

Date: (MM/DD/YYYY)

FLAGSTAFF SURGICAL ASSOCIATES

PATIENT REGISTRATION FORM

PROVIDER:

PATIENT NAME: LAST: FIRST: MI:		RESPONSIBLE PARTY NAME: LAST: FIRST: MI:	
BILLING ADDRESS:		CITY:	STATE: ZIP:
PERMANENT ADDRESS:		CITY:	STATE: ZIP:
HOME PHONE:	BUSINESS PHONE:	MOBILE PHONE:	
SEX: MALE FEMALE	BIRTHDATE: (MM/DD/YYYY)	AGE:	
PATIENT SOC. SEC.#: CHILD OTHER	RESPONSIBLE PARTY SOC. SEC.#:	RELATION TO PATIENT: SELF SPOUSE PARENT	
REFERRING DOCTOR:	REFERRING DOCTOR ADDRESS:		
PRIMARY CARE DOCTOR:	PRIMARY CARE DOCTOR ADDRESS:		
IS INJURY RELATED TO AN ACCIDENT? YES NO	IF YES, WAS ACCIDENT:	AUTO RELATED JOB RELATED	DATE OF ACCIDENT:
RACE:	ETHNICITY: LATINO/HISPANIC OTHER	LANGUAGE:	
PATIENT MARITAL STATUS: SINGLE "*****OARRIED*****F&KQTEGF*****Y&FQYGF		PATIENT EMPLOYMENT STATUS: EMPLOYED STUDENT OHER	
EMPLOYER NAME:	ADDRESS:	PHONE:	
SPOUSE/NEAREST RELATIVE NAME:	ADDRESS:	PHONE:	
<u>INSURANCE INFORMATION</u>			
PRIMARY INSURANCE:		SECONDARY INSURANCE:	
ADDRESS:		ADDRESS:	
SUBSCRIBER NAME:	SEX: M F DOB: (MM/DD/YYYY)	SUBSCRIBER NAME:	SEX: M F DOB: (MM/DD/YYYY)
RELATIONSHIP TO PATIENT:		RELATIONSHIP TO PATIENT:	
EMPLOYER:		EMPLOYER:	
POLICY NUMBER:	GROUP/CLAIM #:	POLICY NUMBER:	GROUP/CLAIM #:
GUARANTOR NAME: DOB: (MM/DD/YYYY) SSN:		GUARANTOR NAME: DOB: (MM/DD/YYYY) SSN:	

AUTHORIZATION TO PAY: I hereby authorize payment directly to the business office of **Flagstaff Surgical Associates** for the surgical and/or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance.

SIGNED (Patient or Parent, if minor): _____ **DATE:** _____



Flagstaff Surgical Associates

77 W. Forest Ave, Suite 201 Flagstaff, AZ 86001 Office (928) 773-2222 Fax (928) 773-2598

Name: _____ Age: _____ Today's date: _____

Reason for today's visit: _____ Referred by: _____

PAST MEDICAL HISTORY

Do you have a history of the following?

Y N Anemia	Y N Heart Murmur	Y N Kidney Stones
Y N Arthritis	Y N High Blood Cholesterol	Y N Benign Prostatic Hypertrophy
Y N Blood clot	Y N High Blood Pressure	Y N Liver Disease
Y N Bleeding disorder	Y N Acid Reflux (Heartburn)	Y N Hepatitis
Y N Diabetes	Y N Hiatal Hernia	Y N Gallbladder disease
Y N Depression	Y N Ulcers (stomach or intestinal)	Y N Gallstones
Y N Seizures	Y N GI bleeding	Y N Migraine headaches
Y N Lung Disease	Y N Irritable bowel syndrome	Y N Stroke
Y N COPD	Y N Crohn's Disease	Y N Thyroid Disorders
Y N Asthma	Y N Ulcerative colitis	Y N Cancer Type _____
Y N Sleep apnea	Y N Diverticulitis	Y N Substance Abuse
Y N Heart Disease	Y N Colon Polyps	Quit in _____
Y N Heart attack	Y N Kidney Disease	
Y N Other Illnesses/disorders(specify) _____		

Past Surgeries/Hospitalizations

Date

Past Surgeries/Hospitalizations	Date

Current Medications (with dosage)

Last Colonoscopy/Sigmoidoscopy (check one)

Colonoscopy Sigmoidoscopy Date: _____

Last Tetanus shot: _____

Allergies

OG/GYN History

Last Period _____

of Pregnancies _____

Last Mammogram _____

History of abnormal mammogram Y N

SOCIAL HISTORY

Single Married Divorced Widowed

Significant other: _____

Children (names, ages):

Employed Unemployed Retired

Caffeine: Y N Type _____ Frequency _____

Exercise: Y N Type _____ Frequency _____

Tobacco use: Present Past None

Type _____ Packs per day _____

Quit date _____ Duration _____

Current Alcohol use: Y N

Frequency _____

Current Illegal drug use: Y N

Type _____

FAMILY HISTORY

Check conditions that any family member has had:

<input type="checkbox"/> Obesity	<input type="checkbox"/> Heart Attack (age)	<input type="checkbox"/> Breast Cancer
<input type="checkbox"/> Diabetes Type II	<input type="checkbox"/> Bleeding problems	<input type="checkbox"/> Ovarian Cancer
<input type="checkbox"/> Diabetes Type I	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Prostate Cancer
<input type="checkbox"/> Stroke	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Cancer
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Other _____

FOR OFFICE USE ONLY:

99241,99201,99212,99242,99202,99213 – No PFSH reqs
99243,99203,99214 – 1 of 3 pertinent PFSH

99215 - 2 of 3 PFSH
99244,99245,99204 - all 3 PFSH

REVIEW OF SYSTEMS

Have you had any of the following symptoms in the past month?

General

Weight changes	Y	N
Fever	Y	N
Chills	Y	N
Night sweats	Y	N
Fatigue	Y	N
Other	_____	

Head

Recent headaches	Y	N
Facial Pain	Y	N
Sinus Pain	Y	N
Other	_____	

Eye

Vision problems	Y	N
Eye pain	Y	N
Sensitivity to light	Y	N
Itching	Y	N
Other	_____	

Ears, Nose, Throat

Ear pain	Y	N
Hearing loss	Y	N
Ringing in ears	Y	N
Nosebleeds	Y	N
Nasal drainage	Y	N
Mouth sores	Y	N
Bleeding gums	Y	N
Throat pain	Y	N
Hoarseness	Y	N
Snoring	Y	N
Other	_____	

Neck

Pain	Y	N
Stiffness	Y	N
Swelling/lump	Y	N
Other	_____	

CV

Chest pain	Y	N
Fast heart rate	Y	N
Palpitations	Y	N
Other	_____	

Lungs

Short of breath	Y	N
Cough	Y	N
Coughing blood	Y	N
Wheezing	Y	N
Waking at night short of breath	Y	N
Use extra pillows	Y	N
Other	_____	

Breast

Pain	Y	N
Nipple discharge	Y	N
Lumps	Y	N
Skin changes	Y	N
Other	_____	

GI

Change in appetite	Y	N
Difficulty swallowing	Y	N
Heartburn	Y	N
Nausea	Y	N
Vomiting	Y	N
Abd pain	Y	N
Diarrhea	Y	N
Blood in stool	Y	N
Other	_____	

GU

Painful urination	Y	N
Increased frequency of urination	Y	N
Blood in urine	Y	N
Dark colored urine	Y	N
Itching	Y	N
Other	_____	

Skin

Rashes	Y	N
Itching	Y	N
Lesions	Y	N
Other	_____	

Endocrine

Excessive sweating	Y	N
Excessive thirst	Y	N
Change in sexual desire	Y	N
Heat intolerance	Y	N
Cold intolerance	Y	N
Abnormal periods (female only)	Y	N
Other	_____	

MS

Joint pain	Y	N
Joint swelling	Y	N
Stiffness	Y	N
Muscle aches	Y	N
Other	_____	

Neuro

Dizziness	Y	N
Feeling of room spinning	Y	N
Fainting	Y	N
Muscle weakness	Y	N
Changes in sensation	Y	N
Other	_____	

Psych

Sleep problems	Y	N
Anxiety	Y	N
Depression	Y	N
Lack of interest in everything	Y	N
Crying spells	Y	N
Other	_____	

FOR OFFICE USE ONLY:

99241,99201,99212 – No ROS requirements
99242,99202,99213 – Problem Pertinent System
99243,99203,99214 – 2-9 systems
99244,99204,99245,99205,99215 – 10+ systems

Flagstaff Surgical Associates

PAYMENT INFORMATION FORM

Welcome to Flagstaff Surgical Associates. We would like to thank you for your confidence and the opportunity to provide your medical treatment and care. Our office is happy to assist you with any questions you may have regarding your appointment. If you are unable to make your appointment, please try to call us at least 24 hours in advance.

As a courtesy to our patients, we will submit your charges to your insurance company. Please bring your insurance card(s) on the day of your appointment. Without insurance information, the patient will be responsible for the bill on the day seen in the office. Any co-pay or deductible is also due on the day of your visit. If you do not have insurance, payment will be required at the time of visit. If you are scheduled for surgery, your portion of that surgery and any deductible will need to be paid before the surgery date.

If you have an insurance that requires a referral or authorization, we must have that before your appointment. Referrals may be brought in or faxed to us. Appointments will need to be rescheduled if the referral or authorization is not received.

I have read the above information and understand the payment requirements

Patient name: _____

Patient signature: _____ Date:
(or guardian)



FINANCIAL POLICY INSURANCE, CO-INSURANCE AND PATIENT PAYMENTS

We are committed to providing you with the best possible care. If you have insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance, and understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, check, Visa, MasterCard, or Discover. We will be happy to process your insurance claim for you. We must, however, receive current insurance information before you see the doctor.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Please know however, that:

- 1) Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
- 2) Most insurance companies have a co-pay and a deductible that must be met before the insurance company will pay their portion. If you have not met your deductible for the year, you are responsible for any charges until that deductible is met. Most insurance companies hold us contractually responsible for collecting a co-pay at EACH visit.
- 3) Patient's deductible and out of pocket patient responsibility is due prior to surgery.
- 4) Not all services are a covered benefit in all contracts. For instance, if your plan does not cover preventive services, you will be responsible for that charge.
- 5) If payment for medical services rendered has not been received in 120 days, the account will be referred to a collection agency.

We must emphasize that as medical providers, our relationship is with you, not your insurance company. We may have an "In-Network" relationship with a particular insurance company; however, your personal benefits still prevail. Insurance companies highly encourage patients to use "In-Network" providers, and consider it a patients' responsibility to find out which providers are "In-Network".

Surgical Procedures

For those patients receiving surgical or diagnostic treatment, please know that we will prior authorize your procedure, this authorization is not a guarantee of benefits; it is merely a statement by your insurance company that they agree with the course of treatment. **You should still call your insurance yourself and notify them of your proposed treatment plan.**

Printed Name

Patient Signature

Date



Medical Appointment Cancellation Policy

Dear Patient:

We strive to render excellent medical care to you and the rest of our patients. In an attempt to be consistent with this, we have a Medical Appointment Cancellation Policy that assists us in scheduling appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient in need of our services.

Our policy is as follows:

We request that you please give our office a 24 hour notice in the event that you need to reschedule your appointment with the physician. This allows other patients to be scheduled into that appointment. It also makes it possible to reschedule your appointment more efficiently. If a patient misses an appointment without contacting our office by noon the day before, it will be considered a missed appointment unless it is an emergency. A fee of \$25.00 will be charged for a missed office appointment, a fee of \$100.00 will be charged for a missed procedure or surgery appointment. If a patient accumulates a total of three (3) missed appointments, the patient may not be rescheduled for future appointments and will be asked to find another physician to continue his/her care.

Additionally, if a patient is more than 15 minutes late to his/her appointment, he/she will be seen when possible that same day.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage and understanding.

I have read and understand the Medical Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), have received a copy of Flagstaff Surgical Associates Medical Appointment Cancellation Policy.

Printed Name of the Patient

Relationship to Patient (if patient is a minor)

Signature of Patient or Responsible Party if a Minor

Date

Flagstaff Surgical Associates
77 W Forest Ave., Ste. 201 Flagstaff, AZ 86001
**Patient Consent for Use/Disclosure of
Protected Health Information**

Patient's Name: _____ Date of Birth: _____
Social Security#: _____ Previous Name (if applicable): _____

I understand that my/the patient's health information is private and confidential. I understand that Flagstaff Surgical Associates work hard to protect my/the patient's privacy and preserve the confidentiality of my/the patient's health information. I understand that Flagstaff Surgical Associates may use and disclose my/the patient's health information to provide treatment to me/the patient, to handle billing and payment, and to take care of other healthcare operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

Flagstaff Surgical Associates has a detailed document called the "Notice of Privacy Practices". It contains more detailed information about how we may use and disclose patient health information. I understand that I have a legal right to read the "Notice" before I sign this consent.

Flagstaff Surgical Associates may update the "Notice of Privacy Practices". If I ask, Flagstaff Surgical Associates will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask Flagstaff Surgical Associates to restrict how my/the patient health information is used or disclosed to carry out treatment, payment, or healthcare operations. I understand that Flagstaff Surgical Associates does not have to agree to my/the patient's request.

I may cancel this consent at any time by writing, signing and dating a letter to Flagstaff Surgical Associates. If I write a letter, it must say that I want to revoke my/ the patient's consent to authorize the use and disclosure of my/the patient's health information for treatment, payment, and healthcare operations.

If I revoke the consent, Flagstaff Surgical Associates does not have to provide any further healthcare services to me/ the patient.

My signature below indicates that I have read and reviewed a current copy of Flagstaff Surgical Associates "Notice of Privacy Practices". My signature means that I agree and consent to allow Flagstaff Surgical Associates to use and disclose my/the patient's protected health information to carry out treatment, payment and healthcare operations.

Patient or legally authorized individual signature

Date

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