Steven Webb, MD, FACS . Kenneth Hagan, MD, FACS . John DePeri, MD, FACS . Arun Rao, MD

3627 University Blvd., S., Suite 700; Jacksonville, FL 32216 . Phone: (904) 399-5678 . Fax: (904) 399-8488

www.memorialadvancedsurgery.com

Welcome to Our Practice

memorialadvancedsurgery
MEMORIAL HEALTH

Office Hours:

Monday through Thursday: 8 am – 5 pm; Friday 8 am – 3 pm

Welcome!

You, our patient, are the most important person in our office. We are committed to providing you with the best possible medical care and excellence is our goal. We have worked to provide a full range of services and have a highly trained and knowledgeable staff. Please do not hesitate to ask us any questions about your health plan or medical care.

Emergencies:

For life-threatening situations, call 911. If you have an urgent problem, please call our office for instructions.

Prescriptions:

Please have your pharmacy fax a refill request to (904) 399-8488. Kindly allow 48-72 hours for the refill. The providers will be happy to write a prescription for 90 day supply. Completion of mail order forms is the patient's responsibility.

Appointments:

For an appointment, please call (904) 399-5678.

- Please call in advance for office visits.
- Make follow-up appointments as you leave.
- We make every effort to stay on schedule, although emergencies arise. If we are seriously delayed, we will attempt to notify patients beforehand.
- As a courtesy to other patients and staff, please call the office as soon as possible if you are unable to keep your appointment or are going to be late.

Insurance:

- Prior to your appointment, please check your insurance information so you will be informed about lab coverage, referrals, co-payments and any deductible required at the time of the visit. We also accept Visa, MasterCard and American Express.
- Labs are processed by outside laboratories. You are responsible for knowing your insurance benefits.
- For your first visit, please bring your insurance card and arrive early to complete the necessary patient information forms.
- We accept most insurers, however, please review all insurance information with our staff prior to services being rendered.

Steven Webb, MD, FACS . Kenneth Hagan, MD, FACS . John DePeri, MD, FACS . Arun Rao, MD
3627 University Blvd., S., Suite 700; Jacksonville, FL 32216 . Phone: (904) 399-5678 . Fax: (904) 399-8488
www.memorialadvancedsurgery.com

Insurance (continued):

- Your health insurance contract is between you and your insurance company. Any complaints regarding your coverage should be directed to your carrier.
- We will always make every attempt to get authorizations for surgeries that require one. It is also the patient's responsibility to follow up with your primary care office to ensure the authorization has been processed before your office visit and/or surgery.

Financial Policy:

- Unless arrangements have been made in advance, co-payments, co-insurance and any outstanding balances are expected at the time of service. Patients may be financially responsible for payment of all services even if their insurance company does not pay. Patient accounts not paid promptly are subject to third party collections and/or legal procedures.
- If we are not participating providers with your plan, we will provide you with a receipt for you to file with your insurance company.
- Any check returned from the bank will result in an additional $30.00 charge that will appear on your account.
- If your insurance carrier has not responded to a claim within 90 days, we reserve the right to formally transfer all associated liability for the claim to the patient/guarantor. Failure to promptly resolve this balance may result in third party collection and/or legal procedures is taken as well as possible discharge from the practice. Please keep a close watch for carrier claim payment and contact the insurance carrier or a clinic patient accounts representative at (904) 399-5678 in the event a claim is not resolved within 60 days from the date of service.

We realize that emergencies do arise that may affect timely payment of your account. If such extreme cases do occur, please contact a patient accounts representative. Please always notify our office of any change in name, address, phone or insurance information.

We need you to:

- Inform our staff of any pertinent changes in insurance, employment, demographic information or relationships with other care/service givers.
- Arrive on time for scheduled appointments or cancel, when necessary, with a phone call.
- Provide payment for services requested and delivered by Memorial Advanced Surgery not covered by insurance within 90 days.
- Notify us of any change in your health status.
- Follow the recommended treatment plan and inform Memorial Advanced Surgery of any physical or mental impairment requiring special accommodation.
- Ask questions if directions and procedures are unclear.

Steven Webb, MD, FACS . Kenneth Hagan, MD, FACS . John DePeri, MD, FACS . Arun Rao, MD

3627 University Blvd., S., Suite 700; Jacksonville, FL 32216 . Phone: (904) 399-5678 . Fax: (904) 399-8488

www.memorialadvancedsurgery.com

You can expect:

- To be treated with respect, dignity and to be informed of your care needs to make appropriate decisions.
- To help plan your care and make changes to it.
- Teaching materials that will help you understand processes and procedures.
- To be informed of Memorial Advanced Surgery's billing process.
- To have your records keep confidential except when consent has been given.
- To expect services to be professional, timely and appropriate.
- To communicate your complaints to the Medical Practice Manager and expect to receive follow-up without negative repercussions or changes in service.
- To receive care without discrimination due to race, religion, age, sex, disability or ethnic origin.

FMLA/Disability Form Policy:

- A visit will be required before the Provider can complete forms.
- The form will be left at the office for the Provider to complete. Forms will not be completed during your visit.
- There is a fee of $25.00 separate from your insurance for completion of forms.
- Please allow 7-10 days for completion.
- Government regulations have very specific guidelines for approval of FMLA and Disability. The request for form completion does not guarantee that your FMLA/Disability will be approved.

Pre-Op Clearance Policy:

- Most surgeries will require clearances from your primary care physician and/or other specialists (cardiology, endocrinology, sleep study, etc). You will need to work with the staff to ensure all of these are scheduled.
- Remember, the reason for pre-op clearance is your safety.

Questions:

Always feel free to call and speak to our Practice Manager with any questions or concerns:

Angela Parete
(904) 399-5678 ext: 201

MEMORIAL ADVANCED SURGERY
Patient Registration Form

How did you hear about us? _____

Your appointment today is with Dr. _____

PATIENT INFORMATION

Patient Name _____ Date of Birth:_____

Address: _____

City, State, Zip _____

Social Security Number _____ Male: _____ Female: _____

Phone Cell _____ Home _____ Work _____

Race: White, Black, Asian/Pacific Islander, Hispanic, American Indian, Other Other: _____ Language: _____

Marital Status Married Single Divorced Widowed

Email Address _____ _____

****Pharmacy**_____**Phone** _____

Referring Physician _____

Primary Care Physician _____

Employment Status Employed ft pt Full Time Student Retired

Employer _____ Occupation _____

Emergency Contact Name _____Phone _____

Emergency Contact Relationship to Patient _____

RESPONSIBLE PARTY INFORMATION (FOR PARENT OR GUARDIAN)

Responsible Party Name _____

Address _____

City, State, Zip _____

Relationship to Patient _____

PRIMARY INSURANCE INFORMATION

Insurance Company _____

Subscriber ID _____ Group ID _____

Name of Subscriber _____Subscriber DOB _____

Relationship to Patient _____

SECONDARY INSURANCE INFORMATION

Name of Subscriber _____Subscriber DOB _____

Insurance Company _____

Subscriber ID _____ Group ID _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient/Responsible Party Signature_____ Date_____

Medication Form

Name:	**Date:**
Allergic to/describe reaction:	**Allergic to/describe reaction:**

☐ **Currently not taking medications**

List all medicine you are currently taking: Prescription and over-the-counter medications (examples: aspirin, antacids), dietary supplements and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin, vitamins and homeopathic remedies)

Date	Name of Medication	Dose	Directions/Date last taken	Date stopped	Reason for taking/changing medication and doctor's name

Memorial Advanced Surgery Patient Medical History

Patient Name_____ Today's Date_____

Age_____ Date of Birth_____

Allergies and Adverse Reactions: (include allergies to antibiotic, latex, X-ray dye, skin preps, pain medications, etc)

_____

_____

Reason for today's visit: _____

History

Surgeries:_____

_____

Hospitalizations (other than surgery): _____

Chronic Illnesses (high blood pressure, diabetes, neurological, cardiac, etc.)

_____

_____

Blood Transfusion: I will accept blood products in an emergency Yes_____ No _____

Have you ever had a reaction to transfusion? Yes_____ No _____

Social History

Marital Status: Single____ Married_____ Divorced_____ Widowed_____

Occupation_____ living Will: Yes No

Daily Caffeine Intake: None_____ 1-3 Servings _____ 4-6 Servings _____ more than 6 servings_____

Drug Use: Marijuana_____ Cocaine_____ Crack_____ Heroine_____ Other_____

Family History:	**Alive/deceased**	**Age**	**Health Problems/ Cause of Death**
Father:	_____	_____	_____
Mother:	_____	_____	_____
Sisters:	_____	_____	_____
Brother:	_____	_____	_____

Current Medical Condition Questionnaire Patient Name_____ DOB_____

Please check any that apply:

Constitutional	☐ Weight loss	☐ Fever/Chills	☐ Fatigue
Eyes	☐ Blurred vision	☐ Double Vision	☐ Eye pain
Head	☐ Headache	☐ Migraine	☐ Recent trauma
Ears	☐ Hearing loss	☐ Itching	☐ Ear discharge
	☐ Dizziness	☐ Ear pain	☐ Roaring sound
	☐ Ear fullness	☐ Pressures sensation	☐ Ringing in the ears
Nose	☐ Nasal obstruction	☐ Snoring	☐ Sinus headache
	☐ Nose bleeding	☐ Allergies	☐ Itchy/Watery eyes
	☐ Nasal congestion		
Throat/Mouth	☐ Sore throat	☐ Hoarseness	☐ Difficulty swallowing
	☐ Change in voice		
Psychological	☐ Anxiety	☐ Depression	☐ Under current treatment
Cardiovascular	☐ Chest pain	☐ High Blood pressure	☐ Palpitations
Respiratory/Lungs	☐ Cough	☐ Wheezing	☐ Coughing blood
	☐ Shortness of breath	☐ Sleep Apnea/CPAP use	
Gastrointestinal	☐ Heartburn/Acid reflux	☐ Nausea	☐ Difficulty swallowing
	☐ Excessive belching	☐ Vomiting	☐ Painful swallowing
Integumentary	☐ Skin lesions	☐ Change to existing lesion	☐ Change in color
Neurological	☐ Tremors	☐ Seizures	☐ Numbness/tingling
	☐ Loss of balance		
Musculoskeletal	☐ Joint pain	☐ Joint swelling	☐ Muscle pain
Endocrine	☐ Cold intolerance	☐ Heat intolerance	☐ Loss of hair
	☐ Hot flashes	☐ Weight gain	☐ Thryoid disorder
Hematologic	☐ Easy bleeding	☐ Easy bruising	☐ Enlarged glands

I have fully completed this form and verify it's accuracy.

Patient Signature_____ **Date**_____ **Reviewed by**_____

MEMORIAL ADVANCED SURGERY FINANCIAL AGREEMENT

PATIENT INFORMATION

PATIENT'S NAME _____
Last First M.I.
ADDRESS _____
BIRTHDATE _____/ _____/ _____ DAYTIME TELEPHONE NUMBER_____
Month Day Year
SOCIAL SECURITY NO. _____

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I have received a copy of **Memorial Advanced Surgery's** Privacy Notice dated _____("Notice"). I understand that I am responsible to read this Notice and notify **Memorial Advanced Surgery**, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. **Memorial Advanced Surgery** has the right to revise this Notice at anytime and will post a copy of the current Notice in the office in a visible location at all times. **Memorial Advanced Surgery** will provide me with a copy of its most recent Notice upon my request.
Date:_____
Patient Signature:_____
Parent, Guardian or Legal Representative Signature:_____
WitnessSignature:_____

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at **Memorial Advanced Surgery**. I am responsible for any applicable deductible or co-payments prior to the provision of services. **Memorial Advanced Surgery** will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, or procedure this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. I further understand that such payment is not contingent on any insurance, settlement or judgment payment. **Memorial Advanced Surgery** may file a claim for payment with my insurance company as a courtesy to me. If the insurance company fails to pay **Memorial Advanced Surgery** in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to **Memorial Advanced Surgery**. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including reasonable attorney's fee.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL

I understand that it is my responsibility to provide **Memorial Advanced Surgery** with a copy of my current insurance card and to obtain a referral from my Primary Care Physician (if required by my insurance). **Memorial Advanced Surgery** is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a Private Pay patient and be financially responsible for the total amount of the services provided. I will notify **Memorial Advanced Surgery** immediately upon any change in my insurance.

MEMORIAL ADVANCED SURGERY FINANCIAL AGREEMENT

INSURANCE WAIVER

I understand that if I do not have a copy of a current insurance card and valid referral, if required, that I can be seen as a "Private Pay" patient. I agree that neither **Memorial Advanced Surgery** nor I will file a claim for the visit. A waiver will be completed for each visit that I am seen as a Private Pay patient. I will be required to pay the total cost of the visit in advance.

NON-COVERED SERVICES WAIVER

I understand that charges for my care will be filed with my insurance carrier as a courtesy by **Memorial Advanced Surgery**. There may be a service that I desire that is not covered under my insurance plan ("Non- Covered Services"). I understand that I will be financially responsible for the cost of any Non-Covered Services. A separate waiver will be completed for each Non-Covered Service. If I have Medicare, I will complete an Advance Beneficiary Notice ("ABN") form.

ASSIGNMENT OF BENEFITS

I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered to patient, directly to **Memorial Advanced Surgery**. I hereby authorize **Memorial Advanced Surgery** to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan.

ASSIGNMENT OF BENEFITS

I hereby authorize and assign all payments of authorized Medicare benefits for medical services and/or surgical procedures rendered to patient, directly to **Memorial Advanced Surgery**. I hereby authorize **Memorial Advanced Surgery** to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by Medicare for which I have signed an ABN.

SIGNATURE

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Date:_____

Patient Signature:_____

Parent, Guardian or Legal Representative Signature: _____

Witness Signature: _____

Section A: This section must be completed for all Authorizations

Patient Name:	**Date of Birth:**	**Patient's Phone:**	**Last 4 digit SSN** (optional)**:**
Provider's Name:	**Recipient's Name:**		
Provider's Address:	**Address 1:**		
	Address 2:		**Recipient's Phone:**
	City:	**State:**	**Zip:**

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Electronic Media, if available (*e.g.*, USB drive, CD/DVD)** ☐ **Encrypted Email** ☐ **Unencrypted Email**

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.*, paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (*e.g.*, virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: **Event:**

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ All PHI in medical record		☐ Operative information		☐ Labor/delivery summary	
☐ Admission form		☐ Cath lab		☐ OB nursing assess	
☐ Dictation reports		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Physician orders		☐ Rhythm strips		☐ Itemized bill:	
☐ Intake/outtake		☐ Nursing information		☐ UB-04:	
☐ Clinical test		☐ Transfer forms		☐ Other:	
☐ Medication sheets		☐ ER information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☐ No

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**