Patient Information Form

Welcome to Memphis Surgery Associates

The following information will allow us to accurately handle your billing and insurance.

Date_____ Referring Physician _____ Primary Care Physician_____

Please present Insurance Card and Photo ID

Patient First Name_____ MI _____ Last_____

Birth Date _____/_____/_____ Marital Status: Married___ Widowed ___ Single ___ Divorced ___

Mailing Address_____ City _____ State____ Zip _____

Home Phone_____ Work Phone_____ Cell Phone_____

Email_____

Male/Female SSN_____

Information required by Federal government

Preferred Language_____

Race: Caucasian/White_____ African American/ Black_____ American Indian _____ Asian _____ Other _____

Ethnic Background: Hispanic _____ Non Hispanic_____

Employment status: Full-time/Part Time/Unemployed

Employer_____ Work Phone_____

May we have access to your prescription records? Yes or No

How may we contact you regarding appointments and medical information? Home__Work__Cell__

Where may we leave a message? (check all that apply) Home___ Work___ Cell____

Primary Insurance_____ Policy #_____ Group #_____

Policy Holder's Name_____ Policy Holder Date of Birth ____/_____/_____

Policy Holder's SSN_____ Relationship to patient _____

Policy Holder's address if other than patient_____ City_____ State___ Zip_____

Policy Holder's place of employment_____

Does this insurance plan require a referral? Yes or No

What Hospital Facility is in network with your insurance plan: _____

Secondary Insurance_____ Policy #_____ Group #_____

Policy Holder's Name_____ Policy Holder Date of Birth ____/_____/_____

Policy Holder's SSN_____ Relationship to patient _____

Policy Holder's address if other than patient_____ City_____ State___ Zip_____

Policy Holder's place of employment_____

Does this insurance plan require a referral? Yes or No

Spouse/(Next of Kin)_____ Relationship_____ Phone_____

Emergency Contact_____ Relationship_____ Phone_____

Pharmacy_____ Location_____ Phone_____

_____ _____ _____

Patient Signature (or guardian) Date Relationship if not patient

Memphis Surgery Associates

Medication Log

Patient Name: _____ Date of Birth:_____ Date:_____

It is important to have a complete record of your current medications. Please list all prescribed and over the counter medications. Include the dosage, how it is taken(scheduled) and the doctor that prescribed this to you.

Medication	Dosage	Schedule (How taken)	Doctor who prescribed

Patient Signature: _____ Date:_____

Memphis Surgery Associates

Patient Name:_____ Date of Birth:_____ Date:_____

Pre-evaluation Patient Questionnaire

****all responses are kept STRICTLY confidential****

Reason for visit:_____

How long has this been a problem? _____

Have you been treated by another physician for this problem in the past? If so, who treated you and what was done: _____

Physician who referred you here: _____

Primary Care Physician:_____

Please note any other conditions for which you see a doctor:

( )Hypertension	( )Diabetes	( )High Cholesterol	( )Dialysis
( )Stroke	( )COPD	( )Kidney Disease	( )Blood Clot/DVT
( )Liver Disease	( )Thyroid(hyper/hypo)		( )Seizures
( )Asthma	( )Congestive Heart Failure		( )Hepatitis
( )GERD	( )Coronary Artery Blockages		( )HIV/AIDS
( )Ulcerative Colitis	( )Diseases Artery Blockages		( )Heart Rhythm Abnormalities
( )Crohn's Disease	( ) Valvular Heart Disease or Heart Murmur		

( )History of cancer? If yes, where and when?: _____

( )History of sexually transmitted diseases? _____

( )History of mental illness? _____

Please list any other conditions:

_____

_____

Have you ever had a colonoscopy? If yes when and by whom?

_____

Have you ever had a mammogram? If yes when and by whom?

_____

Height: _____ Weight: _____

List all prior surgical procedures and hospitalizations with approximate dates:

_____

_____

_____

_____

Patient Name:_____ Date of Birth:_____ Date:_____

Memphis Surgery Associates

Do you take blood thinners? (Aspirin, Plavix, or Coumadin/Warfarin) Yes or No
Do you have any allergies? Yes or No

Please list any allergies and reactions: _____

Social History:

Are you currently employed? If so, what is your occupation? _____
If disabled, please list the nature of your disability:_____
Do you have a history of drug or alcohol abuse? Yes or No_____
Do you drink regularly? Yes or No If yes, please list amount _____
Do you use tobacco products? Yes or No If yes how much per day_____ year started _____
If former smoker the year you quit_____
Are you single/ married? _____

Gynecologic History:

Number of pregnancies _____ Method of delivery_____
Date of last menstrual period or age of menopause _____
Any history of abnormal Pap smear? Yes or No

Family History:

Please list any major illnesses and/or causes of death with family members. (ex. Heart disease, cancer, etc.)
Mother:_____ Living/ Deceased_____
Father:_____ Living/ Deceased_____
Maternal Grandparents:_____
Paternal Grandparents:_____
Others:_____

Review of Systems: Please circle any symptoms that you may be currently experiencing.
GENERAL: Weight loss/ amount _____, anorexia, fatigue, fever, chills
HEAD/NECK: headache, visual changes, hearing problems, sinus congestion
RESPIRATORY: cough, shortness of breath, (at rest or exertion), wheezing, sleep apnea
CARDIOVASCULAR: chest pain/pressure, palpitations, easy fatigue, leg swelling
ABDOMINAL: nausea, vomiting, heartburn, painful swallowing, abdominal pain, constipation, diarrhea, incontinence, blood in stool, dark/tarry stool, jaundice
URINARY/SEXUAL: painful urination, frequency, difficulty starting or stopping your stream, blood in the urine, difficulty achieving or maintain erection, painful intercourse, vaginal discharge
SKIN: rash, easy bruising or bleeding
MUSCULOSKELETAL: joint pain or swelling, arthritis
NEUROLOGIC: Passing out, dizziness, seizures, numbness, or tingling
PSYCHIATRIC: anxiety, bipolar, depression, mania, suicide

Patient Signature:_____ Date:_____
Physician Signature _____ Date: _____

RECORD RELEASE / AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name:_____

Last First Middle

Home Address:_____

_____

Home Telephone:_____ **Date of Birth:** _____

SPECIFY INFORMATION TO BE DISCLOSED: The information that may be disclosed under this Authorization includes

☐ Discharge Summary	☐ Progress/Physician Notes	☐ X-Ray Report	☐ Pathology Report
☐ History & Physical	☐ Nurses Notes	☐ EKG/EMG/EEG Report	☐ Consult Report
☐ Emergency Report	☐ Laboratory Report	☐ Operative Report	☐ Entire Record

☐ Other_____

Records for the period (dates) from _____ to _____

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

☐ Information about mental health or mental retardation services
☐ Psychotherapy Notes created by a mental health professional
☐ Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
☐ Information about sexually transmitted diseases
☐ Information about alcohol or drug abuse treatment program services
☐ Information about sexual assault
☐ Information about child abuse and neglect

RECIPIENT: Name of person or class of persons to whom Memphis Surgery Associates may disclose my health information: _____

Address of the recipient or where my health information should be delivered:_____

_____

TERM: This Authorization will remain in effect:

☐ From the date of this Authorization until the _____ day of _____, 20____.

☐ Until Memphis Surgery Associates fulfills this request.

☐ Until the following event occurs: _____

☐ Other: _____

PURPOSE: I authorize Memphis Surgery Associates to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s): [Note: "at the request of the Patient" is sufficient if the Patient is initiating this Authorization] _____

_____

_____

RECORD RELEASE / AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I understand that once Memphis Surgery Associates discloses my health information to the recipient, Memphis Surgery Associates cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that Memphis Surgery Associates may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Memphis Surgery Associates except, however, if my treatment at Memphis Surgery Associates is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Memphis Surgery Associates may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Memphis Surgery Associates Privacy Office at the address listed below. The revocation will be effective immediately upon Memphis Surgery Associates receipt of my written notice, except that the revocation will not have any effect on any action taken by Memphis Surgery Associates in reliance on this Authorization before it received my written notice of revocation.

I may contact Memphis Surgery Associates Privacy Office by mail at:

6029 Walnut Grove Road Suite 404 Memphis , Tennessee 38104 or by e-mail at HHH-Privacy@TenetHealth.com.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Memphis Surgery Associates to use or disclose my health information in the manner described above.

_____ _____

Signature of Patient **Date**

Note: If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____ _____

Signature of Authorized Personal Representative | Relationship to Patient | Date

Memphis Surgery Associates
6029 Walnut Grove Road Suite 404
Memphis, Tennessee 38120

Memphis Surgery Associates
6029 Walnut Grove Road Suite 404
Memphis, Tennessee 38120
(P) 901726-1056/ (F) 901729-3100
Memphissurgery.com

PATIENT COMMUNICATION CONSENT

We may need to contact you regarding your medical care. This is to acknowledge that you authorize Memphis Surgery Associates to (check all that apply):

☐ Leave a detailed message on voice mail/machine

☐ Call my workplace phone number and leave a message

☐ Call my workplace phone number and speak only to me

☐ Transmit and Receive messages through Patient Portal (NextMD or Other) including secure email

☐ None of the above

I further authorize the disclosure of my PHI to the following individuals or family members:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Signature of Patient/Guardian: _____ Date: _____

Memphis Surgery Associates Financial Policy and Authorizations

We are happy that you selected Memphis Surgery Associates for your healthcare needs and look forward to working with you. To help you understand your financial responsibilities in relation to your medical care, we would like to briefly outline our financial policies.

Patients are expected to provide identification and if insured, a current insurance card(s) at time of service. Patients are financially responsible for all services provided and are expected to pay for services at time of service, including any past due balance from a prior date of service. If the patient is a minor child, the parent or other adult accompanying the child will be financially responsible regardless of legal guardianship. Returned checks will be subject to fees.

Medicare: The office will bill the Medicare intermediary. Patients are responsible for the following:

- Annual Medicare deductible
- All applicable co-pays of the allowed charge
- Any non-covered services
- Any covered service ordered by the physician which does not meet Medicare's medical necessity and for which the beneficiary signed an Advanced Beneficiary Notice (ABN).

Medicare Supplemental and Secondary Insurances: The Practice will bill both Medicare and secondary insurances.

Medicaid: **Patients must provide the Practice with a current Medicaid card at each visit. Medicaid patients are responsible for applicable co-pays and for all non-covered services. Medicaid patients are responsible for securing necessary referrals from their primary care physicians.**

HMOs and PPOs, Commercial Insurance Plans: Patients are responsible for payment of the co-pay, co-insurance and/or deductible, or non-covered amounts at the time of service as well as for any charges for which the patient failed to secure prior authorization, if authorization is necessary. Insurance is filed as a courtesy and benefits are authorized to be paid directly to the Practice. Patients are responsible for the balance in full if not paid by the insurance within 30 days. If the patient is not prepared to pay the co-pay or deductible, a member of the clinical staff will determine if it is medically necessary for the patient to see the physician. If the patient's condition allows, the appointment will be rescheduled.

Self-Pay: **Patients are responsible for payment in full at the time of services for all services rendered.**

Personal Injury/Motor Vehicle Accidents and Other Third Party Liability: The patient is responsible for the balance in full at the time of service. Any settlement you receive from your insurance company or other third party will be handled by you, your insurance company, and/or your attorney.

Out of State Insurance: **If the patient presents with an out of state HMO/PPO insurance card, we will need to verify the patient's benefits for out-of-state or out-of-network benefits. The patient may be required to make payment in full or pay any co-pay, co-insurance or deductible.**

Authorizations and Consent

ASSIGNMENT AND RELEASE: I hereby assign my insurance or other third party carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer (for employer sponsored/paid for claims). I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.

ELECTRONIC CHECK CONVERSION: When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account the same day.

CONSENT FOR TREATMENT: I hereby authorize the physicians, midlevel providers, nurses, medical assistants, and other Practice staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

NO SHOW POLICY: I understand if I fail to come for a scheduled appointment or cancel at least 24 hours prior to the appointment, I will be considered a "no show" and may be subject to a "no show" charge per occurrence. Ongoing occurrences of no shows may result in dismissal from the Practice.

I understand the Financial and No Show Policies, Authorizations and Consent for Treatment, and hereby agree to them:

I understand the Financial and No Show Policies, Authorizations and Consent for Treatment, and hereby agree to them:

_____ _____

Patient or Parent/Guardian if Minor Date 2-23-2007; Rev 2-13-15;
Rev 8-1-15