

**Surgical Associates
604 East Long Street
Claxton, GA 30417
Ph. 912-739-7710**

Introduction

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.

Facilitate Your Visit

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 (Closed from 12:00pm - 1:00pm for lunch)
Friday - 8:00am - 3:00pm

**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 **Employment** Retired Full-time Part-time
Divorced Separated 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: _____

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: _____

**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.
<input type="checkbox"/> Voice Mail/Answering Machine	<input type="checkbox"/> Results of labs test/x-rays Other _____
<input type="checkbox"/> Give information to employer <input type="checkbox"/> Give information to school	<input type="checkbox"/> Appointment absentee information
<input type="checkbox"/> Spouse (provide name and phone #)	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____
<input type="checkbox"/> Parent (provide name and phone #)	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____
<input type="checkbox"/> Other (provide name and phone #)	<input type="checkbox"/> Financial <input type="checkbox"/> 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 you 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

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 <input type="checkbox"/> 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: <input type="checkbox"/> Cath <input type="checkbox"/> Stent <input type="checkbox"/> Bypass		Hernia: _____		
	<input type="checkbox"/> Pacemaker <input type="checkbox"/> Defibrillator		Prostate: _____		
	Vascular: <input type="checkbox"/> Stent <input type="checkbox"/> 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				
	Crohn's disease				

Review of Systems – check any that apply

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

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

SURGICAL ASSOCIATES

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

H. Kyle Parks, MD Rebecca Spahos, MD Brandi Watson, FNP-C

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 Dr. _____,

(Patients name)

(From doctor)

(Address)

to release medical information regarding _____

(Medical condition)

To Surgical Associates please forward the requested records via fax at 912-739-7343.

(Patients signature)

(Date)

(Signature of authorized person, if minor)

(Date)

(Witness Signature)

(Date)