

MINIMAL ACCESS SURGERY CLINIC

CHART #: _____

Patient Registration

DATE: _____

(PLEASE PRINT CLEARLY!)

PATIENT'S NAME: _____
First Name MI Last Name

PATIENT'S SS #: _____

Date of Birth: _____ Male Female Single Married Widowed Divorced Separated

Mailing Address : _____

City/State/Zip Code: _____ Home Phone w/Area Code: _____

Email address: _____ Cell Phone w/Area Code: _____

Patient's Employer: _____ Work Phone w/Area Code: _____

Spouse's Name: _____ SS #: _____ DOB: _____

Spouse's Employer: _____ Spouse's Work Phone #: _____

Responsible Party: _____ Relationship: Self Spouse Parent Other: _____

If patient is a Minor, are parents Married Divorced Custodial Parent: _____

Custodial Parents' Home Phone w/Area Code: _____ Work Phone w/Area Code: _____

Mom's Name: _____ Mom's SS#: _____ Mom's Date of Birth: _____

Dad's Name: _____ Dad's SS#: _____ Dad's Date of Birth: _____

Referring Physician's Name & Phone Number: _____

In case of emergency, contact (not living with you): _____

Phone Number w/Area Code: _____ Relationship to Patient: _____

Is this work-related? Yes No If yes, date of injury? _____ Claim #: _____

How did this injury happen? _____

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION

Insurance Company # 1: _____ Phone Number: _____

Primary Insured's Name: _____ Date of Birth: _____

Policy #: _____ Group #: _____ Relationship: _____

Policy Holder's SS#: _____

Insurance Company # 2: _____ Phone Number: _____

Primary Insured's Name: _____ Date of Birth: _____

Policy #: _____ Group #: _____ Relationship: _____

Policy Holder's SS#: _____

- I hereby authorize treatment and payment of medical benefits to Minimal Access Surgery Clinic for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.
- I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.
- I hereby authorize MASC to release any medical information necessary to complete and process my insurance claims.

I authorize the physicians at Minimal Access Surgery Clinic to treat me and use my personal health information for healthcare operations.

Patient's OR Insured's Signature (If patient is a Minor, must have Responsible Party Signature) Date

**MINIMAL ACCESS SURGERY CLINIC
Billing/Authorization Policy**

The following sets forth the general billing policy of Minimal Access Surgery Clinic (MASC). Please review this information and sign where indicated.

- ❖ I understand that it is my responsibility to provide Minimal Access Surgery Clinic with current, accurate billing information at the time of check in and to notify Minimal Access Surgery Clinic of any changes in this information.
- ❖ I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.
- ❖ I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a \$35 NSF fee. I further understand that to rectify my account, I will be required to pay with either cash, a money order, cashier's check, or credit card.
- ❖ I understand that MASC will verify my insurance eligibility prior to any elective surgery that I may have. I further understand that it is the policy to collect the deductible and/or coinsurance prior to scheduling my elective surgery. I further understand that THE FEE I AM QUOTED IS AN ESTIMATE based on 1) anticipated surgery to be performed and 2) current information provided to MASC by my insurance carrier.
- ❖ I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/ deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.
- ❖ I understand that MASC will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.
- ❖ I understand that the clinic may also take a verbal request to use my listed credit card for payment on my account or they may also use the same listed credit card on my account should my account become delinquent, or to cover an NSF check.
- ❖ I request that payment of authorized Medicare benefits be made on my behalf to MASC for any services furnished me by the physician/physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

My signature below confirms that I have read these billing policies and my financial obligation as pertains to the physicians of Minimal Access Surgery Clinic.

Legal Signature

Date

Relationship to Patient

PATIENT HEALTH QUESTIONNAIRE

Page 1

Patient's Name _____ Date _____

PAST MEDICAL HISTORY

1. MEDICAL

- High Blood Pressure YES ___ NO ___
Diabetes Mellitus YES ___ NO ___
Tuberculosis YES ___ NO ___
Peptic Ulcer Disease YES ___ NO ___
Heart Disease YES ___ NO ___
Lung Disease YES ___ NO ___
Kidney Disease YES ___ NO ___

2. SURGERY

Previous surgical procedures and dates: _____

ALLERGIES

- 1. Antibiotics (List type of reaction) _____
2. Pain Medications _____
3. Iodine _____
4. Sea Foods _____
5. Adhesive Tape _____
6. Latex _____

3. HABITS

- 1. Cigarettes YES (Amount per day) ___ NO ___
2. Chew Tobacco YES (Amount per day) ___ NO ___
3. Dip Snuff YES (Amount per day) ___ NO ___
4. Drink Alcohol YES (Amount per day) ___ NO ___
5. Drink Coffee YES (Amount per day) ___ NO ___

4. CURRENT MEDICATIONS

List all medications and dosages currently taken: _____

REVIEW OF SYSTEMS

1. HEART

- Any difficulty breathing when lying flat in bed YES ___ NO ___
Smothering attacks at night YES ___ NO ___
Must sleep with pillows to prop head and shoulders up YES ___ NO ___
Number of times to get up during the night to urinate _____
Swelling of the feet and ankles YES ___ NO ___
Palpitations YES ___ NO ___
Chest Pain YES ___ NO ___
Describe location and things that seem to bring it on _____

2. LUNGS

- Cough YES ___ NO ___
Sputum production (Phlegm) YES ___ NO ___
Frequent bronchitis YES ___ NO ___
Wheezing YES ___ NO ___

(OVER)

PATIENT HEALTH QUESTIONNAIRE

Page 2

Patient's Name _____ Date _____

3. GU

Difficulty with urination YES _____ NO _____
Frequency of urination YES _____ NO _____
Hesitancy (Inability to start stream) YES _____ NO _____
Dysuria (Burning with urination) YES _____ NO _____

4. GI

Frequent vomiting YES _____ NO _____
History of vomiting blood YES _____ NO _____
Gas or bloating YES _____ NO _____
Indigestion YES _____ NO _____
Constipation YES _____ NO _____
Melena (black, tarry, sticky bowel
Movements) YES _____ NO _____
Bright red bleeding per rectum YES _____ NO _____
History of hemorrhoids YES _____ NO _____

5. NEUROLOGICAL

Seizure YES _____ NO _____
Epilepsy YES _____ NO _____
Slow to learn YES _____ NO _____

6. BLEEDING

Do you bleed easily? YES _____ NO _____
Are you taking blood thinners? YES _____ NO _____
How much aspirin do you take? YES _____ NO _____

7. IMMUNIZATION

Date of last Tetanus shot _____

8. FAMILY HISTORY

Does cancer run in the family? YES _____ NO _____
If so, list relatives with cancer and the type they had: _____

Does diabetes mellitus run in the family? YES _____ NO _____
Is there a family history of heart trouble? YES _____ NO _____
Is there a family history of stroke? YES _____ NO _____
Is there a family history of high blood pressure? YES _____ NO _____

9. SOCIAL HISTORY

Number of children _____
Type of job performed _____
Is there a lot of stress on the job? YES _____ NO _____

I have received a Notice of Privacy Practices from Minimal Access Surgery Clinic

Patient's/Guardian's Signature

Date

(NO MEDICAL OR BILLING INFORMATION WILL BE DISCLOSED TO INDIVIDUALS (TO INCLUDE SPOUSES AND PARENTS/GUARDIANS) UNLESS AUTHORIZED/APPROVED BY THE PATIENT IN THE LISTING BELOW)

I hereby authorize Minimal Access Surgery Clinic to disclose my medical and billing information to:

Name: _____ Relationship: _____

Telephone Number: _____

Name: _____ Relationship: _____

Telephone Number: _____

ADDITIONAL COMMENTS

PLEASE RETURN THIS PAGE TO THE FRONT DESK