MEMORIAL ADVANCED SURGERY

Patient Registration Form

How did you hear about us? _____

Your appointment today is with Dr. _____

PATIENT INFORMATION

Patient Name: _____ Date of Birth _____

Address: _____

City, State, Zip: _____

Social Security Number: _____ Male _____ Female _____

Phone Cell: _____ Home: _____ Work: _____

Race: White, Black, Asian/ Pacific Islander, Hispanic, American Indian, Other _____ Language _____

Marital Status: Married Single Divorced Widowed

Email Address: _____

****Pharmacy:** _____ **Phone:** _____

Referring Physician: _____

Primary Care Physician: _____

Employment Status: Full-Time Part-Time Full-Time Student Retired

Employer: _____ Occupation: _____

Emergency Contact Name: _____ Phone: _____

Emergency Contact Relationship to Patient: _____

RESPONSIBLE PARTY INFORMATION (FOR PATIENT OR GUARDIAN)

Responsible Party Name: _____

Address: _____

City, State, Zip: _____

Relationship to Patient: _____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____

Subscriber ID: _____ Group ID: _____

Name of Subscriber: _____ Subscriber DOB: _____

Relationship to Patient: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____

Subscriber ID: _____ Group ID: _____

Name of Subscriber: _____ Subscriber DOB: _____

Relationship to Patient: _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient/Responsible Party Signature: _____ **Date:** _____

MEMORIAL ADVANCED SURGERY
PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name: _____

Date of Birth: _____

_____(Patient/Representative initials) **Notice of Privacy Practices.**

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient/Representative initials) **Release of Information.**

I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

____ (Patient/Representative Initials) ***I consent*** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

____ (Patient/Representative Initials) ***I do not consent*** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

We want to stay connected with our patients.
Patients in our practice may be contacted via email and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email address or text number below, you understand that you may get these communications from the Practice. You may opt out of these communications at any time.
The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.
The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

OR

_____ (Patient/ Representative Initials) I decline to receive communication via text.
_____ (Patient/ Representative Initials) I decline to receive communication via email.

If you have previously consented to receive communication via text/email and wish to remove the consent

Opt Out/Revocation of communications via email and/or text. In other words, I do not want my email address or cell number to be used any longer for the above mentioned communications.

*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **text**.*
*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **email**.*

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ *Time:* _____

Prescription Order Pick-up.

There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

____ (Patient/Representative Initials) I ***wish*** to designate the following individual to pick up a prescription order on my behalf:
Name: _____ Date: _____

Name: _____ Date: _____

____ (Patient/ Representative Initials) I ***do not want*** to designate anyone to pick-up my prescription order.

Patient/Parent/Guardian/Patient Representative Signature _____ **Date:** _____

Patient/Parent/Guardian/Patient Representative Name (Printed) _____

Patient Name (Printed): _____ **Date of Birth:** _____

MEMORIAL ADVANCED SURGERY

PATIENT NAME_____**DATE OF BIRTH**_____

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

1. _____**(Patient or Guardian Initials)**

Financial Agreement.

- I acknowledge, that as a courtesy, **Memorial Advanced Surgery** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. _____**(Patient or Guardian Initials)**

Third Party Collection. I acknowledge that **Memorial Advanced Surgery** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. _____**(Patient or Guardian Initials)**

Assignment of Benefits. I hereby assign to **Memorial Advanced Surgery** any insurance or other third-party benefits available for health care services provided to me. I understand **Memorial Advanced Surgery** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **Memorial Advanced Surgery,** I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. _____**(Patient or Guardian Initials)**

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **Memorial Advanced Surgery** by the Medicare or Medicaid program.

5. _____**(Patient or Guardian Initials)**

Consent to Telephone Calls for Financial Communications. I agree that, in order for **Memorial Advanced Surgery,** or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **Memorial Advanced Surgery** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **Memorial Advanced Surgery** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____**(Patient or Guardian Initials)**

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X_____Date_____

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify) _____

Memorial Advanced Surgery

Release of Health Information

Fax: (904) 399-8488 | Phone: (904) 399-5678

Section A: This section must be completed for all Authorizations

Patient Name:	**Date of Birth:**	**Patient's Phone:**	**Last 4 digit SSN** (optional)**:**
Provider's Name:	**Recipient's Name:**		
Provider's Address:	**Address 1:** 3627 University Blvd. S. Suite # 700		
	Address 2:	**Recipient's Phone:** (904) 399-5678	
Fax#:	**City:** Jacksonville	**State:** FL	**Zip:** 32216

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Electronic Media, if available (*e.g.*, USB drive, CD/DVD)** ☐ **Encrypted Email** ☐ **Unencrypted Email**

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.*, paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (*e.g.*, virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: **Event:**

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	**Date(s):**	**Description:**	**Date(s):**	**Description:**	**Date(s):**
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical test ☐ Medication sheets		☐ Operative information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm strips ☐ Nursing information ☐ Transfer forms ☐ ER information		☐ Labor/delivery summary ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-04: ☐ Other: ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☐ No

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? If yes, describe:	☐ Yes ☐ No
May the recipient of the PHI further exchange the information for financial remuneration?	☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

MEMORIAL ADVANCED SURGERY

Short Term Disability / FMLA

***Most employers today are requiring short term disability and/or FMLA paperwork completed when an employee misses several consecutive days of work.

Please read carefully and initial and sign the policy for Memorial Advanced Surgery on getting these forms completed. *Please sign even if you do not think you will need forms completed.*

_____ I will allow at least 5-7 business days for my surgeon and staff to complete the forms.

_____ There is a $25.00 fee to complete these forms. Insurance does not cover this.

_____ There will be a specific staff member assigned to my forms.

_____ Forms cannot be completed during an office visit.

_____ If I need the forms faxed directly to my employer, I will supply the number.

_____ I am responsible for following up on the status of my forms before their due date.

I give my permission for Memorial Advanced Surgery to communicate with my employer and their insurance representative regarding any and all requests the completion of Short Term Disability and/or FMLA.

_____ _____

Printed Name Date of Birth

_____ _____

Signature Date

Memorial Advanced Surgery Patient Medical History

Patient Name_____ **Today's Date**_____

Age_____ **Date of Birth**_____

Allergies and Adverse Reactions: (include allergies to antibiotic, latex, xray dye, skin preps, pain medications etc)

_____

_____

Reason for today's visit: _____

History

Surgeries: _____

_____

Hospitalizations(other than surgery):_____

Chronic Illnesses (high blood pressure, diabetes, neurological, cardiac etc)

_____

_____

Blood Transfusion: I will accept blood products in an emergency Yes_____ No _____
Have you ever had a reaction to transfusion? Yes_____ No_____

Social History

Marital Status: Single____ Married____ Divorced_____ Widowed_____

Occupation_____ Living Will: Yes No

Daily Caffeine intake: None_____ 1-3servings _____ 4-6 servings_____ more than 6 servings_____

Drug use: Marijuana_____ Cocaine_____ Crack _____ Heroine_____ Other_____

Family History:	**Alive/deceased**	**Age**	**Health Problems/ Cause of Death**
Father:	_____	_____	_____
Mother:	_____	_____	_____
Sisters	_____	_____	_____
Brother	_____	_____	_____

Current Medical Condition Questionnaire

Patient Name:_____

DOB: _____

REVIEW OF SYSTEMS (PLEASE CIRCLE ANY POSITIVES):

CONSTITUTIONAL: fatigue, fever/chills, malaise, night sweats

SKIN: bruising, eczema, rash, skin cancers

HEENT: visual changes, hearing loss, ringing in the ears, difficulty swallowing, hoarseness, headache

RESPIRATORY: Dyspnea on exertion, shortness of breath, wheezing/asthma, cough, obstructive sleep apnea/use of CPAP mask

CARDIOLOGY: chest pain with exertion, heart murmurs, palpitations, high blood pressure

GASTROENTEROLOGY: abdominal pain, bloating, nausea, reflux/GERD, diarrhea, constipation, vomiting

GENITAL/URINARY: difficulty with urination, urinary frequency, blood in urine, history of stones

FAMILY HISTORY OF BREAST CANCER: YES or NO

FEMALE: date of last menstrual period: _____

MUSCULOSKELETAL: joint pain, morning stiffness, muscle pain, weakness, arthritis, fibromyalgia, swelling of the feet/ankles

NEUROLOGY: gait abnormality, loss of coordination, seizures, syncope, tremors, dizziness

PSYCHOLOGY: anxiety, depression, suicidal thoughts

HEMATOLOGY/LYMP: anemia, easy bleeding, bruising, enlarged lymph nodes, fatigue, fever, sweats

ENDOCRINOLOGY: hair loss, hirsutism, excessive thirst, frequent urination, heat intolerance, cold intolerance, weight gain, weight loss

I have fully completed this form and verify its accuracy:

Patient Signature: _____ Date: _____ Reviewed By: _____

MEMORIAL ADVANCED SURGERY

Medication Form

Name:	**Date:**
Allergic to/describe reaction:	**Allergic/to describe reaction:**

☐ **Currently not taking medications**

List all medications you are currently taking: Prescription and over-the counter medications (examples: aspirin, antacids), dietary supplements and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin, vitamins and homeopathic remedies)

Date	Name of Medication	Dose	Directions/ Date last taken	Date Stopped	Reason for taking/ changing medication and doctor's name

MEMORIAL ADVANCED SURGERY

Patient Name: _____ Date _____

Date of Birth: _____

As part of the quality measures mandated by Centers for Medicare/Medicaid, as a medical provider engaged in your care, we are asked to ask you the following during each visit. As always, the content of this document is your personal and private healthcare information, and is protected under HIPAA. Memorial Advanced Surgery is committed to your privacy.

Please answer the following:

1. **Influenza Immunization:**
   - Have you received your 2017/2018 flu vaccine yet? **YES / NO**
     - If so, when and where? _____
   - If flu vaccine NOT yet received this season, are you interested in receiving one? **YES / NO**
   - If not interested, do you wish to DECLINE a flu vaccine for this season? **YES / NO**

2. **Pneumococcal Vaccine:**
   - Have you ever received a pneumococcal vaccine? **YES / NO**
     - If so, when and where? _____
   - If pneumococcal vaccine NOT yet received, are you interested in receiving one? **YES / NO**

3. **Tobacco Use:**
   - Are you a tobacco user? **YES / NO**
   - If so, **FORMER** tobacco user? Not since: (year) _____, how long did you smoke? _____ year(s)
   - If so, **CURRENT** tobacco user?
     - About how long have you used tobacco? _____ year(s) _____ month(s)
     - What kind of tobacco products do you use?
       - Cigarettes? **YES / NO**
       - Smokeless Tobacco (Snuff or Chew)? **YES / NO**
       - Other? **YES / NO** Please describe: _____
     - How many cigarettes do you usually smoke per day? (1 pack = 20 cigarettes) _____ cigarettes
     - Interested in Smoking Cessation Counseling? **YES / NO**

4. **Alcohol Use:**
   - Do you consume alcohol? **YES / NO**
     - If so, number of drinks per occasion? _____
     - If so, how many number of drinks per week? _____

5. **Screenings:**
   - Last MAMMOGRAM: **YES / NO** Date: _____ Location: _____
   - Last COLONOSCOPY: **YES / NO** Date: _____ Location: _____

6. **Fall Risk Assessment** ***(for patient 65 years and older)*****:**
   - Any history of falls? **YES / NO**
   - If so how many falls have you had in the last three months? _____
   - Do you use devices for ambulation assistance? **YES / NO**
   - What type of ambulation assistance device do you use? **Walker / Cane / Wheelchair / Other:** _____
   - Are there any environmental hazards in your home? **Rugs / Stairs / Other:** _____

Thank You!