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., 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.

I authorize the release of my/the patient's health information including the diagnosis, records; examination rendered to me and claims information to the following:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

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

Please print this form using the button below and sign in **all signature areas**

Print & Sign

Patient History Form

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Date:(MM/DD/YYYY) _____ Name: _____ Date of Birth(MM/DD/YYYY): _____ Age:_____

Describe the main reason for your visit todl·ëÝ_____

_____

_____

_____

Past Medical History

(List any medical conditions that you have such as diabetes, high blood pressure, etc.)

Past Surgical History

(List any prior surgeries)	Date (estimate)

Family History (Other than you)

			Relation
Prostate Cancer	○ Y	○ N	_____
Kidney Cancer	○ Y	○ N	_____
Bladder Cancer	○ Y	○ N	_____
Kidney Stones	○ Y	○ N	_____
Diabetes	○ Y	○ N	_____
Heart Attack	○ Y	○ N	_____
Stroke	○ Y	○ N	_____
Cancer	○ Y	○ N	_____
Bleeding Disorders	○ Y	○ N	_____

Social History

Any history of tobacco use? ○Y ○N

Years of active smoking: _____

Packs per day: _____

Quit? ○Y ○N Date:_____

Alcoholic drinks per day: _____

Recreational drug use? ○Y ○N

Occupation:_____

Marital Status: ○Single ○Married ○hűKŜ№

Age and sex of children:

Current Medications and Supplements

Allergies: Medication and Reaction

Review of Systems

Do you have any problems now or have you had any related to the follow systems? Please circle Yes or No

Constitutional Symptoms		(Comments)
Recent weight change	○Y ○N	
Fever	○Y ○N	
Chills	○Y ○N	
Other	○Y ○N	
Eyes		
Blurry vision	○Y ○N	
Other	○Y ○N	
Cardiovascular		
Chest pain	○Y ○N	
Irregular heartbeat	○Y ○N	
Swelling in ankles	○Y ○N	
Other	○Y ○N	

Genitourinary		(Comments)
Stream is smaller	○Y ○N	
Nocturia (get up at night)	○Y ○N	
Urinary frequency	○Y ○N	
Burning during urination	○Y ○N	
Other	○Y ○N	
Musculoskeletal		
Muscle weakness	○Y ○N	
Joint pain	○Y ○N	
Other	○Y ○N	
Neurologic		
Tremors	○Y ○N	
Dizziness	○Y ○N	
Numbness	○Y ○N	
Other	○Y ○N	

Psychiatric	
Anxiety	○Y ○N
Depression	○Y ○N
Other	○Y ○N
Endocrine	
Excessive thirst	○Y ○N
Too hot/cold	○Y ○N
Other	○Y ○N
Hematologic/Lymphatic	
Easy bleeding	○Y ○N
Easy bruising	○Y ○N
Swollen glands (groin)	○Y ○N
Other	○Y ○N

Respiratory	
Difficulty breathing	○Y ○N
Cough	○Y ○N
Wheezing	○Y ○N
Other	○Y ○N
Gastrointestinal	
Heartburn	○Y ○N
Nausea	○Y ○N
Vomiting	○Y ○N
Abdominal pain	○Y ○N
Constipation	○Y ○N
Other	○Y ○N
Allergic/Immunologic	
Seasonal Allergies	○Y ○N

Form completed by:_____ Date:_____

FLAGSTAFF SURGICAL ASSOCIATES
ESTABLISHED 1976