Flagstaff Surgical Associates

General Surgery • Urology • ENT • Audiology

Provider: Date:

Patient Information

PATIENT NAME: Last: First: MI:	SSN#:	DOB: (mm/dd/yyyy)
BILLING ADDRESS: Street: City: State: Zip:		
PERMANENT ADDRESS: Street: City: State: Zip:		
RACE: LANGUAGE:	ETHNICITY: LATINO/HISPANIC ☐ OTHER ☐	MARITAL STATUS: SINGLE ☐ DIVORCED ☐ MARRIED ☐ WIDOWED ☐
SEX: M ☐ F ☐		
EMPLOYER INFORMATION: EMPLOYED ☐ STUDENT ☐ OTHER ☐ Name: Address: Contact #:		

Patient Contact Information

MOBILE PHONE:	HOME PHONE:	WORK PHONE:
EMAIL:		
EMERGENCY CONTACT OR NEAREST RELATIVE: Name: Phone #: Relation:		

Other Information

PHARMACY CHOICE:	Is injury related to an accident? No ☐ Yes ☐ Auto ☐ Job ☐	Date of Accident:
PRIMARY CARE PHYSICIAN: Name: Address:		
REFERRING PROVIDER: Name: Address:		

Insurance Information

RESPONSIBLE PARTY: Name:	SS#:	Sex: M ☐ F ☐	Phone #:
Address:	DOB:	Relation to patient:	

PRIMARY INSURANCE:	**SECONDARY INSURANCE**:
ADDRESS:	ADDRESS:
GUARANTOR/RESPONSIBLE PARTY: Name: SS#	GUARANTOR/RESPONSIBLE PARTY: Name: SS#
Sex: M ☐ F ☐ Phone #: DOB:	Sex: M ☐ F ☐ Phone #: DOB:
Address: Relation to patient:	Address: Relation to patient:
EMPLOYER:	EMPLOYER:
POLICY #: GROUP/CLAIM#:	POLICY #: GROUP/CLAIM#:

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**: _____

Patient Policy Information

Patient's Name: _____ Date of Birth: _____

Welcome to Flagstaff Surgical Associates (FSA). We would like to thank you for your confidence and the opportunity to provide your medical treatment and care. At Flagstaff Surgical Associates (FSA), we are committed to providing you with the best possible care. If you have insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our policies.

Insurance and Payment Policy

As a courtesy to our patients, we will submit your charges to a contracted insurance company. Please bring your insurance card(s) to your appointment. Any copayment or deductible is also due at your visit. If you do not have insurance or we are not contracted with your insurance, payment will be required at the time of your visit. If you are scheduled for an in office procedure or surgery, your portion and any deductible will need to be paid on or before that date. Without insurance information, the patient will be responsible for the bill at the time of his/her visit. We accept cash, check, Visa, MasterCard and Discover cards.

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. 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 to notify them of your proposed treatment plan.***

Payments for services are due by the time services are rendered unless payment arrangements have been approved in advance by our managers or administrative staff. We will gladly discuss your proposed treatment and answer any question relating to your insurance. Please know however, that:

1) We must receive current insurance information *before* you see the doctor.

2) Your insurance is a contract between you and the insurance company. ***We are not a party to that contract***.

3) Most insurance companies have a copayment and or 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. Copayments are due at *EACH* visit.

4) Your deductible and/or our-of-pocket patient responsibility is due on or before any in-office procedure or surgery.

5) 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.

6) If payment for medical services rendered has not been received in 120 days, the account will be referred to a collection agency. A 35% service fee will be added to the balance for the legal and administrative fees involved when collecting an unpaid bill. 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".

Cancellation Policy

We strive to render excellent medical care to our 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. Additionally, if a patient is more than 15 minutes late to his/her appointment, he/she will be seen when possible that same day or rescheduled to another day.

We request that you please give our office a 24-hour notice in the event that you need to reschedule or cancel your appointment. If you miss an appointment without contacting our office by noon the day prior, then it will be considered a missed appointment. At FSA's sole discretion, a fee of $25.00 may be charged for a missed office appointment, and a fee of $100.00 will be charged for a missed in office procedure or surgical appointment. If a patient accumulates a total of three (3) missed appointments, you may not be rescheduled for future appointments and be asked to find another physician to continue your care.

FSA has the right to amend terms in this agreement. By signing below you agree to be bound by the terms in FSA's Patient Policy Information.

_____ _____

Signature of Patient or Responsible Party if a 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 ○ Arthritis
Y ○ N ○ Blood clot
Y ○ N ○ Bleeding disorder
Y ○ N ○ Diabetes
Y ○ N ○ Depression
Y ○ N ○ Seizures
Y ○ N ○ Lung Disease
Y ○ N ○ COPD
Y ○ N ○ Asthma
Y ○ N ○ Sleep apnea
Y ○ N ○ Heart Disease
Y ○ N ○ Heart attack
Y ○ N ○ Other Illnesses/disorders(specify)_____

Y ○ N ○ Heart Murmur
Y ○ N ○ High Blood Cholesterol
Y ○ N ○ High Blood Pressure
Y ○ N ○ Acid Reflux (Heartburn)
Y ○ N ○ Hiatal Hernia
Y ○ N ○ Ulcers (stomach or intestinal)
Y ○ N ○ GI bleeding
Y ○ N ○ Irritable bowel syndrome
Y ○ N ○ Crohn's Disease
Y ○ N ○ Ulcerative colitis
Y ○ N ○ Diverticulitis
Y ○ N ○ Colon Polyps
Y ○ N ○ Kidney Disease

Y ○ N ○ Kidney Stones
Y ○ N ○ Benign Prostatic Hypertrophy
Y ○ N ○ Liver Disease
Y ○ N ○ Hepatitis
Y ○ N ○ Gallbladder disease
Y ○ N ○ Gallstones
Y ○ N ○ Migraine headaches
Y ○ N ○ Stroke
Y ○ N ○ Thyroid Disorders
Y ○ N ○ Cancer Type _____
Y ○ N ○ Substance Abuse
Quit in _____

_____

Past Surgeries/Hospitalizations

	Date

Current Medications (with dosage)

Last Colonoscopy/Sigmoidoscopy (check one)

Colonoscopy ○ Sigmoidoscopy ○ Date: _____

Last Tetanus shot: _____

Medication 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:

- ☐ Obesity
- ☐ Diabetes Type II
- ☐ Diabetes Type I
- ☐ Stroke
- ☐ Heart Disease
- ☐ Heart Attack (age)
- ☐ Bleeding problems
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Colon Cancer
- ☐ Breast Cancer
- ☐ Ovarian Cancer
- ☐ Prostate Cancer
- ☐ Thyroid Cancer
- ☐ 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 _____

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

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 _____

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 _____

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

Flagstaff Surgical Associates – Ear, Nose & Throat
Office Procedure Consent

Patient (print) _____ Date _____

Nasal endoscopy: examination of the nasal passages with use of a scope
Nasal endoscopic debridement: cleaning of the nasal passages and/or sinuses with the assistance of a scope
Flexible fiberoptic laryngoscopy: examination of the larynx with the assistance of a flexible scope
Nasopharyngoscopy: examination of the nasal cavity and nasopharynx area with a scope
Fine needle aspiration: the collection of cells from a cyst or mass for pathological diagnosis and treatment
Incision and drainage of abscess: procedure done to relieve infection and/or pressure
Biopsy: the collection of tissue for pathological diagnosis and treatment
Removal of foreign body
Control of nasal bleeding: the cauterization and/or packing of the nose to stop bleeding
Excision of lesion: excision of a lesion for pathological study
Coblation of uvula: procedure where radio frequencies are used to shrink the size of or remove the uvular tissue to improve airway
Cerumen removal: removal of ear wax
Mastoid cavity debridement: cleaning of the mastoid cavity of the ears under a microscope
Myringotomy with aspiration: incision of the tympanic membrane to facilitate aspiration of fluid collected in the middle ear
Myringotomy with tube insertion: placement of a ventilation tube in the tympanic membrane
Tympanic membrane patch: patching of a tympanic membrane perforation
Comprehensive audiometry: the testing of a person's ability to hear various sound frequencies used to identify and diagnose hearing loss
Tympanometry: test of the middle ear system
Epley: a technique used to manage dizziness
OAE (Otoacoustic Emissions): echoes emitted by the inner ear hair cells used to evaluate the integrity of the inner ear
Transtympanic steroid injection: injection of steroids into the middle ear space through the eardrum

I understand that during my visit, certain tests/procedures may need to be performed that may incur an additional charge above and beyond the office visit charge. This may appear as a surgical procedure or non-covered procedure on my statement from my insurance company. I may be required to pay additional fees for co-insurance, deductible and/or copay. I acknowledge that this can only be determined **after** submission to my insurance company.

I authorize the physicians and/or audiologists of Flagstaff Surgical Associates – Ear, Nose & Throat to perform any of the in-office procedures listed above. This agreement to pay will remain in effect indefinitely, unless revoked.

Print & Sign

_____
Patient signature