

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 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.

*****Bristol 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.***

*****Marion Office-594 Radio Hill Road, Marion, VA 24354 (This location is open Tues, Wed, Thurs 9 am- 5 pm)***

For 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 #: _____

<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 #: _____

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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. 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

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

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: _____