Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) ______________________ (First) ___________ (MI) _____ Previous Name ____________________

Address Line 1 ____

City, State _____________________________ ZIP _________________

Home Phone ____________________ Cell No. ___________________ Work Phone ________________Ext. __________

Primary Care Provider (PCP) ______________________________ Referring Provider ____________________________

Rendering Provider Name (this practice) _____________________________ E-Mail Address:__________________________

Date of Birth MM ______/DD ________/YYYY ____________ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐American Indian/Alaska Native ☐Asian ☐Native Hawaiian/Pacific Islander ☐Black/African American ☐White ☐Hispanic ☐Other ☐Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other ☐ _________

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-______-________ Employer Name ______________________________________

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name __________________________________ First Name ___________________________

Phone Number ____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient ____ ☐ Guardian

Address Line 1 ____

City, State _____________________________ ZIP _________________

Home Phone ___________________________ Work Phone _________________________ Ext. ________________

Referring Provider Name ____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) _________________________ (First) _________________________ (MI) __________

Guarantor Account Number __________________________ Date of Birth MM ________/DD ________/YYYY ___________

Social Security Number _______-_____-________ Telephone ____________________

E -Mail Address ___________________________________ Sex ☐ F – Female ☐ M - Male

Address Line 1 ____

City, State _____________________________ ZIP _________________

Employer____ Employer Phone Number_____________________

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number____ (______)______________

Name of Insured____ Patient Relationship to Insured__________________

Subscriber ID (Policy Number)_________________ Group ID________________ Copay Amount_________________

Effective Date___________________ Termination Date______________ Date of Birth MM ______/DD ______/YYYY _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number____ (______)______________

Name of Insured____ Patient Relationship to Insured__________________

Subscriber ID (Policy Number)_________________ Group ID________________ Copay Amount_________________

Effective Date______________________ Termination Date_______________Date of Birth MM ______/DD ______/YYYY____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

***Patient (or Responsible Party) Signature*____ *Date*________________**

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General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

______________________________	______________________________
Signature of Patient or Personal Representative	**Date**
______________________________	______________________________
Printed Name of Patient or Personal Representative	**Relationship to Patient**
______________________________	______________________________
Printed Name of Witness	Employee Job Title
______________________________	______________________________
Signature of Witness	**Date**

Surgical Specialist of Clear Lake

Patient Information

PATIENT NAME: ______________________________ DOB: ___________________ SEX: _______ DATE: _______________

REFERRING DOCTOR: ____

PLEASE CHECK **ALL** PREVIOUS AND CURRENT ILLNESSES OR CONDITIONS BELOW:

☐ High Blood Pressure	☐ Asthma	☐ Jaundice	☐ Arthritis
☐ Heart Attack	☐ Tuberculosis	☐ Deep Venous Thrombus	☐ Back injury
☐ Coronary Artery Disease	☐ Other Lung Problems	☐ HIV	☐ Depression
☐ Heart Failure	☐ Ulcers	☐ Sickle Cell	☐ Psychiatric Illness
☐ Other Heart Problems	☐ Diverticulitis	☐ Bleeding Disorders	☐ Glaucoma
☐ High Cholesterol	☐ Gallstones	☐ Blood Transfusions	☐ Eye Problems
☐ Diabetes	☐ Hernias	☐ Anemia	☐ Cancer
☐ Thyroid Problems	☐ Cirrhosis	☐ Kidney Stones	☐ Sleep Apnea
☐ Pulmonary Embolus	☐ Hepatitis	☐ Urinary Problems	☐ Other

If you marked "Other" , please explain:

____

____

Past Surgeries: ☐ None

____

____

Current Medications: ☐ None

____

____

Medication Allergies: ☐ None

____

____

Family History: ☐ None ☐ Heart Disease ☐ Diabetes ☐ Cancer

____

Have you **ever Smoked**? No ☐ Yes ☐ If yes, __________packs a day for __________years. Quit? _________________

Do you drink **alcohol**? ☐ No ☐ Yes If yes, ________ drinks a week of ☐ Wine ☐ Beer ☐ Liquor

Check Symptoms you currently have or have had in the past year:

CONSTITUTIONAL	☐ Palpitations	☐ Constipation	☐ Stroke/TIA
☐ Fever	☐ Chest Pain	☐ Bloody Stools	☐ Weakness
☐ Weight Loss	☐ Irregular Heart Beat	☐ Stool Caliber Change	**HEMME/IMMUNO**
☐ Heat/Cold Intolerance	**REPIRATORY**	☐ Stool Color Change	☐ Bleeding Disorders
EYES	☐ Shortness of Breath	**SKIN & BREAST**	☐ Blood Transfusions
☐ Glasses/Contact	☐ Cough	☐ Skin Lesions	☐ Large Lymph Glands
☐ Blurry Vision	☐ Wheezing	☐ Breast Mass	MUSCULOSKELETAL
EARS & THROAT	**GASTROINTESTINAL**	**URINARY**	☐ Arthritis
☐ Difficulty Hearing	☐ Nausea	☐ Incontinence	☐ Bone Pain
☐ Loose Teeth	☐ Vomiting	☐ Frequency	
☐ Dentures	☐ Heartburn	☐ Urgency	
CARDIAC	☐ Poor Appetite	**NEUROLOGIC**	

Other/Explanation: ____

Date of last colonoscopy:________________________________

For Women ONLY: Last Mamogram: ________________________ Last Pap Smear: _______________________________

Number of Pregnancie: ______________________ Age you started menstruating: _____________ Menopause: ________

Have you ever taken Birth Control Pills: ________________ Have you ever taken Hormone Replacement Therapy:______________

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** ___________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** ___________ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** ___________ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.
☐ **OPTION 1.** I want the **D.** ___________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐ **OPTION 2.** I want the **D.** ___________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.
☐ **OPTION 3.** I don't want the **D.** ___________ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Surgical Specialists of Clear Lake, PLLC

PATIENT NAME____DATE OF BIRTH____________

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

1. **____________(Patient or Guardian Initials)**

Financial Agreement.

- I acknowledge, that as a courtesy, **SURGICAL SPECIALISTS OF CLEAR LAKE, PLLC** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. **___________(Patient or Guardian Initials)**

Third Party Collection. I acknowledge that **SURGICAL SPECIALISTS OF CLEAR LAKE, PLLC** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. **___________(Patient or Guardian Initials)**

Assignment of Benefits. I hereby assign to **SURGICAL SPECIALISTS OF CLEAR LAKE, PLLC** any insurance or other third-party benefits available for health care services provided to me. I understand **SURGICAL SPECIALISTS OF CLEAR LAKE, PLLC** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **SURGICAL SPECIALISTS OF CLEAR LAKE, PLLC,** I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. **______________(Patient or Guardian Initials)**

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **SURGICAL SPECIALISTS OF CLEAR LAKE, PLLC** by the Medicare or Medicaid program.

5. **______________(Patient or Guardian Initials)**

Consent to Telephone Calls for Financial Communications. I agree that, in order for **SURGICAL SPECIALISTS OF CLEAR LAKE, PLLC**, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **SURGICAL SPECIALISTS OF CLEAR LAKE, PLLC** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **SURGICAL SPECIALISTS OF CLEAR LAKE, PLLC** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. **______________(Patient or Guardian Initials)**

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X____Date_________________

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse Guarantor

Surgical Specialists of Clear Lake, PLLC

PATIENT NAME____DATE OF BIRTH____________

Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify)___________________________________