SCCA
Surgical Critical Care Associates, LLP

David Parkus, MD *Dar Kavouspour, MD* *Eric Wooten, DO* *Sarah Tanton, FNP*

2965 Harrison, Ste. 211 Beaumont, Texas 77702 • Ph: 409-899-8501 • Fax: 409-899-8510 • www.surgicalcritical.com

Patient Demographic Information

(Everything in this packet must be filled out before you have been seen by our physician)

NAME: _____ **DOB:** _____ **M / F**

EMAIL: _____ **SS#** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE: _____ **ALT PHONE:** _____

MARITAL STATUS: MARRIED DIVORCED SINGLE WIDOW / WIDOWER

REFERRING PHYSICIAN: _____

PRIMARY CARE: _____

INSURANCE INFORMATION:

PRIMARY: _____ **ID:** _____

POLICY HOLDER: _____ **DOB:** _____

SOCIAL # _____ **PHONE:** _____ **RELATION:** _____

SECONDARY: _____ **ID:** _____

POLICY HOLDER: _____ **DOB:** _____

SOCIAL#: _____ **PHONE:** _____ **RELATION:** _____

Signature: _____ ***Date:*** _____

SCCA
Surgical Critical Care Associates, LLP

David Parkus, MD *Dar Kavouspour, MD* *Eric Wooten, DO* *Sarah Tanton, FNP*

2965 Harrison, Ste. 211 Beaumont, Texas 77702 • Ph: 409-899-8501 • Fax: 409-899-8510 • www.surgicalcritical.com

Patient : _____ DOB : _____

MEDICAL HISTORY/ SUMMARY:

**** You may put this information on a separate sheet of paper if you need more room****

- **ALLERGIES:** _____
- **LOCAL PHARMACY:** _____ **PH** _____

MEDICATION(S) & DOSAGE	*FREQUENCY*	*PRESCRIBING MD*

SURGERY/ PROCEDURE	*DATE OF SERVICE (APPROX)*	*SURGEON*

CURRENT/ PAST MEDICAL ILLNESS/ DIAGNOSIS(S)

DIAGNOSIS	*YEAR DIAGNOSED*

SCCA
Surgical Critical Care Associates, LLP

David Parkus, MD *Dar Kavouspour, MD* *Eric Wooten, DO* *Sarah Tanton, FNP*

2965 Harrison, Ste. 211 Beaumont, Texas 77702 • Ph: 409-899-8501 • Fax: 409-899-8510 • www.surgicalcritical.com

MEDICAL HISTORY /SUMMARY CONTINUED

Patient: _____ DOB: _____

*Circle **YES** or **NO** to the following questions*

Are you allergic to any of the following?

- ☐ Tape / Adhesive
- ☐ Latex
- ☐ Iodine
- ☐ Betadine

TOBACCO HISTORY:

Have you ever smoked tobacco? This includes vaping. ☐ YES ☐NO
How long? _____
Are you an active smoker? ☐ YES ☐NO
Do you use any other tobacco products? ☐ YES ☐NO
If so, what? _____

ALCOHOL HISTORY:

Do you drink regularly? ☐ YES ☐ NO
If so, how often? _____
Have you ever been diagnosed with Alcoholism? ☐ YES ☐ NO

DRUG HISTORY:

Have you ever used recreational drugs? ☐ YES ☐ NO
If yes, what? _____
Have you ever used intravenous drugs? ☐ YES ☐ NO
If yes, what? _____

FAMILY HISTORY:

Heart Disease _____
Stroke _____
Diabetes _____
Thyroid Disease _____
Cancer: _____

SCCA
Surgical Critical Care Associates, LLP

David Parkus, MD *Dar Kavouspour, MD* *Eric Wooten, DO* *Sarah Tanton, FNP*

2965 Harrison, Ste. 211 Beaumont, Texas 77702 • Ph: 409-899-8501 • Fax: 409-899-8510 • www.surgicalcritical.com

Nurse Practitioner Consent

SURGICAL CRITICAL CARE ASSOCIATES, has on staff a ***Nurse Practitioner*** to assist in the delivery of medical care.

Nurse Practitioners are a graduate of a certified training program and are licensed by the state board. Under the supervision of a Physician, a nurse practitioner 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 nurse practitioner. 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 nurse practitioner and request to see a physician.

_____ Date: _____
Printed Name

_____ Date: _____
Patient Signature

SCCA
Surgical Critical Care Associates, LLP

David Parkus, MD *Dar Kavouspour, MD* *Eric Wooten, DO* *Sarah Tanton, FNP*

2965 Harrison, Ste. 211 Beaumont, Texas 77702 • Ph: 409-899-8501 • Fax: 409-899-8510 • www.surgicalcritical.com

CONSENT TO TREATMENT

(If this section is not signed, you cannot be seen)

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 instruction of Dr. Kavouspour, Dr. Parkus, Dr. Wooten, Sarah Tanton, FNP- C and their assistants or designee as it is necessary in their judgment. 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 claims and submissions. I understand that I am financially responsible for all charges not paid by my insurance carrier.

FMLA/ Short-Term Disability/ Return to Work Notices

All FMLA & Short-Term Disability Paperwork will NOT be filled out until you are seen for your post-Operative appointment. We ask that you either email it to us, drop it off, or bring it with you to your appointment. The Post-Op appointment will determine your Return to Work/School/Physical activities time frame. If your work needs/has a specific form that they would like to have filled out, you must provide us with that form.

By Signing below, you have read and understand the above given information.

Signature: _____ Date: _____

SCCA
Surgical Critical Care Associates, LLP

David Parkus, MD *Dar Kavouspour, MD* *Eric Wooten, DO* *Sarah Tanton, FNP*

2965 Harrison, Ste. 211 Beaumont, Texas 77702 • Ph: 409-899-8501 • Fax: 409-899-8510 • www.surgicalcritical.com

Patient : _____ DOB : _____

Patient Responsibility

You as a patient are ultimately responsible for all fees. All payments, copayments, coinsurances, and deductible amounts are due at the time of service. All patients under 18 years of age must be accompanied by their parent or legal guardian at all times during the visit.

Cancellation Policy

Surgical Critical Care Associates, LLP asks that you provide our office with a minimum of 24hours notice if you need to cancel or reschedule your Office Visit and/or Surgical Procedure. Any cancellations made the day of or if you "NO SHOW" your scheduled appointment could result in a fee. This fee is not billable to your insurance(s) and is 100% patient responsibility to be paid. Office Visits could incur a $25.00 charge and all Surgical Procedures could incur a $100.00 charge.

Patients with Healthcare Coverage

We do accept insurance assignment and 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 copayments or balances as required by your specific insurance plan. You will need to bring your insurance card to each visit. If the initial given insurance coverage changes at aby time during your care, immediately provide us with that NEW insurance information before your scheduled appointment/ procedure and provide us with a copy of the new card as well. *IF your insurance plan required an Insurance Referral and/or Authorization submitted by your PCP to see a specialist, this must be obtained BEFORE your appointment. If this is not done, your appointment WILL be cancelled/rescheduled.*

Patients *WITHOUT* Healthcare Coverage

If you do not have healthcare coverage, you are required to make a $200.00 copayment to our office, this is our SELF PAY/ CASH PAY appointment copay. This is to be obtained at the time of service & and must be paid before you see the provider. Surgical Critical Care Associates, LLP accepts the following forms of payment: Discover, Mastercard, Visa, CASH (exact change only).

By signing below, you acknowledge that you have read our office Policies:

Signature: _____ Date: _____

SCCA
Surgical Critical Care Associates, LLP

David Parkus, MD *Dar Kavouspour, MD* *Eric Wooten, DO* *Sarah Tanton, FNP*

2965 Harrison, Ste. 211 Beaumont, Texas 77702 • Ph: 409-899-8501 • Fax: 409-899-8510 • www.surgicalcritical.com

Patient: _____ Date: _____

HIPAA Compliance and Medical Records Release

ALL AUTHORIZATION EXPAIRES ONE YEAR AFTER THE SIGNED DAY. You may revoke authorization by providing a written notice to our administration's attention. I understand that if the person receiving this information is not health plan or healthcare 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 of benefits.

By signing below, you acknowledge you have reviewed the ***"Notice of Privacy Practices"*** for Surgical Critical Care Associates, LLP. I also acknowledge that I was offered my own copy of this document for my records.

Please list the names of anyone whom we are able to speak with regarding your Medical Records and/or Healthcare. If you have a ***Power of Attorney***, please provide us a copy of that info for your chart.

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

Name	Relation	Phone Number

Signature: _____ **Date:** _____