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PATIENT REGISTRATION FORM

as it appears on insurance card

PERSONAL INFORMATION

NAME		PREFERRED NAME		DATE						
ADDRESS <small>(street, city, state, zip)</small>				E-MAIL						
HOME PHONE		CELL PHONE		MARITAL STATUS	<table border="1"><tr><td>S</td><td>M</td><td>D</td><td>SEP</td><td>W</td></tr></table>	S	M	D	SEP	W
S	M	D	SEP	W						
SOCIAL SECURITY NUMBER		DATE OF BIRTH		AGE						
				SEX	<table border="1"><tr><td>Male</td><td>Female</td></tr></table>	Male	Female			
Male	Female									

EMPLOYMENT INFORMATION

PLACE OF EMPLOYMENT		WORK PHONE	
EMPLOYER'S ADDRESS			

SPOUSAL INFORMATION

SPOUSE'S NAME		SOCIAL SECURITY NUMBER		DATE OF BIRTH	
PLACE OF EMPLOYMENT		WORK PHONE			

EMERGENCY CONTACT INFORMATION

NEAREST RELATIVE <small>(not living with you)</small>		RELATION		PHONE NUMBER	
NEAREST FRIEND <small>(not living with you)</small>		PHONE NUMBER			

REFERRAL & PHARMACY INFORMATION

FAMILY DOCTOR		REFERRED BY			
PREFERRED PHARMACY		PHONE NUMBER			

GUARDIAN INFORMATION (minors only)

MOTHER'S NAME		SOCIAL SECURITY NUMBER		DATE OF BIRTH	
FATHER'S NAME		SOCIAL SECURITY NUMBER		DATE OF BIRTH	

MESSAGE AUTHORIZATION

As a policy, we **DO NOT** leave messages on patient answering machines or voicemail systems. **HOWEVER**, if you would prefer for us to leave you a message, please sign below to confirm we have permission to do so.

PATIENT OR GUARDIAN SIGNATURE

AUTHORIZATION FOR USE OF PHOTOGRAPHS

I do hereby consent to and authorize Surgical Associates Of Marshall County to place photographs of me obtained in the office in my chart for medical purposes. I understand these photographs will be utilized for medical and/or educational purposes and will be treated in a confidential manner.

PATIENT OR GUARDIAN SIGNATURE

SURGICAL ASSOCIATES OF MARSHALL COUNTY
Health Hx Form

Date: _____ **Name:** _____ **Date of Birth:** _____

HEIGHT: _____ **WEIGHT:** _____

MEDICATIONS: _____

Are you currently taking any of the following: (if you leave these blank, that means "no")

- ASPIRIN GOODIES IBUPROFEN ADVIL VITAMIN E COUMADIN PLAVIX

ALLERGIES TO MEDICATIONS: (please list) _____

ALLERGIES TO LATEX: yes no

PAST HOSPITALIZATIONS AND SURGERIES:

<u>DATE</u>	<u>HOSPITAL</u>	<u>REASON/PROCEDURE</u>

MEDICAL HISTORY/REVIEW OF SYSTEMS:
(please check all that apply)
(if you leave blank, then that means "no" or "none")

Cardiac:

- chest pain
- shortness of breath
- heart cath in the past
- Bypass surgery in the past
- stent
- abnormal stress and/or EKG

Pulmonary:

- shortness of breath
- coughing up blood
- pain when in chest or ribs when you take a deep breath
- productive cough dry hacking cough
- wheezing

GI:

- fever/chills
- nausea/vomiting
- throwing up blood
- food gets stuck when you swallow
- "acid" reflux and/or heartburn
- constipation
- diarrhea
- abnormal bowel movements
- bright blood in stool
- dark maroon colored bowel movements

SKIN:

- black spot
- skin lesion that has changed shape and/or size/ or color
- skin lesion that bleeds

VASCULAR:

- ulcers on legs
- varicose veins
- painful and swollen legs (especially at night)

- weight loss
- history of a colon polyp
- mass or hernia

Spider Veins

MEDICAL HISTORY/REVIEW OF SYSTEMS (continued):

GENERAL:

- Diabetes
- Hypertension
- Heart trouble
- Atrial fibrillation
- Cancer
- HIV
- Headaches
- Weight loss
- Weight gain
- Snoring
- Sleep apnea
- Do you wear a C-PAP? yes no

WOMEN: age when periods first started:
 last menstrual period:
 Age at menopause:
 Last Mammogram:
 Age at first Pregnancy:

SOCIAL HISTORY: Alcohol: yes no Illicit Drugs: yes no Tobacco: yes no

FAMILY HISTORY:

<u>Relation</u>	<u>Disease</u>	<u>If deceased, cause of death</u>
father:		
mother:		
brother:		
brother:		
sister:		
sister:		
aunt:		
uncle:		

- ANY FAMILY HISTORY OF BREAST CANCER:** yes no
- ANY FAMILY HISTORY OF COLON CANCER:** yes no
- ANY FAMILY HISTORY OF THYROID CANCER:** yes no
- ANY FAMILY HISTORY OF SKIN CANCER:** yes no

By signing below I am stating that I have filled out the above health history to the best of my knowledge and that any item I have left blank is to be considered answered in the negative ("no" or "none")

Signature: _____

Anything else you would like to tell the doctor?

IF YOU WOULD LIKE TO RECEIVE INFORMATION ABOUT ISIS LASER CENTER (pricing, brochures, etc) PLEASE ASK THE OFFICE REPRESENTATIVES.



AUTHORIZATION TO PAY

I hereby authorize the release of any information that may be required or as pertains to my treatment such as operations, consultations, diagnostic tests, physical examinations, etc. a photocopy will be as valid as the original.

I hereby authorize payment directly to the undersigned physician(s), of the surgical and/or emergency medical benefits, including major medical insurance, in any, otherwise payable to me for the services as described below.

I hereby authorize the release of any information to insurance carriers concerning my diagnosis and treatments and I hereby assign to the physician(s) all payments for medical services rendered to my dependents or myself.

I understand that I am responsible for any amount not covered by insurance or any other entity covered by this authorization.

I hereby guarantee the payment of all accounts for services rendered at Surgical Associates of Marshall County. For payment of said accounts for services, I hereby waive claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection, including attorney's fee.

DATE

X

SIGNATURE (INSURED)

MEDICARE & MEDICAID AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF PAYMENT

I request that payment under the Medical Insurance Program be made to Surgical Associates of Marshall County on any bills for services furnished to me by them. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claims. I permit a copy of this Authorization to be used in place of this original and request payment of Medical Insurance Benefits either to myself or to the person who accepts assignment.

I understand that I am responsible for any services that are not covered by Medicare or Medicaid.

I hereby guarantee the payment of all accounts for services rendered at Surgical Associates of Marshall County. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection, including attorney's fees.

DATE

X

SIGNATURE (INSURED)

AUTHORIZATION TO RELEASE MEDICAL RECORDS

To: _____

Please release a copy of my medical records to:

John R. Groves, MD, FACS
Stephen L. Britt, MD, FACS
133 Wall St.
Albertville, AL 35951
256.840.5547 office
256.840.5548 fax

Patients Complete Name (Please Print): _____

Patient's Address: _____

Patient's Date of Birth: _____

Signature of Patient or Authorized Person: _____

Name of Person Signing (if other than patient): _____

Reason Patient is unable to sign: _____

Requested Records

Labs

Complete Record

Progress Notes

X-Ray

Other: _____

Signature of Witness: _____

Date Requested: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

PROTECTING YOUR PRIVACY

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or on the Internet. At Surgical Associates of Marshall County (hereinafter referred to as "the Practice"), privacy is one of our highest priorities.

KEEPING YOU INFORMATION

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims, and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

WORKING TO MEET YOUR NEEDS THROUGH INFORMATION

In the course of doing business, we collect and use various types of information, like name and address and claims information. We use this information to provide service to you, to process your claims, and to bring you health information that might be of interest to you.

KEEPING INFORMATION ACCURATE

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call or write us at the telephone numbers or addresses listed below. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

HOW AND WHY INFORMATION IS SHARED

We limit who receives information and what type of information is shared

- *Sharing information within the Practice.* We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.
- *Sharing information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies and companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.
- *Other.* Patient-specific personally identifiable data is released only when required to provide a service for you and only to those who need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.

The Practice does not share any customer information with third-party marketers who offer their products and services to our patients.

COUNT ON OUR COMMITMENT TO YOUR PRIVACY

You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide us – whether it's at the office, over the phone, or through the Internet.





PATIENT CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I understand that as a part of the provision of healthcare services, Surgical Associates of Marshall County creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been made provided with a *Notice of Privacy Practices* that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that Surgical Associates of Marshall County has the right to change their *Notice of Privacy Practices* and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment, and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment, or healthcare operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my protected health information, which is disclosed for the purposes of treatment, payment, or healthcare operations, be restricted. I also understand that Surgical Associates of Marshall County and I must: agree to any restriction in writing that I request on the use and disclosure of my protected health information; and agree to terminate any restrictions in writing on the use and disclosure of my protected health information which have been previously agreed upon.

PATIENT NAME	SOCIAL SECURITY NUMBER	DATE
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X _____
PATIENT OR GUARDIAN SIGNATURE

X _____
WITNESS SIGNATURE (OPTIONAL)

**Revised and updated:
July 1st, 2004**