

**This form must be completed in full
Cary Surgical Specialists, PC**

| | | | | | |
|---|----------------------------------|-----------------------|-------------|------------------------|-------------|
| Patient Last Name | | Patient First Name | | Middle Initial | Male_____ |
| | | | | | Female_____ |
| Date of Birth | Patient's Social Security Number | Home Number | Work Number | Cell Number | |
| Mailing Address | | | | | |
| Home Address If Different | | | | | |
| Referring Physician (Dr's Name) | | Address | | Phone Number | |
| Primary Care Physician (Dr's Name) | | Address | | Phone Number | |
| Patient's Employer | | Phone Number | | | |
| Spouse's Name | | Spouse's Employer | | Spouse's work Number | |
| Emergency Contact | | Relationship | | Phone Number | |
| Guarantor (Person responsible for bill) | | Date of Birth | | Social Security Number | |
| Address of Guarantor | | | | | |
| Primary Insurance | | Name of Policy Holder | | SS# of Policy Holder | |
| Date of Birth of Policy Holder | | ID# on Policy | | Policy Group # | |
| Policy Holder Employer | | | | | |
| Secondary Insurance | | Name of Policy Holder | | SS# of Policy Holder | |
| Date of Birth of Policy Holder | | ID# on Policy | | Policy Group # | |
| Policy Holder Employer | | | | | |
| Workman's Compensation? (Circle One) Yes No | | | | | |

Full payment is due at the time of service. I agree to be responsible for my expenses. I authorize my insurance company, attorney or any other parties to pay Cary Surgical Specialists, PC. directly and provide any information regarding payment of my medical charges. I accept responsibility for any balance due and any items not covered by my insurance company. I authorize the physician to administer medical care as is necessary.

Signature: _____ Date _____

MEDICAL HISTORY

Name _____

Date of Birth _____

Please check the box if you have the problem now or in the past

| | Now | Past | | Now | Past | | Now | Past |
|-------------------------|-----|------|------------------------|-----|------|-------------------|-----|------|
| General | | | Urinary | | | Endocrine | | |
| Weight loss | | | Frequent urination | | | Thyroid Problem | | |
| Fever/Chills | | | Burning | | | Diabetes | | |
| Fatigue | | | Blood in urine | | | | | |
| Headaches | | | Urinary infection | | | Blood | | |
| | | | Kidney Stones | | | Blood clots | | |
| ENT | | | Incontinence | | | Bleeding problems | | |
| Hearing loss | | | Sexual difficulty | | | Leukemia | | |
| Ringing ears | | | Male testicle pain | | | Anemia | | |
| Blurred vision | | | Female painful menses | | | Phlebitis | | |
| Earaches | | | Female vag. discharge | | | Enlarged spleen | | |
| Nose bleeds | | | | | | Hepatitis | | |
| Bleeding gums | | | Musculoskeletal | | | HIV | | |
| Sore throat | | | Joint pain | | | AIDS | | |
| Swollen glands | | | Stiffness | | | | | |
| | | | Weakness | | | | | |
| Heart | | | Back pain | | | | | |
| Heart failure | | | Cold feet or hands | | | | | |
| Heart Attack | | | Poor circulation | | | | | |
| Angina | | | | | | | | |
| Leg swelling | | | Skin/Breast | | | | | |
| Palpitations | | | Rash/itching | | | | | |
| Rheumatic fever | | | Change in color | | | | | |
| High Blood Pressure | | | Varicose veins | | | | | |
| | | | Breast pain | | | | | |
| Lungs | | | Breast lump | | | | | |
| Pneumonia | | | Breast discharge | | | | | |
| Emphysema | | | Breast cancer | | | | | |
| Bronchitis | | | | | | | | |
| Cancer | | | Neuro | | | | | |
| Shortness of breath | | | Dizzy spells | | | | | |
| Spitting blood | | | Numbness | | | | | |
| Wheezing/Asthma | | | Seizures | | | | | |
| | | | Tremors | | | | | |
| Gastrointestinal | | | Paralysis | | | | | |
| Poor appetite | | | Head Injury | | | | | |
| Diarrhea | | | | | | | | |
| Constipation | | | Psychiatric | | | | | |
| Nausea/Vomiting | | | Memory loss | | | | | |
| Painful bowel move. | | | Nervousness | | | | | |
| Rectal bleeding | | | Depression | | | | | |
| Abdominal Pain | | | Insomnia | | | | | |
| Gall stones | | | | | | | | |

Please complete the reverse side

Previous Surgeries and Dates:

Social History :

Smoking No Yes How Much _____ How many years _____
Alcohol No Yes How Much _____

Marital Status : S M D W

Family History :

| | Age | Medical problems or cause of death |
|-----------------|-------|------------------------------------|
| Father | _____ | _____ |
| Mother | _____ | _____ |
| Siblings | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |

Current Medications and Doses

Drug Allergies and Reaction

Cary Surgical Specialists, PC

Michael A. Tyner, MD
Jon M. Bruce, MD

Patient Consent for Use and Disclosure of Protected Health Information

In signing this form, you consent to the use and disclosure of your protected health information by Cary Surgical Specialists, PC, our staff and our business associates strictly for the purpose of treatment, payment and health care operations.

You acknowledge you have had an opportunity to review our Notice of Privacy Practices prior to signing this consent. We encourage you to review our Notice of Privacy Practices carefully. It provides more detail on how we may use and disclose your information. The Notice of Privacy Practices may change. A current copy may be requested when you are being seen as a patient by contacting our manager at (919) 234-4470 or by visiting our website at www.carysurgical.com

You may request that we restrict how we use and disclose your protected health information for the purposes mentioned above. If you would like to request a restriction, please do so in writing. However, we reserve the right to deny your request. If we grant your request, we are bound by the terms of the agreement.

You may also revoke this consent in writing; however, information on any treatment and services provided using this or prior consents may still be used or disclosed for purposes of treatment, payment, or health care operations. Refer to the Notice of Privacy Practices for further information.

By signing this form, I grant my consent for the practice to use and disclose my protected health information for the purposes of treatment, payment and health care operations

Signature of Patient _____ Date _____
Signature of Parent if Minor _____ Date _____
Power of Attorney Signature _____ Date _____
Name of other that may have your records _____ Date _____
Relationship to Patient _____

For Practice Use Only

Failure to obtain consent:

- Indirect Treatment Relationship
- Substantial Communication Barrier
- Emergency Treatment
- Refusal to Sign
- Other

Description: _____

Practice Signature _____ Date _____

Witness _____ Date _____

Cary Surgical Specialists, PC Financial Policy

Please read and sign the following policy to avoid any misunderstandings. If you have any questions, please ask for clarification.

1. We require a current copy of your insurance card at check-in; otherwise payment will be expected at time of service.
2. All co-pays, co-insurances and deductibles are due at time of service.
3. As a courtesy to you we file most primary insurances, however if you have a secondary insurance that is not on our list of contracted providers we would not file your secondary claim. You would send them a copy of your primary carriers Explanation of Benefits. It has all the information required to process your claim.
4. Please see our list of participating insurance companies. If you have insurance not on our list you may still have “out of network” benefits. Call your insurance company and ask what your options would be “out of network”. Give the doctor’s name; he may be listed under a contracted pricing company.
5. Please realize that if a company deems service “non-covered” you are responsible for payment.
6. Medicare will only pay for services that are deemed “reasonable and necessary”, therefore you will be asked to sign a waiver if we determine that your service would likely be denied, and you therefore would be responsible for those charges.
7. HMO, POS etc. plans: We request when an appointment is scheduled that (if required) the primary care physician fax a insurance authorization before the appointment date; however it is ultimately your responsibility to make sure the authorization has arrived before your service or you may be asked to re-schedule.
8. Please be aware that we do not participate with Tricare or Champus in either “participating” or “non-participating” form; therefore they may not process your claim if you file it yourself. Payment is expected at time of service.
9. All balances are due and payable within 90 days of service; this will allow sufficient time for insurance to process and for you to respond to billing statements.
10. A workman compensation form is required at check-in for any work related injuries. These are available upon request.
11. We do not bill for accidents involving litigation. You will be required to pay at time of service.
12. Self pay patients are asked to pay 50% of any surgery estimates prior to surgery.

13. If you have any deductibles that have not been met prior to surgery. Payment for these deductibles are due the day prior to scheduled surgery date.
14. If you have applied for Medicaid, you must show proof within 30 days or we are not obligated to file your claims, and you will be considered self pay until that proof is provided.
15. We request 24 hour notice if you are canceling an appointment.
16. All Medical-form completion will obtain a charge of \$10.00 per form request. If additional information is needed, that cannot already be found in the chart in order to complete the requested form, a schedule visit may also be required. Once all pertinent information is received, the form will be completed with 7-14 days of submitted payment.
17. Responsibility for any service to minor children rests with the parent seeking treatment unless a court ordered judgment is in place.
18. Before the scheduling of any surgery, please check your dates, we charge \$20.00 if you reschedule your surgery.
19. Please be aware that services you receive in the office or hospital may involve other medical parties, therefore you may have additional charges such as lab, pathology, anesthesia, etc..
20. Any return check by the bank for "NSF" or "closed account" will be charged a \$25.00 service fee
21. Patients are seen by appointment time, not arrival time.

Authorization:

I agree to be responsible for my medical expenses regardless of insurance coverage. I authorize my insurance company, attorney or others parties to provide any payment information regarding my bill and make payment directly to Cary Surgical Specialists, PC. I agree to pay all costs incurred if my account should become delinquent, including reasonable attorneys fees. I have read, understood and agree to this financial policy and I accept full responsibility for any balance due.

I authorize the physician in charge to administer medical care as is necessary, and allow release of medical records and x-rays to any party involved in my treatment.

Signature _____

Date _____