Dear Patient,

We at Bristol Surgical Associates are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive health care available today.

In addition we are also dedicated to making top quality care as cost effective as possible. To assist you with your healthcare investment we provide the following:

***Payment Options*:**

- Cash, including money orders
- Debit and Credit Card **(3.99% service charge for any debit/credit card transaction)**
- Check **(not acceptable for surgery payments)**
- Care Credit –An interest free monthly payment plan. We also, offer an extended low interest option with no annual fees; can apply at carecredit.com online or in the office.

Please have the following available upon check in:
Otherwise appointment may be rescheduled

- **Insurance Card**
- **Co-pays and/or deductibles which are due upon check-in. This means if you have a co-insurance that will be collected day of visit**
- **Your current Medication and Allergy List**

In our efforts to reduce your waiting time patient registration information may be faxed to 423-844-6626 **Email to administrative@bristolsurgical.com** at least 48 hours in advance of appointment; please bring original copy to appointment.

If you are more than ***15 minutes late*** for an appointment (without notifying our office) you may be asked to reschedule that appointment.

We require a 24 hour notice of cancellation for appointments or a fee of $25 will be applied; insurance does not cover this and will be patient responsibility.

Our office is located at 1 Medical Park Blvd., 250 West, Bristol, TN 37620, inside Bristol Regional Medical Center; on the second floor, take a right off the elevator and our door is the only one there. If you have any questions or concerns please feel free to contact our office at 423-844-6620, Monday - Friday 9:00 a.m. to 5:00 p.m.

We look forward to seeing you at your scheduled appointment with:

Dr._____ck-in by_____on_____.

Sincerely,
Bristol Surgical Associates

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

Mailing 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 #:_____

Is the patient under 18 years of age? ☐Yes □No If yes, please fill in below:
Ins. Cardholder Name: _____ DOB: _____ SS#: _____

Worker's Compensation? ☐Yes ☐No
Date of Accident: _____Adjuster:_____

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 will 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. Effective January 1, 2020 a 3.99% service charge will be applied to any credit card transaction and online credit card transaction will be a flat fee of $4.25.

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 HISTORY SHEET

Patient Name:_____Date of Birth:_____Today's Date:_____
Reason for visit:_____How long had issue:_____
How Severe: ___Mild___Moderate___Severe Location of issue:_____
Primary Care Physician: First/Last_____Referring Physician:_____

PAST MEDICAL HISTORY

_____ I deny any past illness

__ Anemia	__ COPD	__ Gerd	__ HIV/AIDS	__ Sleep Apnea
__ Arthritis	__ CPAP	__ Head/Neck Injury	__ Hypertension	__ STD
__ Asthma	__ Deep Vein Thrombosis	__ Headaches	__ Kidney Disease	__ Stomach Ulcer
__ Bleeding Problems	__ Depression	__ Heart Attack	__ Kidney Stones	__ Stress Test
__ Blood Transfusion	__ Diabetes Type 1	__ Heart Murmur	__ Liver Disease	__ Stroke
__ Chest Pain	__ Diabetes Type 2	__ Hepatitis	__ Nervous Disorder	__ Thyroid Disease
__ Congestive Heart Failure	__ Echocardiogram	__ Hernia	__ Pulmonary Embolism	__ Cancer/Type
__ Convulsions	__ Emphysema	__ Hiatal Hernia	__ Seizures	_____

PAST SURGICAL HISTORY

_____ I deny any past surgeries

Indicate the date surgery was performed:

Abdominal Surgery_____ Adenoidectomy_____ Gallbladder_____ Other_____
Appendix_____ Hysterectomy_____ Tonsillectomy_____ Other_____
Hernia_____ Back Surgery_____

Medication Information

List all **MEDICATIONS** you are currently taking including "dosage" & "directions" _____I deny taking any medications

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergy Information

List all **ALLERGIES** (medications,etc) and your "physical reactions" _____I deny having any allergies

_____ _____ _____
_____ _____ _____
_____ _____ _____

Latex Allergy ___Yes ___No Reaction_____

Martial 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_____, Stopped_____# of pks per day____

Smokeless Tobacco: Never Former Smoker Current Age Started_____, Stopped_____

Non-prescription Drug Use: Never Type/Frequency_____

Do you wear dentures: Yes No

Revised 2/2/15

Continued on back

Patient's Personal History

CHECK only the symptoms that YOU have had within the past year.

GENERAL
Fever _____
Chills _____
Fatigue _____
Weight change _____
Night sweats _____

EYES
Change in vision _____
Blurred or Double Vision _____

ENT
Sore throat or voice change _____
Nasal congestion _____
Sinus problems _____
Headaches _____
Hearing loss _____
Ringing in ears _____
Earache or drainage _____
Nose bleeds _____
Mouth sores _____
Bleeding gums _____
Difficulty swallowing _____
Swollen neck glands _____

BREAST
Lumps _____
Tenderness/Pain _____
Discharge _____

CARDIOVASCULAR
Chest pain _____
Irregular heartbeats _____
Shortness of breath on exertion _____
Swelling of feet, ankles or hands _____

RESPIRATORY
Frequent coughing _____
Shortness of breath _____
Sleep apnea _____
Wheezing or Asthma _____
Spitting up blood _____

GASTROINTESTINAL
Heartburn / Indigestion _____
Loss of appetite _____
Nausea / Vomiting _____
Irritable Bowel Syndrome _____
Change in bowel movements _____
Diarrhea _____
Constipation _____
Abdominal Pain / bloating _____
Blood in stool _____
Painful bowel movements _____
Rectal bleeding _____
Hemorrhoids _____

GENITOURINARY
Urgency / frequency _____
Difficulty, painful urination _____
Blood in urine _____
Incontinence or dribbling _____
Urinary tract infections _____
Urinary retention _____
Change of force with urinating _____
Kidney stones _____

SKIN
Rash / itching _____
Change in moles or lesions _____
Varicose Veins _____

NEUROLOGICAL
Tingling or numbness _____
Coordination difficulty _____
Stroke _____
Memory difficulties _____
Seizures _____
Tremors _____
Light headed or dizzy _____
Paralysis _____

MUSCULOSKELETAL
Back pain _____
Joint pain, swelling or stiffness _____
Muscle pain or weakness _____

ENDOCRINE
Excessive Thirst _____
Glandular or hormone problems _____
Thyroid disease _____
Heat or cold intolerance _____
Dry skin / allergic dermatitis _____

PSYCHIATRIC
Anxiety / Nervousness _____
Depression _____
Memory loss or confusion _____
Sleep problems _____

HEMATOLOGICAL / LYMPHATIC
Bruise or Bleed easily _____
Enlarged / Tender lymph nodes _____
Slow to heal after cuts _____
Anemia _____
Phlebitis _____
Past blood transfusion _____
Taking any Blood Thinners _____

MALE
Testicle pain or mass _____

FEMALE
Painful periods _____
Irregular periods _____
Vaginal discharge _____
pregnancies _____,
miscarriage _____
Date of last pap smear _____.
Result pap smear: _____

I have confirmed the above information to be correct.

Patient's Signature _____, Date: _____

Completed by: _____, (if other than the patient). Date: _____

Your relationship to the patient: _____

I have reviewed the patient's history information.

Physician's Signature: _____, Date: _____

Patient Name:

Family History Form

Indicate which relative has the following diseases:

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Aunt(s)	Uncle(s)
Anesthesia Issues										
Bleeding or Clotting Issues										
Cancer - Breast										
Cancer - Colon										
Cancer - Gallbladder										
Cancer - Other Type										
Cancer - Ovarian										
Cancer - Prostate										
Cancer - Stomach										
Diabetes										
Heart Disease										
High Blood Pressure - Hypertension										
Kidney Disease										
Liver Disease										
Nervous Disorder										
Stroke										
Urinary										

Bristol Surgical Associates, P.C.

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.

- 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).
- **Effective January 1, 2020 Customer Pricing Notice- a service charge of 3.99% is applied to any credit card transaction with online credit card payments being a flat fee of $4.25.**

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

Signature: _____

Print Name: _____ **Date:** _____