SURGICAL CRITICAL CARE ASSOCIATES, LLP

PATIENT HISTORY

NAME: _____ **DATE**: _____

AGE: _____ **DATE OF BIRTH**: _____ **HEIGHT**: _____ **WEIGHT**:_____

REASON FOR VISIT: _____

OCCUPATION: _____ **FULL DUTY** _____ **LIGHT DUTY** _____ **NOT WORKING** _____

FAMILY HISTORY: ___Muscle or Bone Disease (Inherited) what kind?_____

___Problems with Anesthesia or Anesthetic: What Happened?_____

___bleeding problems ___Scoliosis ___Arthritis at young age ___Other_____

MEDICATION ALLERGIES: Allergic to:_____ what happens?_____

Allergic to:_____ what happens?_____

CURRENT MEDICATIONS:(List all current medication including over-the-counter such as aspirin and herbal supplements)

_____

_____

DO YOU HAVE ILLNESS? (Check all that apply)

__High/__Low Blood Pressure __Blood Clots __Seizures __Lung Problems/Asthma __Swelling in legs & feet

__Rheumatoid Arthritis __Varicose Veins __HIV __Bleeding Problems __Thyroid __Hyper __Hypo

__Sleep Apnea __C-Pap __Kidney Problems __Gout __Hepatitis __Ulcer/Stomach Problems

HEART: __Heart disease __Heart Attach __Murmur __Mitral Valve Prolapse __Congestive heart failure

DIABETIC: __Insulin __Oral Meds __Diet CANCER: __Benign __Malignant

PRIOR SURGERIES: (Include all surgeries and dates of surgeries)

_____

_____

_____

Do you drink alcohol? Y N Quantity?_____ Do you smoke Y N Quantity?_____ Do you use drugs? Y N

FEMALES ONLY: Are you pregnant? Y N Have you had a baby within the last month? Y N Date:_____

Are you on hormone therapy? Y N Name:_____ Dose_____

Are you currently taking birth control pills? Y N How long?_____

__Hysterectomy __Full __Partial __Tubal Ligation Date of last menstrual period?_____

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PATIENT REGISTRATION FORM

Name:_____ Date of Birth:_____ Age:_____ Sex: F M
Last First MI

Address:_____ City:_____ State:_____ Zip:_____

Email(SCCA use only)_____ Social Security Number_____-____-_____

Home Phone:_____ Cell Phone:_____ Work:_____Ext:_____

Marital Status: ___Single ___Married ___Divored ___Separated ___Widowed

Preferred Pharmacy:_____ City:_____ Phone:_____

WHO MAY WE CONTACT IN CASE OF AN EMERGENCY?

Name:_____ Relationship:_____ Phone:_____

IF PATIENT IS LESS THAN 21 YEARS OF AGE PLEASE LIST:

Mother's Name:_____ Phone:_____

Father's Name:_____ Phone:_____

Insurance Information: (We need to make a copy of your insurance cards for our billing records)

1.Insurance:_____ ID#_____Group#_____

Name of insured:_____

Insured's SS#:_____ Insured's Date of Birth:_____

Insured employed by:_____ Work Phone:_____

2.Insurance:_____ ID#_____Group#_____

Name of insured:_____

Insured's SS#:_____ Insured's Date of Birth:_____

Insured employed by:_____ Work Phone:_____

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MEDICAL INFORMATION RELEASE: HIPPA (Initial #1 and complete #2)

1._____(Initial) I acknowledge I was provided with the "Notice of Privacy Practices" of SCCA.

Complete #2 for anyone that you authorize SCCA to speak with regarding your private health information. Without this authorization SCCA is unable to discuss any information with anyone (including spouse) outside of the medical field.

2. I hereby authorize the use and disclosure to individually identifiable health information relating to me as indicated below to be released to the following individuals: (including spouse, parent, child, ect. If applicable)

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Check boxes of information authorized to release to the above noted person(s):

__Medical records/X-rays __Billing records __Testing/lab results __Appointments issues __All the above

ALL AUTHORIZATION EXPIRES ONE YEAR AFTER SIGNED DAY. You may revoke any authorization by providing written notice to our administrations attention. I understand that if the person receiving this information is not health plan or health care provider covered by the federal privacy regulations; the authorized information may be re-disclosed by the information release and that my refusal to sign in no way affects my treatment; payment; enrolled in a health plan; or eligibility for benefits.

Signature_____ Date:_____

FINANCIAL POLICY AND PATIENT FINANCIAL RESPONSIBILITY

PATIENT RESPONSBILITY: You as a patient are ultimately responsible for all fees. All payments, co-payments, co-insurances, and deductibles are due at the time of service. All patients under 18 years of age must be accompanied by an adult who is responsible for any necessary payments and deductibles at the time of service.

PATIENTS WITH HEALTH COVERAGE: We do accept insurance assignment and we will file your insurance claims for you if you have provided us with a copy of your insurance card at the time of service. You are responsible for all co-payments or balances as required by your specific insurance plan. You need to bring your insurance card to each visit. Your appointment will be rescheduled if your insurance card is not available. If the initial given insurance coverage change at any time during your care, immediately provide a copy of the new insurance card to SCCA patient representative or our billing company. If your insurance plan REQUIRES A REFERRAL, THIS MUST BE OBTAINED FROM YOUR PRIMARY CARE PHYSICIAN PRIOR TO YOUR COMING INTO THE OFFICE. It is your responsibility to obtain the referral. If this referral is not received or obtained when you arrive for your visit your insurance company will not honor the visit so your appointment will be rescheduled.

PATIENTS WITHOUT INSURANCE COVERAGE: If you do not have healthcare coverage, you are required to make a $200.00 payment prior to seeing the physician. Immediately following your appointment the cashier will total the chart for the cost of the visit. If the charges exceed $200.00 you will be asked to pay the remaining balance. If the total is under $200.00 you will be refunded the difference.
SCCA accepts the following methods of payments: Cash, Check, Money Order, debit, Mastercard, or Visa.

Signature_____ Date:_____

Surgical Critical Care Associates, LLP

Please read and sign where indicated:

Consent of Treatment:
I know I have a condition that requires medical or diagnostic treatment. I hereby do voluntarily consent to such care and/or procedure and to such medical or other services under the general instruction of Dr. Parkus, Dr. Kavouspour, and/or Dr. Wooten, their assistants, or their designee as is necessary in their judgement. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as the result of treatment.

Signature_____ Date_____

Assignment of the Benefits and Release:
I certify that I, and/or my dependent(s), have insurance coverage with the above mentioned carrier(s), and assign directly to Surgical Critical Care Associates, LLP all insurance benefits for services rendered. I authorize the use of my signature on all insurance claim submissions. I understand that I am financially responsible for all charges not paid by my insurance carrier.

Signature_____ Date_____