MEMORIAL AND KATY SURGICAL SPECIALISTS

Patient Information

Date_______________

Patient Name ____
Last First Middle

Address____

City___________________________________ State___________________Zip____________________

Birthdate_________________ Age_________ Sex ___M ___ F Social Security#_________________________

Race (Please circle) American Indian Asian Black Native Hawaiian Pacific Islander White

Ethnicity (Please circle) Hispanic/Latino Other Language preference____________________

Marital Status ___S ___M ___W ___D Spouse name:____

Home phone__________________________Cell phone_____________________Spouse cell_______________

Email address____

Patient's employer____ Phone # ____________________

Employer address____
Street City State ZIP

Referring physician____Phone #____________________

Primary care physician____Phone# ____________________

Emergency contact____Phone #_________________

Pharmacy Name_____________________________ Pharmacy Phone Number_____________________

Pharmacy address or intersection____

PRIMARY INSURANCE

Ins. Co. name____ Phone # __________________________

Group #____________ Subscriber ID#__________________Subscriber name ___________________________

Subscriber DOB:____________ Patient relationship to insured: ___self ___spouse ___child ___ other

SECONDARY INSURANCE

Ins. Co. name____ Phone # __________________________

Group #____________ Subscriber ID#__________________Subscriber name ___________________________

Subscriber DOB: ____________ Patient relationship to insured: ___self ___spouse ___child ___ other

MEMORIAL AND KATY SURGICAL SPECIALISTS

AUTHORIZATIONS

Release of information:

I hereby authorize the release of medical or any other information to my insurance carrier(s), including Medicare, to determine benefits payable for related medical services. A copy of this authorization may be provided to the insurance carrier if requested. The original authorization will be kept on file by Memorial and Katy Surgical Specialists.

Benefits to physician:

I authorize direct payment of all insurance benefits, including Medicare, to Memorial City Surgical Associates, dba Memorial and Katy Surgical Specialists, for all medical services rendered to me during the course of treatment provided by Memorial and Katy Surgical Specialists. I understand and agree this assignment of benefits will have continuing effect for so long as I am being treated or cared for by Memorial and Katy Surgical Specialists.

I also understand that I am responsible for any portion of my bill not covered by my insurance company.

______________________________	______________	
Patient name (printed)	Date of birth	
______________________________	______________________	______________
Insured name (printed)	Insured signature	Date

Consent for medical treatment:

I hereby authorize Memorial and Katy Surgical Specialists to render the treatment necessary in evaluating, diagnosing and treating my medical condition or the treatment of my dependent named below.

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

______________________________	______________
Print name of patient/parent/guardian	Relationship
______________________________	______________
Signature	Date

MEMORIAL AND KATY SURGICAL SPECIALISTS

HIPAA PRIVACY RULE

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's **Notice of Privacy Practices** provides a complete description *of* the uses and disclosures of my health information. I understand that:

- I have the right to review this facility 's Notice of Privacy Practices prior to signing this acknowledgement;
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I have provided if requested.

______________________________ ____________________________________
Print patient name Patient/Guardian signature Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barrier prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement

Other (please specify) ____________________________________HIPAA officer________________Date__________

HIPAA PRIVACY RULE

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

________________________ ________________________ ____________
Print patient name Patient signature Date

MEMORIAL AND KATY SURGICAL SPECIALISTS

Financial Policy

Thank you for selecting our practice for your surgical care. We are committed to providing you with the best medical care and expertise. Your understanding of our financial policy is an essential element of your care and service. If you have questions regarding any aspect of our policy, please feel free to consult with our staff.

Insurance

We will verify your insurance prior to your appointment. All co-pays, coinsurance, or deductibles will be explained to you prior to your visit and are due at the time of service.

Referrals and pre-certification

If your insurance requires a referral from your primary care physician, it is your responsibility to obtain the referral. If surgery is indicated and your insurance requires pre-certification, we will initiate the request for pre-certification; however, it is your responsibility as well to confirm with our office prior to the surgery that the pre-certification has been authorized.

Surgical Procedures

If surgery is required, you will be contacted by our business office to discuss the insurance benefits and financial responsibility. Your estimated financial obligation will be required as a surgical deposit prior to the procedure. After the insurance has processed your claim, any balance remaining is due upon notice.

The surgery scheduler will contact you within 3-4 days after your office visit to discuss available dates, time and facility options. Some surgical cases require an assistant surgeon and/or surgical assistant. Such assistants are contracted by the surgical facility and bill independently under their group name. Questions regarding fees for the surgical assistant should be directed to the billing office of that group. Some ancillary groups providing services may not be contracted with all insurance. It is your responsibility to verify with your insurance carrier any services provided other than those services performed by Memorial and Katy Surgical Associates. Examples: pathology, laboratory, radiology, anesthesiology and surgical assistants.

Medical Records

Medical records requests will be processed when accompanied with a signed HIPAA compliant medical record release. Fees for copies of medical records are in accordance with the rules of the Texas Medical Board.

Disability Forms

A $25.00 fee is required for completion of disability forms. This fee must be paid prior to completing the form.

Payment Options

We accept cash, check, money order, Mastercard, Visa, Discover, and American Express. There is a $25.00 returned check fee.

ACKNOWLEDGEMENT OF FINANCIAL POLICY RECEIPT

A copy of the Memorial and Katy Surgical Specialists financial policy has been provided to me.

____

Patient/guardian signature

____

Print patient name

____

Date

MEMORIAL AND KATY SURGICAL SPECIALISTS

Authorization of Use and Disclosure of Protected Health Information

APPOINTMENT REMINDERS, TEST RESULTS, BILLING ISSUES, SURGERY SCHEDULING

This office may use your information to notify you of any changes in your scheduled appointment, to inform you of test results, physician instructions, scheduled surgery instructions and/or billing issues.

Please indicate how you would like to be notified with the information.
(Check all that apply)

______Home telephone #____________________________

______Cell Phone #________________________________

If you have an answering machine/voice mail, may we leave detailed messages regarding appointments, treatment, information pertinent to your healthcare and/or payment for your healthcare provided by Memorial and Katy Surgical Specialists? _____YES _____NO

______Work telephone #____________________________

______Work voice mail May we leave detailed messages? _____YES _____NO

______Email address:____

______You may discuss any of my medical information with the following emergency contacts:

______________________________	____________	____________
Name	Relationship	Telephone
______________________________	____________	____________
Name	Relationship	Telephone

______________________________ ____________
Patient name (please print) Date of Birth

______________________________ ____________
Patient/Guardian signature Date

MEMORIAL AND KATY SURGICAL SPECIALISTS
Medical History Questionnaire

DATE:____________

Last Name:	**First Name:**	**MI**	**Date of birth:**	**Age:**
Referring Doctor:			**Height**	**Weight**

LIST CURRENT PROBLEMS

CURRENT MEDICATIONS (include weight reduction meds)	**DRUG ALLERGIES** **Reaction to drug**

Past Medical Diagnoses of: (circle: Y=yes; M=taking medication; N=not diagnosed)											
Diabetes	Y	M	N	Reflux	Y	M	N	Glaucoma	Y	M	N
Heart attack	Y	M	N	Arthritis	Y	M	N	Asthma	Y	M	N
Stroke	Y	M	N	AIDS	Y	M	N	Emphysema	Y	M	N
Angina/chest pain	Y	M	N	HIV infection	Y	M	N	Ulcers	Y	M	N
High blood pressure	Y	M	N	Kidney failure	Y	M	N	Cancer	Y	M	N
Heart failure	Y	M	N	Thyroid problem	Y	M	N	If yes, type & location of cancer			
Hepatitis	Y	M	N	Colitis	Y	M	N				
Jaundice (yellow skin)	Y	M	N	Sleep apnea	Y	M	N				
Bleeding problems	Y	M	N	High cholesterol	Y	M	N	Other:			

Previous Surgeries	**Year**	**Comments (to be completed by physician)**
Problems with anesthesia? ___yes ___no Explain:		

Tobacco Use (circle)		**Alcohol Consumption (circle)**		**Substance Abuse (circle)**			
1	No	1	No	1	None	4	Heroin
2	Cigarettes _____packs per day	2	Yes _____ drinks per week	2	Marijuana	5	Other
3	Smokeless tobacco			3	Cocaine		

Family Medical History: (circle)		**Family History of: (circle) Relationship to you:**							
1	Both parents living and well	Heart attack	Y	N		Bleeding	Y	N	
2	One parent deceased, caused by:	Diabetes	Y	N		Anesthesia problems	Y	N	
		Breast Cancer	Y	N					
3	Both parents deceased, caused by:	Ovarian Cancer	Y	N					
	Mother:	Lung Cancer	Y	N					
	Father:	Colon Cancer	Y	N					