Marshall Surgical Clinic

Patient Information Sheet

NAME:_____ BIRTHDATE:_____

REASON FOR VISIT_____

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING:

- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Bronchitis
- ❑ Bleeding Disorder
- ❑ COPD
- ❑ Deep Vein Thrombosis
- ❑ Diabetes
  - ❑ Type I ❑ Type II
- ❑ Emphysema
- ❑ Glaucoma
- ❑ Heart Disease
- ❑ Hepatitis
  - ❑ A ❑ B ❑ C
- ❑ Hernia
- ❑ High Cholesterol
- ❑ High Blood Pressure
- ❑ HIV
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Pacemaker
- ❑ Prostate Problem
- ❑ Stroke
- ❑ Seizures
- ❑ Thyroid Problem
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Cancer

When was your last:

Flu Shot: _____

Pneumonia Shot: _____

Mammogram: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING SURGERIES:

- ❑ Appendectomy
  - ❑ Laparoscopic
  - ❑ Open
- ❑ Breast Biopsy Left
- ❑ Breast Biopsy Right
- ❑ Bilateral Tubal
- ❑ C-Section
- ❑ Cardiac Stent
- ❑ Cataracts
- ❑ Colectomy
- ❑ Colonoscopy
- ❑ Coronary Artery Bypass
- ❑ EGD
- ❑ Gallbladder
  - ❑ Laparoscopic ❑ Open
- ❑ Gastric Bypass
- ❑ Hemorrhoids
- ❑ Hernia
- ❑ Hysterectomy
- ❑ Lap Band
- ❑ Oophorectomy
- ❑ Open Heart (other than bypass)
- ❑ Sphincterotomy
- ❑ Splenectomy
- ❑ Tonsillectomy
- ❑ Total Hip
- ❑ Total Knee
- ❑ Other:_____

HAS ANYONE IN YOUR IMMEDIATE FAMILY HAD ANY OF THE FOLLOWING:

- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ Diabetes
  - ❑ Type I ❑ Type II
- ❑ Heart Disease
- ❑ Kidney Disease
- ❑ Other Cancer _____

SELECT ANY OF THE FOLLOWING SOCIAL HISTORY THAT APPLIES:

- ❑ Alcohol
- ❑ Drug Usage
- ❑ Tattoos
- ❑ Tobacco Usage

PLEASE SELECT ANY CURRENT SYMPTOMS:

GENERAL
- ❑ Fever
- ❑ Weight Loss
- ❑ Sweats
- ❑ Chills

HEENT
- ❑ Hoarseness
- ❑ Sinus Problems
- ❑ Difficulty Swallowing

GENITOURINARY
- ❑ Kidney Stones
- ❑ Blood in Urine

GASTROINTESTINAL
- ❑ Bloating/Gas
- ❑ Constipation
- ❑ Diarrhea
- ❑ Heartburn
- ❑ Hemorrhoids
- ❑ Nausea
- ❑ Rectal Bleeding
- ❑ Stomach Pain
- ❑ Vomiting

CARDIOVASCULAR
- ❑ Chest Pain
- ❑ Irregular Heartbeat
- ❑ Ankle Swelling
- ❑ Varicose Veins

RESPIRATORY
- ❑ Cough
- ❑ Short of Breath
- ❑ Sleep Apnea
- ❑ Wheezing

SKIN
- ❑ Change in Moles
- ❑ Rash

ENDOCRINE
- ❑ Excessive Thirst
- ❑ Hair Loss

HEME/LYMPH
- ❑ Abnormal Bruising
- ❑ Anemia
- ❑ Enlarged Gland

NEUROLOGICAL
- ❑ Headaches
- ❑ Seizures

MEN ONLY
- ❑ Breast Lump
- ❑ Testical Lump

WOMEN ONLY
- ❑ Breastfeeding
- ❑ Breast Lump
- ❑ Breast Pain
- ❑ Menopause
- ❑ Nipple Discharge

MEDICATIONS List medications you are currently taking	ALLERGIES to medications or substances
Do you currently take any blood thinners, including aspirin? ❑ Yes ❑ No	
Pharmacy Name:	Phone:

Patient Name _____ Date _____

Address _____

City, State, Zip _____ Phone _____

Email address _____

Employer _____ Work Phone _____

Employer's Address _____

Sex _____ Race _____ Marital Status S M W D Birth Date _____

Social Security No. _____ Driver's License No. _____

Spouse _____ Work Phone _____

Spouse's Employer & Address _____

Parent or Guardian (if minor) _____ Work Phone _____

Parent's Employer & Address _____

Emergency Contact (not living in your home) _____ Phone _____

Person Responsible for Payment _____ Phone _____

Primary Insurance Company _____ Effective Date _____

Policy Holder _____ Policy Holder's Birth Date _____

Policy No. _____ Group No. _____

Secondary Insurance Company _____ Effective Date _____

Policy Holder _____ Policy Holder's Birth Date _____

Policy No. _____ Group No. _____

Referring Doctor _____ Family Doctor _____

How did you hear of Marshall Surgical Clinic: Newspaper _____ Internet _____ Friend _____ Other _____

If work injury, please ask front desk for additional paperwork.

AUTHORIZATION TO RELEASE INFORMATION

The undersigned authorizes Marshall Surgical Clinic, P.C. to release any medical or other information about the patient which may be necessary for the proper filing of insurance claims, review of services or receipt of benefits. In addition, the undersigned authorizes the release and disclosure of any and all medical records to or from any other entity, including, but not limited to, referring physicians, hospitals, or other health care providers, which may be of assistance in providing treatment.

INSURANCE AUTHORIZATION, ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

In consideration of medical and/or surgical service provided to me by MARSHALL SURGICAL CLINIC, P.C., I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and any other health plans to MARSHALL SURGICAL CLINIC, P.C. A copy of this assignment is to be as valid as an original. I understand that I am financially responsible for all charges, whether or not paid by said insurance, and collection fees if they become necessary (including reasonable attorney's fees, legal expenses, and costs). I hereby authorize said assignee to release all information necessary to secure payment. This signature shall remain effective for billing purposes until terminated in writing.

Patient _____ Date _____
(Agreement to Pay)

Guarantor _____ Date _____
(Agreement to Pay)

PATIENT CONTACT INFORMATION SHEET

PATIENT NAME_____

BIRTHDATE_____

HOW WOULD YOU PREFER TO BE CONTACTED FOR APPOINTMENT REMINDERS?

HOME PHONE_____ CELL PHONE_____ MAY WE LEAVE A MESSAGE?_____YES _____NO

Any physician, staff, employee or representative of Marshall Surgical Clinic, 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:

_____ CHECK HERE IF YOU CHOOSE **NOT** TO ALLOW ACCESS OF YOUR MEDICAL RECORDS TO ANYONE.

Or if you approve please fill in information below.

NAME	RELATIONSHIP	PHONE NUMBER(s)	(Yes or No) leave message
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____

I understand that authorizing the release of my information to the above individuals is voluntary and does not affect my access to treatment. I can sign a refusal 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 re-disclosure by the individual(s).

Patient Signature_____Date_____

MARSHALL SURGICAL CLINIC, P.C.
Notice of Privacy Practices Summary

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 any questions about this Notice please contact our Privacy Officer who is Janet Downes at 256-593-1611.

This is a summary of our Notice of Privacy Practices which describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by law to maintain the privacy of your protected health information and to provide you with a notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time, and reserve the right to do so. The new notice will be effective for all protected health information that we maintain at that time.

We will use your protected health information as part of rendering patient care, including treatment, payment and healthcare operations.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

We may use or disclose your protected health information in certain situations without your authorization or opportunity to agree or object.

You have the right to request a restriction of your protected health information.

You have the right to request to receive confidential communications of your protected health information.

You have the right to inspect and copy your protected health information.

You have the right to amend your protected health information.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

You have the right to obtain a paper copy of this notice from us.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This summary was published along with the notice of privacy practices. This notice becomes effective April 14, 2003.

MARSHALL SURGICAL CLINIC, P.C.
Notice of Privacy Practices Acknowledgement

I, _____ acknowledge I have received a copy of the notice of privacy practices.

_____ _____
Signature of Patient or Personal Representative | Name of Patient or Personal Representative (please print)

_____ _____
Date | Relationship to patient (or other authority to serve)

Marshall Surgical Clinic, P.C.

FINANCIAL POLICY and PATIENT RESPONSIBILITY

PLEASE NOTE: WE ARE NOT PART OF THE HOSPITAL AND OUR BILLING IS A SEPARATE MATTER

After two missed appointments, with failure to notify 24 hours in advance, you will be charged a $25 no show fee prior to rescheduling.

Co-pays are due now, if you are unable to pay we will be glad to reschedule your appointment.

If you have an existing balance you must pay now or speak with the billing manager. If you have surgery needs and do not know your deductible, please ask the front desk for information or/and call your insurance provider.

Thank you for coming to Marshall Surgical Clinic. We believe that good care for you and your family starts with good communication. If at any time you have questions or problems with our payment process, please do not hesitate to contact Janet in our billing department (256-593-1611)

By consenting to our services, you are consenting to payment and to receive billing statement.

Non-payment accounts will be forwarded to Collection Services.

Patient acknowledgment:

I understand the above information and I will be financially responsible for the patient below:

Name (Print)_____

Signature _____

Date_____

STATEMENT OF FINANCIAL RESPONSIBILITY: Unless otherwise prohibited, I unconditionally guarantee payment in full to Dr. Thomas Downes of Marshall Surgical Clinic that may render treatment and services to me.

I hereby authorize and consent to the release of all medical and personal information (including but not limited to my home phone, cell phone, work phone, address and email address) by or to the hospital and by or to any and all healthcare professionals involved in my care; Interpretation of test results; account billing and collections; payment posting and/or processing; or related healthcare functions. This authorization shall remain in effect until such time as all account balances extending from the encounter have been fully satisfied.

I authorize the hospital and all clinical providers who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using 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.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign and authorize and direct payment to Dr. Thomas Downes of Marshall Surgical Clinic all insurance benefits, including those provided under Medicare and Medicaid under Title XVIII/XIX of the Social Security Act, payable under their respective terms for my services and medical treatment. Unless otherwise provided by law, the filing or processing of any claim shall not be a condition precedent to any collection of any unpaid charges, and shall not be constructed as the assumption of any duty with regard to the insurance.

To the extent allowed by law, I remain responsible for any portion of the hospital bill not paid by insurance, including co-insurance, denied claims or deductibles; I understand that if a private room is requested or provided, I am responsible for any additional unpaid charges incurred.

RELEASE OF INFORMATION: In addition to that provided above, the hospital and its physicians may disclose all or any part of the patient's record when such disclosure is necessary for my continued treatment, the payment for the services I receive, for healthcare operation or as may be required or allowed by applicable law. For detailed information about how your healthcare information may be used, please review the Marshall Surgical Clinic's Notice of Privacy Practices. I permit a copy of these authorizations and assignment to be used in place of the original.

Signature of Patient/Guarantor Date	Signature of Patient Representative/ Spouse and Relation ship Date