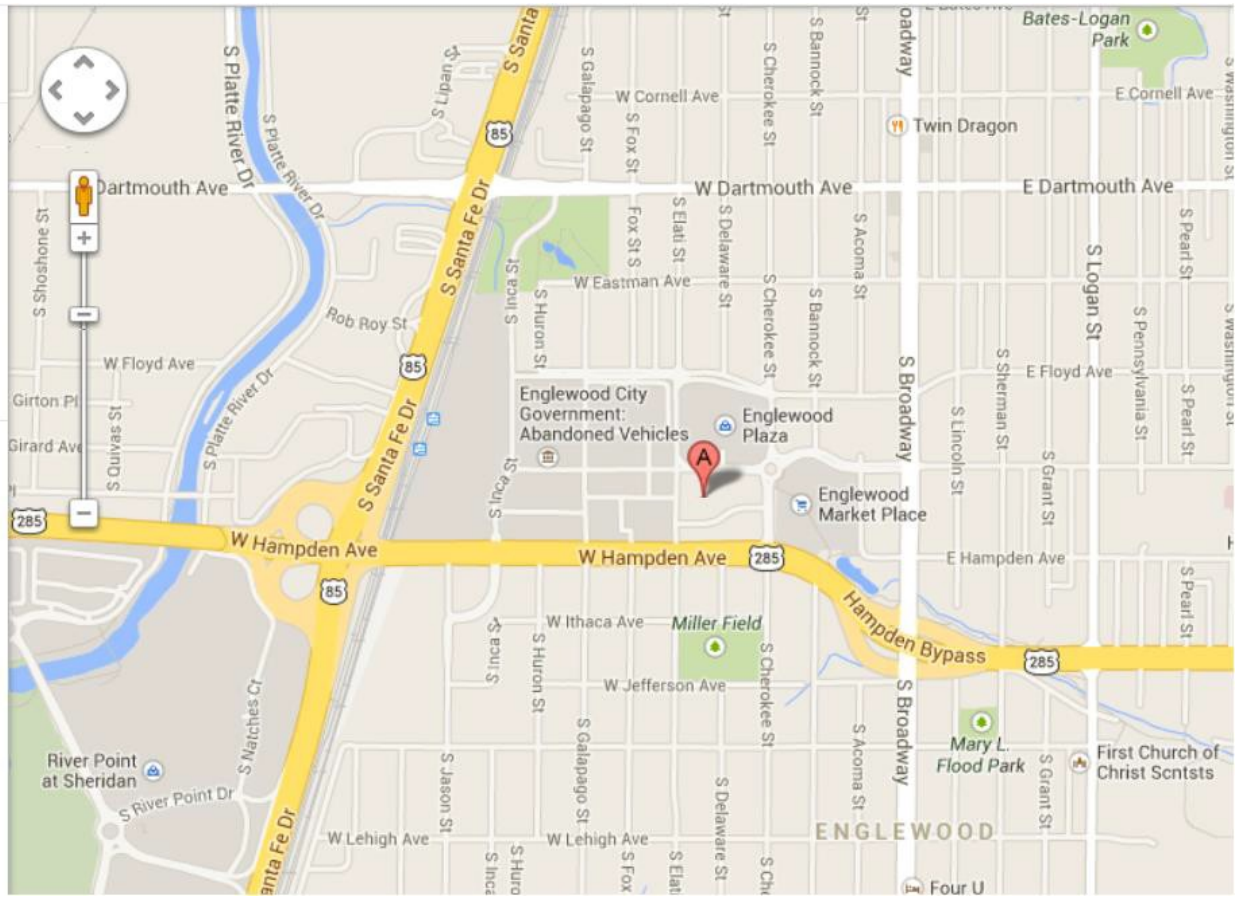

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Patient Information:

First Name: _____Last Name: _____

Male: ___ Female: ___

Date of Birth: Month: _____ Day: _____ Year: _____

Medical History/ Review of Systems:

Medical Providers to Receive Correspondence: (PCP, Referring Doctor):

_____

_____

Height: _____ Weight: _____

Reason for Visit: _____

_____

Medications: Please List All Medications Including Doseage:

None ( )

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____

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Allergies:

No Known Allergies ( )

1. _____
2. _____
3. _____
4. _____
5. _____

Past Medical History: Mark all that apply

None ( )

Thyroid Disorder:	( )	Reflux/GERD:	( )
Osteoporosis:	( )	LPR/Silent Reflux:	( )
Reaction to Anesthesia:	( )	Gastroparesis:	( )
High Blood Pressure:	( )	Stomach Ulcers:	( )
Hearth Attack:	( )	Esophagitis:	( )
Heart Failure:	( )	Hiatal Hernia:	( )
High Cholesterol:	( )	Crohn's Disease:	( )
Diabetes:	( )	Irritable Bowel:	( )
Stroke:	( )	Depression/Anxiety:	( )
Pulmonary Embolism:	( )	Emphysema/COPD:	( )
Obesity:	( )	Sleep Apnea:	( )
Arthritis:	( )	Asthma:	( )
Achalasia:	( )	Barrett's Esophagus:	( )
Sinus Infections:	( )	Aspiration Pneumonia:	( )
Cirrhosis:	( )	Hepatitis:	( )
Other: _____		Multiple Sclerosis:	( )
_____		Pancreatitis:	( )

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Family History: Mark All That Apply

None ( )

Gallbladder Disease:	( )	Diabetes:	( )
Reaction to Anesthesia:	( )	Bleeding Disorders:	( )
Breast Cancer:	( )	Ovarian Cancer:	( )
Heart Attack:	( )	Colon Cancer:	( )
Esophageal Cancer:	( )	Gastric Cancer:	( )

Other Cancer: _____

_____

Previous Surgical History: Mark All That Apply

None ( )

Appendix:	( )	Gallbladder:	( )
Other abdominal	( )	Colon:	( )
Stomach:	( )	Esophagus:	( )
Sinus/Facial:	( )	Cardiac:	( )
Kidney:	( )	Throat/Neck:	( )
Other Cancer:_____		Bones/Joint:	( )

_____

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Social History:

Do You Smoke? Yes: ( ) No: ( )

If Yes:

How much per day? _____

If a former smoker, when did you quit? _____

Do You Drink Alcohol? Yes: ( ) No: ( )

If Yes:

How much per day? _____

Are You On A Special Diet? Yes: ( ) No: ( )

If Yes, Describe:

_____

What Over The Counter Medications Do You Take?

None: ( )

Anti-Inflammatories:_____

Tylenol: _____

Aspirin: _____

Herbals: _____

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Review of Systems: Mark All That Apply For the Past 6 Months

Cardiac:
None:_____( )
Chest Pain:_____( )
Pacemaker:_____( )
Heart Valve:_____( )

Respiratory:
None:_____( )
Shortness of Breath:_____( )
Chronic Cough:_____( )
Bronchitis:_____( )
Pneumonia:_____( )
Sleep Apnea:_____( )
Wheezing:_____( )

Gastrointestinal:
None:_____( )
Abdominal Pain:_____( )
Nausea:_____( )
Vomiting:_____( )
Constipation:_____( )
Diarrhea:_____( )
Heartburn:_____( )
Regurgitation:_____( )
Difficulty Swallowing:_____( )
Rectal Bleeding:_____( )

Musculoskeletal/Skin:
None:_____( )
Back/Neck/Joint Pain:_____( )
Loss of Sensation:_____( )
Arthritis:_____( )
Osteoporosis:_____( )

Neurological:
None:_____( )
Numbness/Tingling:_____( )
Loss of Strength:_____( )
Headaches:_____( )

Cancer:
None:_____( )
Type: _____
Date: _____
Treatment: _____

Endocrine:
None:_____( )
Fatigue:_____( )
Excess Thirst:_____( )
Diabetes:_____( )
Thyroid Problems:_____( )
Weight Loss:_____( )

Constitutional:
None:_____( )
Fever:_____( )
Chills:_____( )
Night Sweats:_____( )

Blood/Immune:
None:_____( )
Anemia:_____( )
Blood Clots:_____( )
Lupus:_____( )

Psychological/Emotional:
None:_____( )
Anxiety:_____( )
Depression:_____( )

Head/Neck/Eyes/Ears:
None:_____( )
Ear Symptoms:_____( )
Eye Symptoms:_____( )
Nose/Sinus Symptoms:_____( )
Throat Symptoms:_____( )

SurgOne, P.C.

I Authorize This Office to Contact Me by Email: ___Yes ____No

PATIENT INFORMATION

Patient Email Address: _____

Requesting/Referring Physician_____Primary Care Physician_____

Name (Legal): ***Last***:_____ ***First***:_____ ***M.I.***_____ ***Mr. Mrs. Ms.*** Nickname:_____

Address:_____***City***:_____ ***State***:_____ ***Zip***:_____

Sex: M F ***Martial Status***: S M W D ***SS#***:_____ ***Date of Birth***: _____ _____ _____ ***Age***:_____
MM DD YYYY

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

Patient's Employer:_____***Patient's Occupation***:_____

Employer's Address:_____Employer's Phone #:_____

Spouse/Guardian Name:_____ ***Date of Birth***_____ _____ _____***SS#***_____
MM DD YYYY

Address (If different from patient):_____ City:_____ State:____ Zip:_____

Spouse/Guardian Employer:_____Employer's Address:_____

Spouse/Guardian Home Phone:_____ ***Work Phone***:_____ ***Cell/Pager***:_____

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:_____

Long Term Contact: Relative/Friend, **not living with you** (Should we need to contact you in future years if you have moved from address given in patient info. above).

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_____

DOB:_____***Phone #:*** ( )_____***Employer carrying insurance***:_____

Deductible:_____ Copay:_____ **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_____

DOB:_____***Phone #:*** ( )_____***Employer carrying insurance***:_____

Deductible:_____ Copay:_____ **If Accident**:☐ WorkComp or ☐ Auto: Date of Injury _____ Claim No._____

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 AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PHYSICIAN 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:_____

(Revised 05 11 12)

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.

_____ Initial

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.

- **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.

Financial Responsibility Waiver

Patient Name: _____

I understand that I have received care or will receive care from SurgOne, P.C. and:

- ☐ I have **no Insurance coverage.** I am financially responsible for all services provided.

- ☐ I have **furnished my current insurance information** to SurgOne, P.C., for an insurance company currently contracted with SurgOne, P.C. I understand I will be responsible for any of my plan deductibles, co-pays, co-insurance, or for services that are not covered by my insurance plan plan. **(Remember, your insurance company may require a referral or precertification for your surgery, however, such a referral or precertification is not a guarantee of benefits.)**

- ☐ **I failed to furnish** insurance information **(a physical card for our office to copy.)** If I do not provide a copy of my current insurance card or the correct information within one week, SurgOne P.C. will bill me for my services. If my insurance information is provided after I have been billed, SurgOne, P.C. will then bill my insurance company. If I have paid for services and my insurance company also pays for those services, I understand SurgOne P.C. will reimburse me accordingly. **I understand it is my responsibility to obtain a current referral if required by my insurance company.**

- ☐ I have presented insurance information to SurgOne P.C., from an insurer with which SurgOne, P.C. is not contracted, therefore, I will be seen as an **out-of-network patient.** SurgOne, P.C. may bill my insurance company as a courtesy, but I understand that I am responsible for the balance of charges incurred. **(Please contact your insurance company for information regarding your out-of-network benefits, or if your claims have not been paid in a timely manner.) Thank you.**

- ☐ I have **failed to furnish a current referral** from my primary care physician. I understand that if my insurance company denies the charges for services provided to me, I will be financially responsible for those services. If my primary care physician does issue a referral and payment is made for my services after I have already paid for them, SurgOne, P.C. will reimburse me accordingly.

Referring Doctor: _____

Telephone Number: _____

Contact Name: _____

I have been advised that it is my responsibility to obtain the information needed so that SurgOne, P.C. may be reimbursed for services provided, and that if non-sufficient information is given, or if I do not have appropriate insurance coverage, payment arrangements must be made as soon as possible **(Billing department _____)**. I understand that it is my responsibility to obtain a current referral if required by my insurance company. I assume full responsibility for the cost of services provided to me.

Thank you.

Date: _____ Signature of Patient or Guardian: _____

SURGONE, P.C.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have questions about this notice or want more information, please contact: Rena Bach, HIPAA Compliance Officer. The effective date of this notice is September 23, 2013.

To appropriately treat you and receive payment for the services we provide, we need to obtain information from you including your full name and address, insurance company, family medical history, current medical history, and current medical condition. We will use and disclose this information and other information we collect in the ways described below. To help you understand how we will use and disclose your information we have put the different uses and disclosures into categories and give examples of each. All of the ways we use or disclose your information will fit into one of the categories listed below, but we cannot list all of the uses and discloses in each category.

We may use and disclose your health information for treatment, payment, and health care operations.

- **Treatment**. We may use and disclose your information to provide you with medical treatment and services. Your information may be disclosed to individuals and facilities providing care to you. These individuals and facilities need your information to provide care, and to coordinate and provide services (such as prescriptions, lab tests, meals, and x-rays).
- **Payment**. We may use and disclose your information to receive payment for the services and treatment provided to you. We use your information to create a bill and disclose your information when we send the bill to your insurance company, you, or a third party. The individual or entity paying the bill may request more information to determine whether the bill is covered by your insurance. We may tell your health plan about a treatment you are going to receive to get approval for payment or to determine whether your health plan will cover the treatment.
- **Health Care Operations**. We may use and disclose your information for health care operation purposes. Health care operations includes review of the care you receive for quality assessment, educational, business planning, and compliance plan purposes.

We may disclose and use your health information and you authorize SURGONE to use and disclose your information for:

- **Appointment Reminders**. We may provide appointment reminders to you. You may request in writing that we send reminders to a confidential or alternative address.

- **Treatment Alternatives**. We may provide you with information about treatment alternatives and other health related benefits and services.

We may also disclose your health information to outside entities without your consent or authorization in the following circumstances:

- **Required by Law**. We disclose information as required by law. For example, we are required to report gunshot wounds to the police.
- **Public Health Purposes**. We disclose information to health agencies as required by law for preventing or controlling disease. Examples are reporting of sexually transmitted, communicable, and infectious diseases.
- **To Prevent a Serious Threat to Health or Safety**. We may disclose information about you to law enforcement or an identified victim to prevent a serious threat to your health or safety or the health or safety of another individual or the public.
- **Research**. Your information may be used by or disclosed to researchers for research approved by a privacy board or an institutional review board.
- **Health Oversight Activities**. Your health information may be disclosed to governmental agencies and boards for investigations, audits, licensing, and compliance purposes.
- **Judicial and Administrative Proceedings**. We may be required to disclose your health information to a court or for an administrative proceeding.
- **Law Enforcement Activities**. We may be required to disclose your information as required by law, pursuant to a court order, warrant, subpoena, or summons.
- **In Emergency Circumstances**.
- **Deceased Individual**. We may disclose information for the identification of the body or to determine the cause of death.
- **Military and Veterans**. If you are a member of the armed forces we may release information about you as required by military command authorities. We may also release information about foreign military personnel to the appropriate foreign military authority.
- **Inmates**. If you are an inmate of a correctional institution or under the custody of a law enforcement official. This release must be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety or security of the correctional institution.
- **Protective Services for the President and Others**.
- **Organ and Tissue Donation**. If you are an organ donor, we may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ bank, as necessary to facilitate organ or tissue donation.
- **Workers' Compensation**. We may release medical information about you for workers' compensation or similar programs.

- **National Security and Intelligence Activities**. We may release information about you to authorized Federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

We will give you the opportunity to object to the following uses and disclosure of your information:

- **Notification**. We may tell your friends, relatives and other caretakers information which is relevant to their involvement in your care.
- **Disaster Relief**. We may disclose information about you to public or private agencies for disaster relief purposes.

Except as provided above, we will obtain your written authorization prior to disclosure of your information for any other purpose. Specifically, written authorization is required prior to the disclosure of your information:

- **Psychotherapy Notes**. We will not use or disclose your psychotherapy notes without a written authorization except as specifically permitted by law.
- **Marketing**. We will not use or disclose your information for marketing purposes, other than face-to-face communications with you or promotional gifts of nominal value, without your written authorization.
- **Sale of Information**. We will not sell your PHI without your written authorization, including notification of the payment we will receive.

Where a disclosure is made under your written authorization, you have the right to revoke the authorization at any time. Revocation of an authorization must be in writing. The revocation is effective as of the date you provide it to SURGONE and does not affect any prior disclosures made under the authorization.

If a state or federal law provides additional restrictions or protections to your information, we will comply with the most stringent requirement.

Your Rights

- You have the right to request a restriction on how information about you is used and disclosed. If you want to request a restriction of a use or disclosure of your information, contact your SurgOne physician's office directly or our Privacy Officer at the number listed at the end of this form. We are required to agree to a request for a restriction related to disclosure of information to your health plan for payment or healthcare operations where you pay for the service in full. **We are not otherwise required to agree to any restriction on the use or disclosure of your information.**
- You have the right to request communications with you be made at an alternative address or phone number. To request that communication be made at a different address or phone number contact your SurgOne physician's office directly or our Privacy Officer at the number listed at the end of this form to obtain the form to make your request.

- You have the right to inspect and copy your medical record. To inspect and copy your medical record a request must be made in writing on the form provided by SURGONE. To obtain a form contact your SurgOne physician's office directly or our Privacy Officer at the number listed at the end of this form.
- If you believe the information we have about you is incorrect or incomplete you may request that we amend your medical record. Your request must be made in writing on the form provided by SURGONE. To request a form contact your SurgOne physician's office directly or our Privacy Officer at the number listed at the end of this form.
- You have the right to receive an accounting of disclosures, a list of individuals and entities that received your health information for reasons other than treatment, payment, or healthcare operations. You may receive one (1) free accounting during a twelve (12) month period. If you request more than one (1) accounting in a twelve (12) month period, you will be charged a fee. An accounting is not provided for disclosures prior to April 14, 2003. To request an accounting of disclosures, contact your SurgOne physician's office directly or our Privacy Officer at the number listed at the end of this form.
- You have the right to request a paper copy of this Notice.

Our Duties

- We are required by law to maintain the privacy of PHI and to provide individuals with this Notice of our legal duties and privacy practice regarding health information.
- We are required to notify you if there is a breach of your unsecured PHI.
- We are required to follow the terms of the current Notice.
- We may change the terms of this Notice and the revised Notice will apply to all health information in our possession. If we revise this Notice, a copy of the revised Notice will be posted and a copy may be requested from our Privacy Officer at the number listed at the beginning of this form.

Complaints

If you believe your privacy rights have been violated you may contact:

Rena Bach, Privacy Officer at (303) 957-1310 or the Office of Civil Rights. You will not be penalized for filing a complaint.

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

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:**_____

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 solely 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