EVANS MEMORIAL
SURGICAL ASSOCIATES

Welcome to Surgical Associates. Thank you for choosing us for your surgical and diagnostic evaluation needs. This packet will answer a number of potential questions relating to this practice.

You can help make your visit more complete and speed your visit by filling out the attached **Patient Information** form and **Patient Questionnaire** before your visit. Please also sign the **financial policy**, indicating that you have read and understand this policy. You may drop this off or mail this back to us if you feel it will have time to arrive before your visit. If you can, make a copy to keep and bring this with you if you mail the forms back. **Address: Surgical Associates, 604 East Long Street, Claxton, GA 30417.** Even if you cannot return the forms to us before your visit, it will save you time by filling these out and bringing them to the appointment with you.

Bring The Following (very important)

Please bring the following with you to the office the day of the appointment

- If your x-rays were done at some facility other than Evans Memorial, please bring your **X-ray films** with you as directed. These will have to be checked out from the facility where they were performed. If you are not sure if you should bring x-rays, call 912- 739-7710 (9:00-4:30 weekdays) several days prior to your appointment to make this determination (or if you have questions about obtaining the films). *If mammograms, you will need to bring them including from Evans Memorial. This is very important for **breast visits** so that a decision can be made regarding recommendations for your care.*
- Please **complete the medication list** provided in this packet including: name of medication,
- strength, how many, how often. Bring your **insurance card** / information.
- Complete and sign all of the **attached forms**. Bring them to the office at the time of your visit even if you faxed them to us.

Office Hours
Monday - Thursday 8:00am - 5:00pm
Friday - 8:00am - 3:00pm

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SURGICAL ASSOCIATES
PATIENT INFORMATION

Name_____
last first middle

Address_____
Mailing Address city state zip

Birthday: _____ Age: _____ Social Security #_____-_____-_____ Sex: M / F

Race: _____ Language: _____Ethnicity: ☐Hispanic ☐Non-Hispanic

Phone: _____☐Home ☐Cell ☐Work Phone: _____☐Home ☐Cell ☐Work

Would you like to utilize the patient portal? ☐Yes ☐No If yes, what is your email address? _____

Employer / School _____

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

Employment ☐Retired ☐Full-time ☐Part-time ☐None ☐Disabled

Spouse or Parent

Name_____
last first middle

Birthday _____ Phone: _____☐Home ☐Cell ☐Work ☐Other

Emergency Contact Information

Name		
Relationship		
Phone number		
Address		

Other Information

Family Physician: _____☐None Reason for appointment: _____

Other Physicians: _____

Please read and sign below giving us permission to treat the patient and release insurance information. We request that office visits be paid at the time of service unless other arrangements have been made.

AUTHORIZATION: I hereby authorize the physician indicated to furnish information to insurance carriers concerning this illness / accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

RESPONSIBILITY: I understand that it is my responsibility to notify Surgical Associates of any special requirements which my insurance company may impose (ie, in network labs, pathologists, hospitals, precertification requirements, etc.).

RELEASE OF RECORDS: I understand that a medical record will be produced as a result of this and subsequent evaluation(s). That information will likely be forwarded/ faxed to your referring physician, other physicians who care for you, a hospital if hospital care is required, and your insurance carrier.

Signature or Responsible Party: _____Date: _____

EVANS MEMORIAL
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Financial Policy of Surgical Associates

Please read this financial policy carefully. If you have any questions about this policy, a member of our staff will be glad to assist you.

1. Payment for services: Our office staff will inform you of the amount due prior to evaluation. This amount is due at the time of service. We will file your insurance claims, but you must provide the appropriate insurance information and a copy of your insurance card. All co-pays and co-insurance is due at time of service. Please note that the entire balance is your responsibility, and we will not hold the insurance company responsible for payment.

2. Surgeries / Procedures: If a procedure is scheduled, we will contact your insurance company to confirm benefits and co-insurance. A deposit will be required at the time of your preop visit.

3. Methods of payment: You may pay your bill with cash, personal check or credit card. For your convenience, we accept Visa, MasterCard, Discover and American Express.

4. Returned checks: A $25.00 service charge will be added on all checks returned to us for insufficient funds.

5. Special Needs: We realize that temporary financial problems may make it difficult for you to pay your balance immediately. If such problems should arise, please contact us promptly so that we may set up a payment plan that will meet your needs. We are willing to work with you on your account, but it is your responsibility to inform us of any reason that you are unable to pay the outstanding balance.

6. Collection Policy: Delinquent accounts will be forwarded to a collection agency. We will inform you of your account status on your statement, and we will attempt to contact you by letter before your account is forwarded. If you are unable to pay your balance promptly, please call us so that we may arrange to hold your account.

7. Questions? We are here to help should you have any questions regarding your statement or insurance. You may contact us between the hours of 9:00 am and 4:30 pm, Monday through Friday.

Note: Any concern with our financial policy should be brought to the attention of the business office. We will be glad to discuss these concerns with you in private.

Patient/Guardian Signature:_____ Date:_____

EVANS MEMORIAL
SURGICAL ASSOCIATES

Surgical Associates
Compound Authorization for Release of Information

Due to new laws and regulations we cannot give out any information on you unless we have written authorization.
Please check (x) the entity or person we may give information to. In the box beside the entity please check (x) what information we can give to the entity or person, also in order for the named person to receive the information they must listed below.

Patient Name:_____ Date of Birth:_____
Surgical Associates is authorized to release protected health information about the above named patient to the entities named below.

Entity to Receive Information Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail/Answering Machine	☐ Results of labs test/x-rays Other_____
☐ Give information to employer ☐ Give information to school	☐ Appointment absentee information
☐ Spouse (**provide name and phone #**)	☐ Financial ☐ Medical as follows:_____
☐ Parent (**provide name and phone #**)	☐ Financial ☐ Medical as follows:_____
☐ Other (**provide name and phone #**)	☐ Financial ☐ Medical as follows:_____

Rights of the Patients
I understand that I have the right to revoke the authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to **Surgical Associates.** I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. This authorization shall be in effect until revoked by the patient.

_____ _____
Signature of Patient or Personal Representative Date

SURGICAL ASSOCIATES
604A EAST LONG STREET CLAXTON GEORGIA 30417
912-739-7710

ACKNOWLEDGEMENT OF PRIVACY PRACTICES RECEIVED

PATIENT'S NAME: _____

Date of Birth: _____

I, _____HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE PRIVACY PRACTICES NOTICE FROM SURGICAL ASSOCIATES IN REGARDS TO MY PROTECTED HEALTH INFORMATION.

_____ _____
Patient signature **Date**

SURGICAL ASSOCIATES
NOTICE OF PRIVACY PRACTICES

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.

Who is Subject to this Notice?:

- All physicians, nurses, or other health care providers with authority to enter information in your medical record and;
- Certain employees of Surgical Associates and Evans Memorial Hospital;
- Business Associates of Surgical Associates and Evans Memorial Hospital.

How We May Use or Disclose Your Health Information.

For Treatment: Physicians, nurses or other health care providers may use your health information to provide you with medical treatment or services. For example: a physician, nurse, or other person providing health services to you, will record information in your medical record that is related to your treatment. This information is necessary to create a record of the treatment you received. Your information may also be made available to laboratory, radiology personnel, or other hospital departments as needed.

Emergency Treatment: In an emergency, if you are unable to understand the information contained in this notice, we may use and disclose information in your medical record as deemed necessary in the professional judgment of the health care provider to appropriately treat your condition. As soon as you are stabilized and/or the emergency condition has been resolved, we will provide you with a copy of this notice. Treatment of Certain Conditions: We will use or disclose your health information regarding certain specific conditions, such as HIV,AIDS, alcohol or drug treatment, mental health issues, and sexually transmitted diseases only

- as permitted or required by law;
- by court order or subpoena;
- if in the professional judgment of your doctor such is required to protect you or others from serious harm or death..

For Payment: We may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you, or a third-party such as an insurance company, HMO, Medicare or Medicaid. We may utilize the services of a third-party to perform billing services or collection of unpaid bills. The information on the bill or explanation of benefits from your insurance company may contain information that identifies you, your diagnosis, treatment and supplies used in the course of your treatment.

For Health Care Operations: We may use and disclose health information about your for operational purposes. For example: your health information may be disclosed to affiliated entities, auditors, consultants, legal, risk, or quality improvement personnel, insurance carriers, and others, as Business Associates to:

- evaluate the performance of physicians;
- assess the quality of care and outcomes in your cases and similar cases;
- learn how to improve our services;
- determine how to continually improve the quality and effectiveness of the health care we provide;
- test for fraud and abuse detection;
- manage our business and general administrative requirements.

Business Associates: We may use and disclose health information about you with Business Associates that we contract with to perform certain services on our behalf that require the use of health information. We will enter into a Business Associate Agreement with the Business Associate to provide confidential treatment of the health information received by the Business Associate.

Required by Law: We may use and disclose information about you as required by law. For example, information may be disclosed for the following purposes:

- for judicial and administrative proceeding pursuant to legal authority;
- to report information related to victims of abuse, neglect or domestic violence; and
- to assist law enforcement officials in their law enforcement duties.

Public Health: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, disability, or for other health oversight activities. For example, we are required to report all births, deaths and certain diseases.

Decedents: Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation: Your health information may be used or disclosed for organ, eye or tissue donation purposes.

Research: Your health information may be used for research purposes when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Health and Safety: Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions: Specialized Government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

Workers Compensation: Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.

State Law: Should State Law require additional uses, disclosures or greater protection of your health information, we will comply with State Law.

Authorization/Consents: No other release of your health information will be made other than as specified in this Notice without your written authorization or consent.

Appointments or Other Services: We may contact you in order to remind you about appointments, health screenings, test results or other services including information from Evans Memorial Hospital that may benefit you. Fund-raising: We may contact you regarding fund-raising activities being undertaken to benefit Evans Memorial Hospital.

Your Health Information Rights

You have the right to:

- request a restriction on certain uses and disclosures of your information, however, we are not required to agree to all requested restrictions;
- obtain a paper copy of this notice of privacy practices;
- inspect and obtain a copy of your health record;
- request an amendment of your health record;

- request communications of your health information by alternative means or at alternative locations;
- revoke your authorization to use or disclose health information except to the extent that action has already been taken; and
- receive an accounting of disclosures made of your health information.

All such requests to exercise your rights set forth in this Notice must be made in writing addressed to the Privacy Officer of Surgical Associates.

Our Obligations
We are required to:

- maintain the privacy of protected health information;
- provide you with this Notice of our legal duties and privacy practices with respect to your health information;
- abide by the terms of this Notice;
- notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations and;
- obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted by Law.

Complaints If you feel your privacy rights have been violated, you may complain to Surgical Associates and to the Department of Health and Human Services. There will be no retaliation for filing a complaint.

To file a complaint with Surgical Associates:
Surgical Associates
Attn: Privacy Officer
604 East Long Street
Claxton Georgia 30417

To file a complaint with Evans Memorial Hospital:
Evans Memorial Hospital
Attn: Privacy Officer
200 North River Street
Claxton Georgia 30417

To file a complaint to HHS:
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington D.C. 20201

Contact Information or if you need additional copies of this notice of Privacy Practices, please contact:
Surgical Associates
604A East Long Street
Claxton Georgia 30417

Surgical Associates reserves the right to change our information practices and to make the new provisions effective for all protected health information we maintain. Revised notices will be made available to you by contacting Surgical Associates

Effective date April 28, 2005

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Medications (including herbal and non-prescription medications)

Medications	**Dose (mg)**	**How often? (Daily; Twice per day; etc.)**
Do you take a blood thinner (Coumadin, Plavix, Lovenox, Xarelto, Effient, Brilinta, Pradaxa, etc.)? ☐Yes ☐No If you take Coumadin, when and Where was your last PT / INR level? _____		
Pharmacy:	Phone number	

Allergies

The following questions are very important to answer in preparation for any surgery.

☐I am not allergic to any medications (NKDA) to my knowledge. ☐I have medication allergies as listed below.

☐I am not allergic to **Betadine** (or shellfish) to my knowledge. ☐I am allergic to **Betadine**.

☐I do not have a known **Latex** allergy. ☐I am allergic to **Latex**.

☐I do not have a known **Tape** allergy. ☐I am allergic to **Tape** except _____.

☐I do not have a known **Food** allergy. ☐I am allergic to the following **Food:** _____ _____.

Please list medication you are allergic to	**Reaction (rash, swelling, etc)**

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Past History…
Check only those that apply. For empty spaces, write in any additional items.

Medical History: ☐ None

√			√			√	
	Asthma			Barrett's esophagus			Anticoagulant use? _____
	COPD (chronic obstructive pulmonary disease)			Hiatal hernia			Bleeding disorder
	Wheezing			Reflux			Diabetes
	Sleep Apnea □CPAP?			Gallstones			Thyroid disorder
	Heart disease			Hepatitis			Stroke
	High blood pressure			Constipation			Seizures
	High cholesterol			Irritable Bowel		Cancer: type _____	
	Congestive heart failure			Hemorrhoids		Other:	
	Mitral valve prolapse			Colon polyps			
	Blood clots / Deep vein thrombosis			Diverticulosis coli			
	Aneurysm: Where: _____			Hernia: Where? _____			

Surgical History: ☐ None

	Perioperative nausea or vomiting			Colon removal			Orthopedic:
	Anesthetic problem			Upper endoscopy / EGD			
	Breast: _____			Colonoscopy: Last ____		Other:	
	Heart: ☐Cath ☐Stent ☐Bypass			Hernia: _____			
	☐Pacemaker ☐Defibrillator			Prostate: _____			
	Vascular: ☐Stent ☐Bypass			Hysterectomy			
	Appendectomy			Ovaries removed			
	Gallbladder removal			C-section			

Social History:

Smoking History:		Alcohol		Reside
	Current smoker ____pk / day		Never		Home
	Former smoker Stop year: _____		Occasional		Nursing facility: _____
	Never smoked		Frequent		
	Use other tobacco product		Daily		Disabled

Family History: ☐None / negative

	Hypertension		Colon polyps		Cancer: type _____
	Heart disease		Colon or rectal cancer		Diabetes

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			Crohn’s disease		

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Review of Systems – check any that apply

General	□ None	□Fever □Malaise □Fatigue □Chills □Sweats □Pain □Weight gain □Weight loss
Eyes	□ None	□Eye pain □Blind spots □Excessive blinking □Tearing □Drainage □Injury
HEENT	□ None	□Headache □Dizziness □Light headedness □Ear pain □Drainage □Nose bleeding □Hearing loss
Pulmonary	□ None	□Wheezing □Cough □Congestion □Excessive sputum □Shortness of breath □Asthma
Endocrine	□ None	□Hair loss □Excessive thirst □Heat intolerance
Cardiovascular	□ None	□Chest pain □Palpitations □Syncope □Heart murmur □Hypertension □Coronary artery disease □Pedal edema
Gastrointestinal	□ None	□Change of appetite / bowel patterns □Difficulty swallowing □Heartburn □Nausea □Vomiting □Diarrhea □Abdominal pain □Rectal bleeding □Heme + stool □Melena / black tarry stools □Constipation
Genitourinary	□ None	Urinary problems such as: □Frequency □Painful urination □Bloody urine □Discolored urine □Little urine production
Neurologic	□ None	□Concussion / Loss of consciousness □Frequent headaches □Migraines □Difficulty with memory □Difficulty with speech □Numbness / tingling □Seizures □Tremor □Vertigo
Musculoskeletal	□ None	□Joint pain / swelling / injury □Limitation of motion □Muscle weakness / pain / cramps □Back pain □Arthritis □Gout
Skin	□ None	□Rash □Itching □Abnormal pigmentation □Hair loss □Growth □Lesions □Infection / erythema
Psych	□ None	□Anxiety □Depression □Insomnia □Panic Attacks □Memory Loss
Hematologic	□ None	□Easy bruising □Excessive bleeding □Prior blood clots / Deep vein thrombosis □MRSA □Transfusion

Any additional information you would like for the provider to know…

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Fall Risk Assessment
For patients 65 and over

YES	NO	
		I have fallen in the last 6 months.
		I use or have been advised to use a cane or walker to get around safely.
		Sometimes I feel unsteady when I am walking.
		I steady myself by holding onto furniture when I walk.
		I am worried about falling.
		I need to push with my hands to stand up from a chair.
		I am often dizzy when I first stand up.
		I have trouble stepping up onto a curb.
		I often have to rush to the bathroom.
		I have lost some feeling or have pain in my feet.
		I take medicine that sometimes makes me feel light-headed or more tired than usual.
		I take medicine to help me sleep or improve my mood.
		I often feel sad or depressed.
Total		4 or more marked **yes** indicates potential fall risk.

Patient's signature: _____ Date: _____

☐ Pass ☐ Fail
☐ Patient advised to continue use of cane or walker.
☐ Patient advised to use cane or walker to reduce risk of falling.

SURGICAL ASSOCIATES

Rebecca Spahos, MD Kevin Timperman, MD

604 East Long Street Claxton, GA 30417

Phone: 912-739-7710 Fax: 912-739-7343

AUTHORIZATION TO RELEASE INFORMATION

(Disclosure of Protected Health Information)

I am scheduled for surgical consultation and authorize the use/disclosure of health information about me as described below:

Please forward all documents listed below to Surgical Associates.

Patients Name: _____

Date of Birth: _____

I _____, hereby request _____,

(Patient's name) **(Provider/Facility)**

_____

(Address)

to release medical information regarding _____

_____

to Surgical Associates. Please forward the requested records via fax to 912-739-7343.

_____ _____

(Patients signature) **(Date)**

_____ _____

(Signature of authorized person, if minor) **(Date)**

_____ _____

(Witness Signature) **(Date)**