SurgOne, P.C.

PATIENT INFORMATION

Requesting/Referring Provider ______________________**Primary Care Provider** ___________________________

Name (Legal):***Last***: _________________________ ***First***:_____________________ ***M.I.***_____ Preferred Name:_______________

Address: ____***City***:__________________ ***State***:______ ***Zip***:_________

Sex: M / F ***Marital Status***: S / M / W / D ***Date of Birth***: _____ _____ _____ ***Age***:_____________

MM DD YYYY

SS#: _____-_____-_____ ***Email:*** _______________________________________

Phone: □ ***Home*** ( )___________________ □ ***Cell*** ( ) _____________________ □ ***Work*** ( ) ___________________

PLEASE CHECK PREFERRED PHONE NUMBER

Patient's Employer: ________________________________ □**RETIRED** ***Patient's Occupation***: ______________________________

Employer's Address:____Employer's Phone #:___________________

Emergency Contact: (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 #:*** ( )________________***Policy Holder Employer***:________________________

SECONDARY Insurance:____***Subscriber ID#***:______________________

Group# _________________***Mailing Address (for claims)***:____

Policy Holder Name____***Relationship***: Self / Spouse / Child / Other___________

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

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:___________________________

(Revised 10-11-2019)

Randy Taylor, M.D., Ph.D.
Jeffrey Chain, M.D.
Carol J. Langdoc, M.D.
Laurie Burns, MSN, FNP-C

REVIEW OF SYSTEMS

Please circle all symptoms present ***WITHIN THE LAST 24 HOURS***:

General
Fever
Chills
Weight Loss
Night Sweats
Appetite Loss
Fatigue

Cardiovascular
Chest Pain
Palpitations
Fainting
Murmur

Respiratory
Shortness of Breath
Cough
Wheezing
Hemoptysis

Gastrointestinal
Abdominal Pain
Constipation
Diarrhea
Nausea
Vomiting
Heartburn
Jaundice

Genitourinary
Blood in urine
Trouble urinating
Frequent urination
Kidney/Bladder infection
Frequent/Heavy Menses (female only)

Neurologic
Decreased memory
Weakness
Tingling
Tremor
Headache
Loss of sensation
Numbness
Convulsions

Musculoskeletal
Joint Pain
Joint Swelling
Joint Redness
Muscle Pain
Back Pain
Arthritis

Endocrine
Appetite changes
Cold intolerance
Heat intolerance
Excessive thirst
Hair Loss

Dermatologic
Hives
Rash

Psychiatric
Anxiety
Depression
Mood Swings
Disorientation
Insomnia
Nervousness

Hematologic
Easy bruising
Excessive/prolonged bleeding
Enlarged lymph nodes

Preferred Pharmacy: ____

NAME PHONE LOCATION

PATIENT: ____

Name (Please Print) Date of Birth (DOB)

Protected Health Information and Communication Consent

Your provider 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, gmail, 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 regard to your medical and/or billing information:

	PLEASE CIRCLE		NAME AND PHONE NUMBER
Spouse or Partner	Yes	No	If yes, name/number:__________________________________
Son or Daughter	Yes	No	If yes, name/number:__________________________________
Mother or Father	Yes	No	If yes, name/number:__________________________________
Friend/Neighbor	Yes	No	If yes, name/number:__________________________________
Other __________	Yes	No	If yes, name/number:__________________________________

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 03/26/2019

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. 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 business 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.

- If a patient is more than 15 minutes late for a scheduled appointment, SurgOne reserves the right to reschedule the appointment.

- 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 business 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

NOTICE OF PRIVACY PRACTICES
<u>ACKNOWLEDGEMENT</u>

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

____
Print Name

____________________________________ ______________________
Signature Date

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF INFORMATION (42 CFR §164.508)

INDIVIDUAL NAME: ____________________________ **D/O/B** _________________ **SS#** ___________________________

PARENTS NAME (IF INDIVIDUAL UNDER AGE OF 18): ____

PREVIOUS NAME/ALIAS (IF APPLICABLE): ____

Information Requested: I consent and authorize SurgOne, P.C. to disclose all Protected Health Information in any form (including oral, written or electronic) to **MYSELF** (the "Requestor"). Additionally, I authorize SurgOne, P.C. to disclose the PHI via mail or facsimile. I expressly request that SurgOne, P.C. disclose full and complete PHI from the **time period of** __________ **to** _________ including, but not limited to, the following:

- All medical records, including, but not limited to: inpatient, outpatient & emergency room treatment; all clinical charts, reports, documents, correspondence, test results, subjective and objective complaints, statements, questionnaires/histories, office and doctor's handwritten notes; and records received from other physicians or healthcare providers;
- All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram & cardiac catheterization reports;
- All radiology films; mammograms; myelograms; photographs, CT scans; bone scans, pathology, cytology, histology, autopsy, immuno-histo-chemistry specimens; cardiac catheterization videos; and echocardiogram videos;
- All prescription and pharmaceutical records, including, but not limited to: NDC numbers and drug information handouts/monographs;
- All correspondence to/from/about me, memos, office notes, narrative summaries, and telephone messages;
- All billing records, including, but not limited to: all statements, invoices, itemized bills, and insurance records;
- All documents related to the amendment of any record requested.

I request the information be disclosed in the following format ______________________________. (If blank, format and method of disclosure will be determined by SurgOne, P.C.)

- I acknowledge that SurgOne, P.C. is receiving remuneration in the amount of ___________ for this disclosure.

---

1. Purpose of Release

____

____

AUTHORIZATION EFFECTIVE UNTIL:

- ☐ 1 YEAR FROM DATE OF THIS AUTHORIZATION
- ☐ DATE _______________________________
- ☐ OTHER EVENT OCCURS _____________________________________

I understand that this authorization may be revoked at any time, except to the extent already acted upon, by giving written notice to Requestor at the address listed above. I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned upon signing this authorization. I understand that the Requestor may redisclose this information, and if re-disclosed, the information would no longer be protected by federal privacy rules and regulations. Any facsimile or copy of this authorization authorizes the release of the records requested herein.

Signature of Individual (if 18 years of age or older): _______________________________________ Date _______________

Signature of Parent or Legal Representative (if applicable): _______________________________________ Date _______________

Relationship to Individual, if not signed by Individual: ____

In addition to the authorization provisions above, I authorize the release and re-disclosure of all information, data, notes, records, reports, and all other documents to the Requestor, its consultants, experts, agents and/or other counsel relating to:

- ☐ SUBSTANCE ABUSE (ALCOHOL/DRUG)
- ☐ MENTAL HEALTH (INCLUDING PSYCHOLOGICAL TESTING)
- ☐ HIV-RELATED INFORMATION (INCLUDING AIDS TESTING)
- ☐ GENETIC INFORMATION

THIS FORM DOES NOT AUTHORIZE RE-DISCLOSURE OF MEDICAL INFORMATION BEYOND THE LIMITS OF THIS CONSENT. WHERE ALCOHOL/DRUG ABUSE INFORMATION HAS BEEN DISCLOSED THROUGH RECORDS THAT ARE PROTECTED BY FEDERAL LAW, OR MENTAL HEALTH RECORDS PROTECTED BY STATE LAW, FURTHER DISCLOSURE IS PROHIBITED WITHOUT SPECIFIC WRITTEN CONSENT OF THE INDIVIDUAL OR AS OTHERWISE PERMITTED BY SUCH LAW AND/OR REGULATIONS. A GENERAL AUTHORIZATION IS NOT SUFFICIENT FOR THESE PURPOSES.

Signature of Individual (if 18 years of age or older): _______________________________________ Date _______________

Signature of Parent or Legal Representative (if applicable): _______________________________________ Date _______________

Relationship to Individual, if not signed by Individual: ____