

Flagstaff Surgical Associates
 Gastroenterology • General Surgery • Urology • ENT • Allergy • Audiology



Patient Information

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

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 <input type="checkbox"/> Yes <input type="checkbox"/>	Auto <input type="checkbox"/>	Date of Accident:
		Job <input type="checkbox"/>	
PRIMARY CARE PHYSICIAN:			
Name:		Address:	
REFERRING PROVIDER:			
Name:		Address:	

Insurance Information

RESPONSIBLE PARTY:		SS #:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Phone#:
Name:				
Address:		DOB:	Relation to patient:	
PRIMARY INSURANCE:			SECONDARY INSURANCE:	
ADDRESS:			ADDRESS:	
GUARANTOR/RESPONSIBLE PARTY:		SS#	GUARANTOR/RESPONSIBLE PARTY:	
Name:			Name:	
Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Phone#:	DOB:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>	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, Discover, and CareCredit 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 out-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 90 days, or if 3 or more statements have been sent, the account will be referred to a collection agency. 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 24 hours 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, a fee of \$100.00 will be charged for a missed in office procedure if canceled within one 1 week, a fee of \$100.00 will be charged for any cancellations within 2 weeks for surgical appointments.

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 and Phone # _____ Relationship _____

Name and Phone # _____ Relationship _____

Name and Phone # _____ 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.

Signature of Patient or Responsible Party if a Minor

Date



FSA Gastroenterology • Health History Form

77 West Forest Avenue • Suite 107 • Flagstaff, AZ 86001 • Phone: 928-773-2222 • Fax: 928-774-9625

Date: ___/___/___ Name: _____ Date of Birth: ___/___/___ Age: _____

Main reason for your visit today: _____

Preferred Lab: _____ Preferred Pharmacy: _____

Past Medical History: Check any illnesses you have had, and estimated date.

<u>Cardiac Disease</u>	Date
Pacemaker	
Heart valve	
Mitral valve prolapse	
Heart attack	
Heart failure	
A-fib	
Coronary Artery Disease	

<u>GI Disease</u>	Date
Ulcer	
Heartburn	
Pancreatitis	
Diverticulosis	
Irritable bowel syndrome	
Inflammatory bowel disease	
Hemorrhoidal bleeding	
H. pylori	

<u>Liver Disease</u>	Date
Hepatitis	
Cirrhosis	
Yellow jaundice	
Alcoholism	

<u>Lung Disease</u>	Date
Asthma	
Tuberculosis	
Hay Fever	
Emphysema	
COPD	

<u>Kidney Disease</u>	Date
Kidney stones	
Pain when urinating	
Blood and urine	

<u>Miscellaneous</u>	Date
Arthritis	
Anemia	
Thyroid disease	
High blood pressure	
Diabetes	
Stroke	
Glaucoma	
Depression	
Transplant	

<u>Cancer? Type?</u>	Date

Current Medications and Supplements:

Allergies: Medication and Reaction:

NO KNOWN ALLERGIES

1.	5.
2.	6.
3.	7.
4.	8.

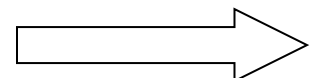
1.
2.
3.
4.

Family History: Check if any of your blood relatives have had any of the following.

	Mother	Father	Sibling		Mother	Father	Sibling
Bladder Cancer				Liver Disease			
Colon Cancer				Ovarian Cancer			
Crohn's Disease				Pancreatic Cancer			
Diabetes				Stomach Cancer			
Esophageal Cancer				Ulcer			
Heart Attack				Ulcerative Colitis			
Jaundice				Uterine Cancer			
Kidney Cancer				Other Cancer?			

Social History:

Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Do you consume alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No Drinks Per Day_____
Are you employed? <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Self employed	Do you have a history of Alcohol Abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when_____
Occupation: _____	Do you have a history of drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No When_____
Do you exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, What_____ How often _____	Do you use caffeine? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, how much_____
Do you use Tobacco or Vape? <input type="checkbox"/> Yes <input type="checkbox"/> No Packs Per Day?_____	Do you use marijuana? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Medical <input type="checkbox"/> Recreational How Often?_____
Have you quit smoking? <input type="checkbox"/> Yes <input type="checkbox"/> No When?_____	Have you traveled outside of the U.S. recently? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Where_____ When_____
If Yes, how many years did you smoke?_____	



Past Surgical History: Type of surgery and best estimated year.

	Year		Year		Year
1.		3.		5.	
2.		4.		6.	

Have your symptoms required an Emergency Department visit? If so When and Where?

Date	Location

Review of Symptoms: Do you have any problems now or have you had any related to the following systems?

Constitutional

- Loss of appetite
- Unintentional weight loss
- Fever
- Chills
- Difficulty sleeping

Eyes

- Blurry vision

Cardiovascular

- Chest pain
- Irregular heartbeat
- Swelling in ankles

Genitourinary

- Nocturia (get up at night)
- Urinary frequency
- Burning / discharge

Musculoskeletal

- Muscle weakness
- Joint pain

Neurologic

- Tremors
- Dizziness
- Numbness

Psychiatric

- Anxiety
- Depression

Endocrine

- Excessive thirst
- Too hot/cold

Hematologic/Lymphatic

- Bleeds easily
- Bruises easily
- Swollen glands

Respiratory

- Difficulty breathing
- Chronic cough
- Wheezing

HEENT

- Headaches
- Dry mouth
- Dental problems
- Mouth sores or ulcers
- Hearing difficulty

Allergic/Immunologic

- Seasonal allergies

Current Gastrointestinal Symptoms: Check if you are currently having any of the following:

- Abdominal pain
- Difficulty swallowing liquids or solids
- Persistent nausea and/or vomiting
- Loss of appetite
- "Backwash" of stomach contents into the mouth
- Black or tarry stools
- Rectal pain or itching
- Mucous stools
- Chronic diarrhea
- Gas, bloating, or belching
- Constipation
- Whole body itching
- Vomiting blood or coffee grounds
- Spastic colon/irritable bowel
- Heartburn
- Blood from the rectum

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Stool test positive for blood in the last 6 months?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Cologuard testing? When: ___/___/___ Who ordered? _____

Gastrointestinal procedures: Have you ever had any of the following?

	Year	Location	Result (if known)
Colonoscopy			
Endoscopy			
Sigmoidoscopy			

Gastrointestinal Imaging: (X-ray, CT scan, MRI) in the last year with location completed:

	Date	Location
X- RAY		
CT scan		
MRI		

Have you had any blood labs in the last year? Location? (LabCorp, Sonora Quest, Etc.).

1.	2.	3.	4.
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Form completed by: _____ Date: ___/___/___