

SURGICAL ASSOCIATES OF THE SHOALS, P.C.

Phone: (256)386-1125

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Please give your ID and insurance cards to the receptionist.

If you do not have insurance, please pay on day of visit.

Patient's Name: _____ Date: ___/___/___

Age: _____ Birth date: ___/___/___ Circle Sex: Male or Female

Social Security Number: _____ - _____ - _____ Circle marital status: S M D W Separated

Patient's address: Street: _____

City: _____ State: _____ Zip: _____

email address: _____

Home phone: (_____) _____ - _____ Cell phone: (_____) _____ - _____

Language: _____ Race: _____ Ethnicity: _____

Patient's employer: _____ Employer Phone #: (_____) _____ - _____

Spouse's name: _____ Spouse's birth date: ___/___/___

Spouse's phone #: (_____) _____ - _____ Spouse's SSN: _____ - _____ - _____

Primary insurance company: _____ Policy # _____ group # _____

Name of insured (if other than patient) _____ date of birth ___/___/___

Secondary insurance company: _____ Policy # _____ group # _____

Name of insured (if other than patient) _____ date of birth ___/___/___

Emergency Contact: _____

Relationship to patient: _____ phone #: (_____) _____ - _____

Referring physician: _____

SURGICAL ASSOCIATES OF THE SHOALS, P.C.

Patient Contact Information Sheet

Patient Name: _____

Any physician, staff, employee or representative of Surgical Associates of the Shoals, P.C. has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications, or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment, and payment:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Surgical Associates of the Shoals, P.C. or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals, it may be subject to redisclosure by the individual(s).

Patient Signature: _____ Date: ____/____/____

SURGICAL ASSOCIATES OF THE SHOALS, P.C.

ePrescribing Form

Patient Name: _____

Date of Birth: ____/____/____

Local Pharmacy: _____

Pharmacy Address: _____

City: _____ State: _____ Zip code: _____

Pharmacy Phone Number: _____

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program.

PATIENT CONSENT

By signing this consent form you are agreeing that Surgical Associates of the Shoals, P.C. may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient signature: _____ Date: ____/____/____

Name: _____ Date of Birth: ____/____/____

MEDICATIONS

Please list any medications you are currently taking.

Include dose and frequency.

DRUG Allergies

Please list any DRUG allergies you have.

NONE: _____

SURGICAL HISTORY

Please take the time to carefully review your surgical history with us.

Check all that applies to your personal surgical history.

___ No relevant surgical history

___ Appendix

___ Axilla (under arm)

___ Breast

___ Coronary arteries (CABG)

___ Carotid arteries

___ Carpal tunnel

___ Cataracts

___ Cervical Disc

___ Gallbladder

___ Colectomy

___ Colonoscopy

___ Coronary stents

___ C-section

___ EGD/Upper endoscopy

___ Gastric bypass

___ Hernia repair

___ Hysterectomy

___ Incision and Drainage

___ Lumbar disc

___ Mastectomy/breast surgery

___ Kidney removed

___ Prostate

___ Tonsils

___ Tubal ligation

___ Vasectomy

___ Shoulder surgery

___ Knee surgery

___ Hip surgery

Other surgeries:

SOCIAL HISTORY

Please take the time to carefully review your social history with us.
Check all that applies to your personal social history.

Alcohol consumption

- None
- Occasional
- Daily
- Weekly

Tobacco use

- Never smoked
- Former smoker
- Current some-day smoker
- Current daily smoker
- _____ # of packs per ___ day ___ week
- Vape

Smokeless tobacco (dip or chew)

- Non-user
- Former user
- Current user

Recreational drugs

- None
- Occasional
- Regularly

Exercise

- Often
- Rarely
- Never

Marital Status

- Single
- Married
- Divorced
- Widowed
- Separated

Sexual activity

- Not active
- Sexually active

Occupation

- Full time
- Part time
- Disabled
- Student
- Retired
- Unemployed

MEDICAL HISTORY

Please take the time to carefully review your medical history with us.
Check all that applies to your personal medical history.

- No relevant medical history
- Anemia
- Anxiety
- Asthma
- Atrial fibrillation
- Breast cancer
- Cancer _____
- Low heart rate/bradycardia
- Chronic kidney disease
- Chronic pain
- Colon polyps
- Congestive heart failure
- COPD
- Coronary artery disease
- Depression
- Diabetes
- Diverticulitis
- Degenerative Joint Disease
- History of DVT/deep vein thrombosis
- Fibromyalgia
- GERD/reflux
- Gout
- High cholesterol
- High blood pressure
- Hypothyroidism
- Inflammatory bowel disease
- Irregular heart beat

- Lupus
- Kidney stones
- Stroke
- Vascular disease
- Prostate cancer
- Multiple sclerosis
- Obstructive Sleep Apnea
- Osteoarthritis
- Rheumatoid arthritis
- Pulmonary embolus
- Pneumothorax
- Skin cancer

Other:

FAMILY HISTORY

Please take the time to carefully review your family history with us.
Check all that applies to your personal family history.

FATHER

- Deceased
- Alcoholism
- Dementia
- Arthritis
- Asthma
- Bleeding disorder
- Breast cancer
- Colon cancer
- COPD
- Diabetes
- Emphysema
- Heart disease
- High cholesterol
- High blood pressure
- Hypothyroidism
- Kidney disease
- Issues with anesthesia
- Seizures
- Skin cancer
- Stroke

Other:

MOTHER

- Deceased
- Alcoholism
- Dementia
- Arthritis
- Asthma
- Bleeding disorder
- Breast cancer
- Colon cancer
- COPD
- Diabetes
- Emphysema
- Heart disease
- High cholesterol
- High blood pressure
- Hypothyroidism
- Kidney disease
- Issues with anesthesia
- Seizures
- Skin cancer
- Stroke

Other:

SIBLINGS

- Deceased
- Alcoholism
- Dementia
- Arthritis
- Asthma
- Bleeding disorder
- Breast cancer
- Colon cancer
- COPD
- Diabetes
- Emphysema
- Heart disease
- High cholesterol
- High blood pressure
- Hypothyroidism
- Kidney disease
- Issues with anesthesia
- Seizures
- Skin cancer
- Stroke

Other:

SURGICAL ASSOCIATES OF THE SHOALS, P.C.

Please read the following carefully.

It is the policy of Surgical Associates of the Shoals, P.C. that the person receiving services is responsible for payment of the account. If the patient is a minor, the parents or legal guardian then assumes the responsibility. Medical insurance is filed as a convenience to our patients. **OUR BILL IS WITH OUR PATIENTS, NOT THEIR INSURANCE COMPANIES.** If a problem arises, it is the patient's responsibility to communicate with the insurance company and handle the problem. If you have any questions or need assistance, please do not hesitate to ask the receptionist, the insurance clerk, collections clerk, or the office manager. We will be glad to help in any way possible. Thank you.

Insurance Authorization and Assignment

I hereby authorize Surgical Associates of the Shoals, P.C. to furnish information to insurance carriers, government agency providing benefits, or to anyone for charges concerning my illness and treatments and hereby assign to the physician all payments for medical services rendered to myself or my dependent. I understand that I am responsible for charges not covered by my insurance.

I have read and fully understand that I am responsible for payment of services rendered to _____(patient). I understand that if Surgical Associates of the Shoals, P.C. does not participate with the insurance plan I have in force at the time services are rendered that I will pay the balance due. I also agree to pay costs of collections including attorney fees and any other collection charges plus 1.5% interest per month and I waive my exemption under the constitution and laws in the state of Alabama.

Signature of Guarantor: _____ Date: _____

SURGICAL ASSOCIATES OF THE SHOALS, P.C.

Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible health care at the lowest possible cost. Please understand that the payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

All patients must complete our patient information form before seeing the doctor. Present your insurance cards, driver's license, and social security number to our receptionist to copy for your chart. Co-pays and deductibles are due at the time service is rendered. All patients assume responsibility for helping to prevent identity theft by supplying the above information and for informing us if your insurance has special requirements, i.e. pre-certification admission or specific hospital, second opinion, or a referral from your primary care physician.

Adult patients are responsible for their co-pays and deductibles at the time services are rendered. The adult accompanying a minor, the parents or guardian of the minor are responsible for their co-pays and deductibles at the time services are rendered.

There is a \$35.00 returned check fee. Accounts with balances after insurance payments not collected within 90 days will be turned over to our attorney for collection with additional collection or attorney fees, plus 1.5% interest per month. Non-insured accounts must have payment arrangements. Accounts with failed payment arrangements will be turned over to the attorney for collection with additional collection fees added and we waive our exemption under the constitution and laws in the state of Alabama.

If you have insurance coverage, we file your claims and are anxious to help you receive your maximum allowable benefits. By law your insurance carrier should remit payment or deny your insurance claim within 30 days of initial notice of claim. If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier. Please remember that few insurance companies attempt to cover all medical costs. In regards to insurance plans where we are a participating provider, all co-pays and deductibles are due at the time of treatment.

We believe that good physician/patient relationships are based upon understanding and good communications. Thank you for reading and understanding our financial policy. If you have questions about these financial arrangements, please feel free to talk with our collection specialist. We will make every effort to clarify any misunderstanding you have concerning your balance. We are here to help you.

I have read, understand, and agree to this financial policy:

Patient Signature: _____ Date: ____/____/____

Person responsible for bill (if other than patient): _____

Relationship to patient: _____ phone #: (____) _____ - _____

Address: Street: _____

City: _____ State: _____ Zip: _____

SURGICAL ASSOCIATES OF THE SHOALS, P.C.
Authorization to Disclose Health Information

Patient Name: _____ Social Security #: _____

1. I authorize Surgical Associates of the Shoals, P.C. to use or disclose the above named individual's health information as described below.
2. The type and amount of information to be used or disclosed: (check blank if appropriate)
 - ___ Entire record
 - ___ Problem list
 - ___ Medication list
 - ___ List of allergies
 - ___ Most recent history and physical
 - ___ Most recent discharge summary
 - ___ Laboratory results From date _____ to date _____
 - ___ Xray and imaging reports From date _____ to date _____
 - ___ Consultation reports From doctors: _____
 - ___ Patient account statement/billing records
 - Other: _____
3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
4. This information may be disclosed to and used by the following individual or organization:
Name & Address: _____
For the purpose: _____
5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the privacy officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
If I fail to specify an expiration date, event, or condition, this authorization will expire in one year.
6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524 of the Federal Register Rules and Regulations. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the privacy officer.

Patient or Legal Representative Signature: _____

Date: ____/____/____