

Patient Update Sheet

Patient Name: _____ Date of Birth: _____
Reason for visit: _____; How long have you had this issue: _____
How Severe: Mild Moderate Severe Location of Issue: _____
Primary Care Physician: Full Name _____

Please check if you've had the following since last seen:

<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> COPD	<input type="checkbox"/> Hiatal Hernia
<input type="checkbox"/> CPAP	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Echo	<input type="checkbox"/> Stress Test
<input type="checkbox"/> Gerd	<input type="checkbox"/> Head/Neck Injury

Please check if any blood relative had the following:

Anesthesia Issues
 Bleeding Problems

Past Surgical History I deny any past surgeries

Abdominal Surgery _____	Adenoidectomy _____	Appendix _____
Back Surgery _____	Gallbladder _____	Hernia _____
Hysterectomy _____	Tonsilectomy _____	Other _____

Medication Information I deny taking medication

List all MEDICATIONS you are currently taking including "dosage"

_____	_____
_____	_____
_____	_____
_____	_____

Allergy Information I deny any allergies

List all ALLERGIES (medication, latex, etc) and your "physical reaction"

_____	_____
_____	_____
_____	_____
_____	_____

Latex Allergy Yes No Reaction: _____

Marital Status: Single Married Separated Divorced Widowed Significant Other

Alcohol Use: Never Rarely Moderate Daily, amount per week _____

Tobacco Use: Never Former Smoker Current Age Started _____, Stop _____ pks per day _____

Smokeless Tobacco: Never Former Smoker Current Age Started _____, Stop _____

Do you wear dentures: Yes No

PATIENT INFORMATION

Last Name: _____, First Name: _____, Middle: _____, DOB: _____

Gender: Male Female SS#: _____ Race: White African American Other

Marital Status: Divorced Married Single Widowed Ethnicity: Hispanic Non-Hispanic Other

Street Address: _____
City State Zip

Phone: Home: _____, Cell: _____, E-mail Address Required: _____

Pharmacy: _____ City: _____ State: _____ Phone: _____

Primary Care Physician: First/Last _____ Referring Physician: _____

Preferred Communications: Phone Text Email Portal May we leave a message: Yes No

Employer: _____, Occupation: _____, Work #: _____

<p>Is the patient under 18 years of age? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please fill in below: Ins. Cardholder Name: _____ DOB: _____ SS#: _____</p>	<p>Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Accident: _____ Adjuster: _____</p>
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I authorize Bristol Surgical Associates to communicate my healthcare, appointment and/or billing information to the following people:

Name: _____ D.O.B.: _____ Relationship to patient: _____ Phone #: _____
Name: _____ D.O.B.: _____ Relationship to patient: _____ Phone #: _____
Name: _____ D.O.B.: _____ Relationship to patient: _____ Phone #: _____

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history including, symptoms, examination, test results, diagnoses, treatment, and any plans for further care or treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the many health professionals who contribute to my care, a source of information for applying my diagnosis and surgical information to my bill, a means by which a third party payer can verify that services billed were actually provided, and a tool for routine healthcare operation such as assessing quality and reviewing the competence of healthcare professionals.

I CONSENT TO TREATMENT NECESSARY FOR THE CARE OF THE UNDERSIGNED PATIENT.

We do not assume responsibility for determining if your insurance carrier requires a second opinion. We do not assume responsibility for motor vehicle / liability claims. We are not participating providers with all insurance carriers, it is the responsibility of the patient to verify insurance participation with Bristol Surgical Associates. Payment is due upon check in; any balance 90 days or older will be subject to a 12% APR. Outstanding accounts will be turned over to collection and the undersigned will be responsible for all collection agency fees, court costs and attorney fee.

INFORMATION RELEASE/BENEFIT ASSIGNMENT

I hereby assign and authorize payment directly to the attending physicians / surgeon for services rendered. I further authorize the release of any medical information or medical records for purposes of benefit payment. I hereby authorize Bristol Surgical Associates to obtain my credit report for the sole purpose of obtaining payment. I authorize a representative including but not limited to collection or billing companies of Bristol Surgical Associates to contact me by any and all contact information, including wireless or mobile telephone numbers listed within my medical record. I hereby give my consent to be contacted by any means including but not limited to a dialing service or pre-recorded message listed within my EHR.

The undersigned individual obligates himself to the payment of this account incurred by the patient in accordance with regular rates and terms of this office. The undersigned certifies that he has read, accepts and understands these terms.

No Show Policy for Doctor Appointment

I understand if an appointment is not cancelled at least 24 hours in advance I will be charged \$25; this will not be covered by the insurance company and will be patient responsibility.

Patient's Signature: _____ Today's Date: _____

Responsible Party's Signature: _____ Today's Date: _____
(Required if patient is under the age of 18)

Patient Financial Agreement

The following information is provided to all of our patients, new and established, to inform patients of our office financial policies and of patient financial responsibility requirements.

Please ask one of our team members if you have any questions regarding these policies.

- We will be happy to bill your insurance as a courtesy; however, all charges, regardless of insurance coverage are the patient's responsibility. We do expect payment for your portion at the time of service. (co-pays, co-insurance, deductibles). We ask that if your insurance has not paid within 45 days that you follow up with them. Our office contracts with most insurance carriers.
- If you are seen for both a wellness/annual exam and an illness of separate problem is also addressed, proper coding will be used which may result in a charge for both services. Additionally, some medically indicated lab work may not be covered by all wellness policies. Your individual contract with your insurance carrier will determine how your insurance will pay. We make every effort to bill each visit with the proper diagnosis and procedure codes according to national coding guidelines. Please understand that we cannot make exceptions to our coding practices due to federal and state legal compliance concerns, and we are unable to bill for services other than those documented in your medical record.
- Injections and some medical supplies must be paid for in advance at the time of service. Specialized products or services must be preauthorized with insurance prior to service; otherwise, these services will need to be paid in full by the patient at the time of service.
- For surgical care, we will pre-certify your insurance and obtain the estimated patient responsibility for the procedure. This amount is due prior to the scheduled date of surgery. If the procedure results in additional charges, these fees will be billed to you. We would ask that you pay the balance within 30 days following your surgery. Acceptable payment includes cash, check, VISA, MasterCard, Discover, American Express or CareCredit.
- We routinely send our laboratory testing to third-party laboratory companies. The aforementioned providers may or may not participate with your health plan. You may request that we refer your testing to another location. This request will need to be done with each visit.
- It is necessary to strictly enforce the policy of financial obligation. All co-pays, patient self-payment, and estimated care patient financial responsibility may be paid by cash, check, VISA, MasterCard, Discover, American Express or Care Credit. Only additional fees will be invoiced by the office to the patient. These are due within 30 days of receipt of invoice.
- There may be a charge for a no show of less than 24 hour cancellation (business hours) of \$25.00 for office visits and \$100 for surgical procedures. This fee is the responsibility of the patient and cannot be filed with insurance companies. Cancellation messages must be made with the office during regular business hours and cannot be made with the after-hours answering service in an effort to avoid this charge.
- Paperwork (for example Family Medical Leave Act (FMLA) & Short Term Disability applications) will be completed within a week of presentation. The charge for each form is \$10, payable in full at the time the form is left for completion.
- Finance charges will accrue on balances over 90 days at a rate of 1.0% per month (12% per annum (APR)).

I have read and understand the above information and agree to comply with these financial policies.

Signature: _____

Print Name: _____

Date: _____