Surgical Associates of the Shoals

J.Ryan Conner, MD FACS
Randall K. Mansell II, DO
Kristy Oden, CRNP, DNP
Mary Grace Stewart, PAC

Patient Name

Date of Birth

Patient Information

Date: _____ How Did You Hear about Us? _____

Referred By: _____ Primary Care Physician: _____

Patient Name: _____ Gender: M / F

Social Security Number: _____ Date of birth: _____ Age: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: (___) _____ Cell Phone Number: (___) _____

E-mail Address: _____

Marital Status (circle one): S M W D

Race (circle one):
White Hispanic American Indian Other Pacific Islander
African American Asian Native Hawaiian Other

Ethnicity (circle one)
Hispanic or Latino
Not Hispanic or Latino

Employer: _____ Occupation: _____

Work Phone Number: (___) _____

Spouse's Name: _____ Social Security Number: _____

Date of Birth: _____ Cell Phone Number: (___) _____

Employer: _____ Occupation: _____

Responsible Party/Guarantor (Please complete the following if the patient is under 18):

Name: _____ Relationship to Patient: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____ Date of birth: _____ Phone: (___) _____

Insurance Information

We must have a copy of your insurance card(s)

Primary Insurance: _____

Secondary Insurance: _____

Emergency Contact

Name: _____ Phone Number: (___) _____

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ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program.

These include:

- Formulary and benefit transaction- Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transaction- Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification- Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

This benefits you by:

- Less confusion over handwritten prescriptions or unclear phone calls
- Reduced possibility of medical errors
- Less chance of adverse drug reactions
- Fewer trips to the pharmacy and waiting for prescriptions
- A safer, faster, easier way to get your prescription filled

I have been made aware and understand that Northwest Alabama Practice Management may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my provider(s) using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my provider(s) to see this protected health information.

Patient or Responsible Party's Signature:	Date:
Relationship to Patient: Self / Guardian / Parent	

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HIPAA Release

Patient Name: _____ **Date of Birth:** _____

I authorize the release of my protected health information, including diagnosis, records, and examinations rendered to me. This also includes claims information. I also understand that this protected health information is available to me upon request.

This information may be released to:

[ ] Spouse: _____

[ ] Children (Please list below)

[ ] Other (Please list below)

Name:	Relationship to Patient:	Contact Number:
		( ) -
		( ) -
		( ) -
		( ) -

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated or changed by me in writing.

Messages

If unable to reach me:

[ ] You may leave a detailed message

[ ] Do not leave a message

[ ] Please leave a message asking me to return your call

Privacy Practices Acknowledgment

[ ] I acknowledge that I am provided with a copy of the privacy practices once a year and that a copy will be provided to me at any time upon request.

_____ _____

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

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Medical History

Circle any of the following that you have experienced:

Emphysema Tuberculosis Acid Reflux Stomach Ulcers Heart Attack Mitral Valve Prolapse

Anemia Bleeding Disorder Blood Transfusions Diabetes Mellitus Migraine Headaches

Hypertension Stroke Epilepsy/Seizures Thyroid Disease HIV+ Hepatitis

Pneumonia Asthma

Past Medical History (PMH):

Have you ever had cancer? □ YES □ NO If yes, please list type:_____

Any other medical problems:_____

When was your last: Colonoscopy:_____ Mammogram: _____
PSA: _____ Flu Vaccination:_____
Pap Smear:_____ Pneumonia Vaccination:_____

Current Medications:

What Pharmacy do you use? _____ **Location:**_____

Are You Allergic to Any Medications/Latex? YES NO
List the Name and Your Reaction: _____

_____

Social History (SH):

Occupation:_____

Have you ever smoked? □ YES □ NO
How old were you when you started smoking? _____
At most, how many packs a day did you smoke? _____/day
Alcohol Intake (amount per week): _____

Are you a current smoker? □ YES □ NO

When did you last smoke? _____
Any Recreational Drug Use? □ YES □ NO

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Past Surgical History (PSH)

List any previous surgeries, date of surgery, and name of surgeon: ☐ Never Had Surgery

Procedure Name:	Date of Procedure:	Surgeon Name:

Family History (FH):

Mother: Alive/Deceased Age:_____

Circle all that apply.
Bleeding Disorder Hypertension Lung Disease
Cancer:_____ Stroke Heart Disease
Other:_____

Father: Alive/Deceased Age:_____

Bleeding Disorder Hypertension Lung Disease
Cancer:_____ Stroke Heart Disease
Other:_____

Siblings: Alive/Deceased # of Sisters:_____
# of Brothers:_____

Bleeding Disorder Hypertension Lung Disease
Cancer:_____ Stroke Heart Disease
Other:_____

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Consent for Treatment

CONSENT FOR TREATMENT: I, knowing that I (or the patient name on this Admission Record if the patient is unable to consent) (is) am suffering from a condition requiring medical treatment do hereby voluntarily consent to such diagnostic procedures needed to address my condition that may include, but is not limited to laboratory or x-ray treatment, drug and/or alcohol screens/tests, and to such medical and hospital care deemed appropriate by the attending provider named on this record, any assistants or designee as is necessary in his/her judgment.

I acknowledge and understand that in order to insure, to the greatest extent possible under current medical guidelines, that there is not a transmission of blood borne diseases such as Hepatitis B or Acquired Immune Deficiency Syndrome and that it may be necessary to draw and test my blood while I am a patient in this clinic. Such action would be necessary should a healthcare worker be stuck by a needle while drawing my blood or, should a healthcare worker sustain an injury in the course of my treatment or, should either I or any healthcare worker rendering care to me incur a parenteral or mucous membrane exposure to blood or other body fluids of one another. I therefore consent to have my blood drawn and tested. I further understand that my blood will not be routinely tested for diseases, that the results of any testing will be kept strictly confidential, and that I will not be charged for the tests in an exposure situation.

PERSONAL PROPERTY: The clinic will not be liable for damage to, loss, or theft of any money, jewelry, documents, or other personal belongings to a patient.

ASSIGNMENT OF INSURANCE BENEFITS: In the event the patient is entitled to health benefits of any type because of any insurance policy insuring the patient or someone else who is responsible for paying the patient's clinic or provider bills, the undersigned hereby agrees that these benefits can be paid directly to the clinic and applied to the patient's bill. The patient and or the undersigned are responsible for any portion of the bill not paid by an insurance company. The undersigned agrees to assist in processing claims for benefits.

MEDICARE AND/OR CHAMPUS AUTHORIZATION: I certify that the information given by me to the clinic in applying for payment under Title XVII of the Social Security Act or Champus program is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administrator or its intermediaries or carriers any information needed for this or related Medicare/Champus claim. I request the payment of authorized benefits be made on my behalf to the clinic or provider providing interpretations in which the clinic bills.

AUTHORIZATION TO RELEASE INFORMATION: The undersigned authorizes the clinic and any provider rendering service to release medical or other information about the patient, which may be necessary for the completion of insurance claims, review of services, or receipt of benefits. Such information may include current medical records. The information may be released to third party payers, including the third party payer's agent and or/representative or anyone responsible for payment of the hospital and/or provider charges.

FINANCIAL RESPONSIBILITY: The undersigned agrees to pay for services, accommodations, and provider services rendered to the patient, and he or she is hereby obligated to pay the account of the clinic. It is understood and agreed that charges not paid may be placed with an attorney or collection agency. It is understood and agreed that reasonable cost of collection including attorney fees, collection agency fees, and/or open account interest charges assessed are payable by the undersigned. To the extent not expressly prohibited by applicable law, the undersigned agrees to pay all clinic charges not paid in full to the clinic by third-party payer. The clinic accepts cash, checks, MasterCard, Visa, and Discover as forms of payment. The undersigned is aware that there will be a $30 fee for any check that is returned for lack of funds. The undersigned is aware that in some cases the patient's bill may not be covered in full by the insurance company. The undersigned is aware of the fact the (patient/responsible party/guarantor) are responsible for any balance insurance does not pay. This balance due may include provisions set by your insurance company such as: co-payments, deductibles and "usual and customary" allowances. Co-payments and deductibles are due upon visit and must be paid at time of service.

"I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND UNDERSTAND ITS PURPSOSE AND CONTENT"

Guarantor (Agreement to pay)

Witness (to guarantor signature)

Date

Patient (or authorized representative /relationship to patient

Witness (if anyone other than the patient signs)

Date