David Parkus, MD
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PATIENT DEMOGRAHIC INFORMATION

(Everything in this packet must be filled out)

NAME: ______________________________ **DATE OF BIRTH:** ____________

EMAIL: ______________________________ **SOCIAL SECURITY #:** ____-___-_____

ADDRESS: ______________________ **CITY/STATE:** ______________ **ZIP:** ________

PHONE #: __________________ **ALTERNATE #:** ______________________

REFERRED BY: ____

PRIMARY CARE: ____

MARITAL STATUS: (CIRCLE ONE) **SINGLE** **MARRIED** **WIDOWED** **DIVORCED**

INSURANCE INFORMATION

PRIMARY: ______________________________ **ID #:** ____________________

POLICY HOLDER: __________________________ **DOB:** ____________________

SOCIAL SECURITY: _____-____-______ **PHONE:**________________ **RELATION:** ______________

SECONDARY: ______________________________ **ID #:**____________________

POLICY HOLDER:__________________________ **DOB:** ____________________

SOCIAL SECURITY: ____-___-_____ **PHONE:** ____________________ **RELATION:**______________

MEDICAL SUMMARY

•: CURRENT DIAGNOSED MEDICAL ISSUES (must be diagnosed by a Physician)

Current Medical Issues	How Long?

• PAST HISTORY & SURGICAL PROCEDURES

Procedure/Illness	Year

• List ALL medications including vitamins/herbal supplements.

Name of Medication	Dosage	Prescribing Physician

ALLERGIES: ______________________________

NOTICE OF PRIVACY PRACTICES

Effective Date April 14, 2003

SURGICAL CRITICAL CARE ASSOCIATES

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.

This Notice explains the ways in which we may use and disclose medical information about you. It describes your rights and certain obligations we have regarding the use and disclosure of your medical information. The law requires us to (1) Ensure your medical information is protected; (2) Provide you with this Notice describing our legal duties and privacy practices with respect to medical information about you; (3) Follow the current terms of the Notice in effect.

WAYS WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following sections describe different ways that we may use and disclose your medical information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure will be listed. All of the ways we are permitted to use and disclose information, however, will fall within one of the following categories.

Some information such as certain drug and alcohol information, HIV information and mental health information is entitled to special restrictions related to its use and disclosure. Our office shall abide by all applicable state and federal laws related to the protection of this information.

1. Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other personnel who are involved in your care. For example, a doctor treating you may need to know if you have diabetes because diabetes may slow the healing process. We may also share medical information about you with our office personnel or other providers, agencies or facilities in order to provide or coordinate such things as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside our office who may be involved in your continuing medical care after you leave our office such as other health care providers, transport companies, community agencies and family members.

2. Payment. We may use and disclose medical information about the treatment and services you receive at our office so that payment may be collected from you, an insurance company or a third party. For example, we may need to give information to your health plan about treatment you received at our office so your health plan will pay us or reimburse you. We may also tell your health plan about a proposed treatment in order to obtain prior approval or to determine whether your plan will cover the treatment.

3. Health Care Operations. We may use and disclose medical information about you to support our office operations. These uses and disclosures are made to improve our quality of care. Your medical information may also be used or disclosed to comply with laws and regulations, for contractual obligations, patients. claims, grievances or lawsuits, health care contracting, legal services, business planning and development, business management and administration, the sale of all or part of our office to another entity, underwriting and other insurance activities. For example, we may review medical information to find ways to improve treatment and services to our patients. We may also disclose information to doctors, nurses, technicians, and other personnel for performance improvement and educational purposes.

4. Appointment Reminders. We may contact you to remind you that you have an appointment at our office.

5. Treatment Alternatives. We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

6. Health-Related Benefits and Services. We may contact you to tell you about benefits or services that we provide.

7. Others Involved in Your Care. We may release medical information to anyone involved in your medical care, For example, a friend, family member, personal representative, or an individual you identify. We may give information to someone who helps pay for your care or we may tell your family or friends about your general condition.

8. Research. Your medical information may be important to further research efforts. We may use and disclose your medical information for research purposes, subject to the confidentiality provisions of state and federal law.

9. As Required By Law. We will disclose medical information about you when required to do so by federal or state law; If asked to do so by law enforcement in response to a court or administrative order, subpoena, discovery request, warrant, summons or other lawful process; or for intelligence, counterintelligence, and other national security activities authorized or required by law.

10. To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you for public health purposes or when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat

11. Workers' Compensation. We may use or disclose medical information about you for Workers' Compensation or similar programs as authorized or required by law. These programs provide benefits for work-related injuries or illness.

12. Inmates. If you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release medical information about you to the correctional institution as authorized or required by law.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Although the medical information we obtain about you is the property of our office, you do have the following rights:

1. **Inspect and Copy**. With certain exceptions, you have the right to inspect and/or receive a copy of your medical and billing information. To inspect and/or to receive a copy of your information, you must submit your request in writing to our **Office Manager [Medical Practice Address]**. If you request a copy of the information, we may charge a fee for these services. We may deny your request to inspect and/or to receive a copy in certain limited circumstances. If you are denied access to medical information, in most cases, you may have the denial reviewed. Another licensed health care professional chosen by the Our office will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

2. **Request an Amendment or Addendum**. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record). You have the right to request an amendment or addendum for as long as the information is kept by or our office. To request an amendment, your request must be made in writing and submitted to our **Office Manager**. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: Was not created by our office; Is not part of the medical information kept by or for Our office; Is not part of the information which you would be permitted to inspect and copy; or Is accurate and complete in the record. An addendum must not be longer than 250 words per alleged incomplete or incorrect item in your record.

3. **Accounting of Disclosures**. You have the right to receive a list of the disclosures we have made of medical information about you that were for purposes other than treatment, payment, health care operations and certain other purposes. To request this accounting of disclosures, you must submit your request in writing to our **Office Manager**. Your request must state a time period that may not be longer than the six previous years and may not include dates before April 14, 2003. You are entitled to one accounting within any 12-month period at no cost. If you request a second accounting within that 12-month period, we may charge you for the cost of compiling the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

4. **Right to Request Restrictions**. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information to a family member about a surgery you had. ***We are not required to agree to your request.*** If we do agree, our agreement must be in writing, and we will comply with your request unless the information is needed to provide emergency treatment. To request a restriction, you must make your request in writing to our **Office Manager**. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

5. **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to our **Office Manager**. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

6. **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

CHANGES TO OUR PRIVACY PRACTICES AND THIS NOTICE

We reserve the right to change our office's privacy practices and this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice at our office. The Notice will contain the effective date on the first page in the top right-hand corner. In addition, at any time you may request a copy of the current Notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our **Office Manager [Medical Practice Address]**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we will retain our records of the care provided to you as required by law.

Surgical Critical Care Associates

HIPAA Compliance & Medical Records Release

______ I acknowledge I was provided with the "Notice of Privacy Practices" of SCCA

Below please list the names of anyone that we may speak to regarding your Medical Records and or/ Health Care. If you have a ***Power of Attorney***, please provide those documents to us.

Name: ____ ***Relation:*** ______________

Name: ____ ***Relation:*** ______________

Name: ____ ***Relation:*** ______________

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

__Complete Medical Record(s) __Billing records __Imaging/lab results __All the above

Please note that there will be a $25.00 charge for anyone other than the patient when picking up the records

ALL AUTHORIZATION EXPIRES ONE YEAR AFTER SIGNED DAY. You may revoke any authorization by providing written notice to our administration's 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: _____________________

Nurse Practitioner (N.P.) / Physician Assistant (P.A.)
Consent for Treatment

This facility has on staff a N.P. to assist in the delivery of medical care.

A Nurse Practitioner (N.P.) is not a doctor. A N.P. is a graduate of a certified training program and is licensed by the state board. Under the supervision of a Physician, a N.P. can diagnose, treat, and monitor acute and chronic diseases as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of the supervising physician, but rather overseeing the activities of an accepting responsibility for the medical services provided.

A N.P. may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Offering counseling and education
- Supplying sample medications and writing prescriptions
- Making appropriate referrals

I have read the above, and hereby consent to the services of a nurse practitioner for my health care needs.

I understand that at any time I can refuse to see the o nurse practitioner and request to see a physician.

____

Printed Name

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Signature

____

Date

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient: ________________________________ Date of Birth: ______________________

Phone: ________________________________ Email: ___________________________

Address: __________________________ City _________________ State ______ Zip______

I Request and Authorize:

Name of healthcare provider(s) or facility to release information:

____

Address: ________________________ City _______________ State _____________ Zip __________

Phone: ____________________________ Fax: ______________________________

To release healthcare information on the patient named above to:

Surgical Critical Care Associates, LLP

2965 Harrison Ave, Ste 211 Beaumont, Tx 77702

P. 409-899-8501 F. 409-899-8501

The following information to be disclosed:

- ☐ Physician Notes
- ☐ Lab Results
- ☐ Cardiac Studies
- ☐ Pulmonary Studies
- ☐ All imaging (Xray, dx imaging, ultrasound, CT, MRI etc.)
- ☐ Complete Medical Record
- ☐ Other ______________________________________

I understand that my medical record may contain reports, test results & notes that only a physician can interpret. I understand I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding the information. I will not hold Surgical Critical Care Associates liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for his/her interpretation. I understand the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency (HIV). It may also include information about behavioral or mental health services or treatment for alcohol & drug abuse.

Right to revoke: I understand I have the right to revoke this authorization at any time. I understand my revocation must be in writing. I understand the revocation will not apply to information already released. Other rights: I understand I may inspect or obtain a copy of the information to be used or disclosed. Expiration for this Authorization will be 1 year from the signed date.

Signature of Patient or Legal Representative: ____________________________________

If being signed by representative, what is the relationship? ___________________________

Date: __________________________________

Surgical Critical Care Associates, LLP

Financial Policy & Patient Financial Responsibility

PATIENT RESPONSBILITY:

You as a patient are ultimately responsible for all fees. All payments, co-payments, coinsurances, 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 changes 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 $250.00 payment due at check in, and MUST be paid before seeing the provider for that visit. SCCA accepts the following methods of payments: Cash, Checks, Money Orders, VISA, MASTER, or DISCOVER cards. *If paying with cash, please bring the exact amount due.

By Signing Below, you acknowledge that you have read our office Financial Policies

Signature: ______________________________ Date: ______________

Consent to Treat

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: ______________________

Surgical Critical Care Associates, LLP
PATIENT OCCUPATION/EMPLOYMENT INFO

Patient Name: ______________________________ DOB: ______________

If you are not employed, please do not fill this page out.

Employment Status: Full- Time or Part- Time

Employer Info:

Company Name: _____________________________________

Supervisor: ____

Phone: _________________________ Fax: ________________

Job Information:

Job Title: ____

Please List ALL of your current Job Duties:

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If your Employer requires a specific Release form be filled out, please bring that with you to your POST-OP appointment. No releases will be given until cleared by one of our physician's.

Signature: _______________________________ Date: ________________________________