Independence Surgical Clinic

* Jared B. Smith, MD, FACS * Mindi S.T. Beahm, MD, FACS * John Lewandowski, MD

PLEASE PRINT CLEARLY, COMPLETING EACH ITEM.	**DATE:**	
Name ***(First, M.I, Last.):***	☐ **M** ☐ **F**	**Date of Birth:**
Marital status: ☐ **Single** ☐ **Partnered** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**		
Address:	**City, State, Zip:**	

Social Security No.:	**Home Phone:**	**Cell Phone:**
Occupation:	**Employer:**	**Employer Phone No.:**
Referring Physician:	**Primary Care Physician:**	**Email:**
Pharmacy:	**Pharmacy Location:**	

IN CASE OF EMERGENCY

Emergency Contact:	**Relationship to Patient:**	
Home Phone No.:	**Cell Phone No.:**	**Work Phone No.:**

INSURANCE INFORMATION

Please indicate Primary insurance:		
Subscriber's Name:	**Subscriber's Date of Birth:**	**Subscriber's Social Security:**
Policy/ID No.:	**Group No.:**	**Specialty Co-payment:**
Patient's relationship to subscriber/self:		

Name of Secondary insurance (if applicable)		
Subscriber's Name:	**Subscriber's Date of Birth:**	**Subscriber's Social Security:**
Policy/ID No.:	**Group No.:**	**Patients relationship to subscriber/self:**

Is this visit related to a Workman's Compensation Insurance Claim? Yes or NO	**Date:**

RACE/ETHNICITY FORM

Independence Surgical Clinic, INC is required by law to provide the Missouri State Agencies with information regarding the race and ethnicity of their patient population. Our mission is to plan for and support the development of a healthcare system that meets the current and future healthcare needs of their patients. In doing so, we ask that you assist us in providing this information by making the most appropriate selection regarding race and ethnicity from the choices listed below.

Ethnicity:	☐ **Hispanic**	☐ **Non-Hispanic**	☐ **Decline Response**
Preferred Language:	☐ **English**	☐ **Spanish**	☐ **Other**
Race:	☐ **American-Indian or Alaskan native**	☐ **Black/African American**	☐ **Hispanic**
	☐ **Native Hawaiian or other Pacific Islander**	☐ **White**	☐ **Other**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Independence Surgical Clinic, INC or insurance company to release any information required to process claims.

Signature of Patient/Patient Representative Date

PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECK, MASTERCARD, VISA, AND DISCOVER.

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Patient Financial Policy Statement

The physicians and staff of Independence Surgical Clinic, INC are here to serve your needs as our patient. Our PATIENT FINANCIAL POLICY is intended to describe our expectations regarding the payment for services we provide. Please note that payment is due at the time of service.

Our staff is prepared to provide patients with any assistance or resources in making arrangements for services. We can help patients contact the appropriate entities to obtain documents needed to ensure proper payment such as referrals and pre-authorizations for procedures. We ask that patients recognize their responsibility to understand what services their insurance covers as well as what documents are required to assure payment is made.

THE PATIENT FINANCIAL POLICY details the expectations of our medical group as they relate to patients making payments for services. Patients should acknowledge the following policy requirements:

1. The patient or their designated guarantor is responsible for payment of services.
2. All office charges, co-payments, co-insurance, and applicable deductible amounts are due at the time of service.
3. The provision of an insurance card for payment of services will be filed on behalf of the patient; however, the patient is still responsible for payment if their insurance coverage fails to adequately provide payment in a timely or appropriate manner. If you do not have your insurance card you are considered a self-pay patient.
4. It is the obligation of the patient to obtain and provide any referral notifications required by the patient's insurance carrier. Without the appropriate referral the patient's appointment may be rescheduled.
5. Arrangements for co-insurance payments must be made prior to the scheduled surgery date in order to prevent possible delays in surgery.
6. Patient account balances are due within 30 days of the receipt of the billing statement.
7. Account balances over 60 days old may be charged interest at the highest rate allowed by the law.
8. Patients may contact our patient accounts representative to make payment arrangements. After 90 days, if no arrangements have been made for payment, or if no payments have been received, then collection proceedings will begin.
9. Delinquent accounts may be assigned to a collection agency. All collection costs, including legal fees will be added to your outstanding account balance and will become an additional cost to you. We will not be held responsible for any collection agency or legal fees.
10. From time to time, various forms including to but not limited to disability and FMLA forms need to be filled out. There is a $25.00 fee to complete each form. There is a fee to copy medical records, cost is based on the number of pages as per MO statues allow.
11. We accept MasterCard, Visa and Discover Cards. Checks returned for closed accounts or non-sufficient funds will be charged a $30.00 service fee and sent to the respective state reporting agencies.

Signature of Patient/Patient Representative Date

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Acknowledgement of Receipt of Notice of Privacy Practices

I give Independence Surgical Clinic, INC permission to disclose my protected health information to the following individuals involved in my health care and/or payment for health care goods and services. *If you decline to give such permission, leave the following blank.*

Spouse:	Phone Number:
Children:	Phone Number:
Other:	Phone Number:

I give Independence Surgical Clinic, INC permission to leave a message with the person who answers the telephone or voice-mail message at the most current telephone number on file concerning appointment reminders or requesting that I contact my health care provider. *If you decline to give such permission, leave the following blank.*

Telephone Number(s):

I give Independence Surgical Clinic, INC permission to contact me at the following telephone number or send a message to the most current e-mail on file to notify me of any breach of my protected health information. *If you decline to give such permission, leave the following blank.*

Telephone Number(s):	☐ Same as above
Email Address:	☐ Same as above

TERMINATION, RELEASE, COPIES AND FACSIMILES

This release shall terminate on the first to occur of: (1) two years following my death, or (2) upon my written revocation actually received by the covered entity. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, electronic mail, or any other receipt evidencing actual receipt by the covered entity. This release shall not be affected by my subsequent disability or incapacity. There are no exceptions to my right to revoke this release. Each covered entity that acts in reliance on this release shall be released from liability which may result from disclosing my individually identifiable health information and other medical records. Copies or facsimiles of this release shall be as valid as the original release.

I acknowledge that I have received a copy of Independence Surgical Clinic, INC Notice of Privacy Practices with the effective date of July 01, 2015.

_____ _____

Signature of Patient/Patient Representative (Expires one year from date signed)

Date

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AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As set forth more fully in our "Notice of Privacy Practices," we are required by law to obtain your authorization for any use or disclosure of your health information for purposes not other than treatment, payment or health care operations. In our "Notice of Privacy Practices," we provided you information about how Independence Surgical Clinic, INC can use or disclose your health information. You have a right to review our "Notice of Privacy Practices" before signing the authorization.

Patient Name: _____ DOB: _____ SSN: _____

_____

Address City, State, Zip Phone Number

- OFFICE USE ONLY - PLEASE READ –
(to be filled out at time needed)

I hereby authorize _____
(Insert name and address who is authorized to receive the protected health information.)

to release to Independence Surgical Clinic, INC the following patient records including care and treatment relating to mental health conditions, drug or alcohol abuse, HIV testing, infection status, or care and treatment for AIDS:

Medical Records	Radiology Reports
Laboratory Reports	Other

for the following purposes: _____
(*Describe the purpose of the requested use or disclosure*)

RESTRICTIONS: Only medical records that have originated through this health care facility will be photocopied. This consent shall remain in effect for one (1) year from the date executed unless revoked earlier by me. If revoked earlier, it is understood by all parties that the information released prior to being notified of such revocation was made at my request with my consent Independence Surgical Clinic, INC Group may not require that you sign this Authorization to receive treatment. Once release of this information is made to the above named person or persons, your information may be subject to re-disclosure by that person or persons. A photo static copy of this consent and authorization shall be considered as effective and valid as the original.

_____ _____

Signature of Patient/Patient Representative **Date**

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**

YOUR REASON FOR TODAYS VISIT

PERSONAL HEALTH HISTORY		
Please list any current or past medical history and or treatment (Heart problems, Diabetes, Cholesterol, etc.)		
Surgeries		
Year	Reason	Hospital
Date of Last Physical Exam:		
Have you ever had a colonoscopy?	☐ Yes	☐ No

SOCIAL HISTORY	
Do you currently smoke or use tobacco products? ☐ Yes ☐ No Frequency _____ Have you ever smoked or used tobacco products? ☐ Yes ☐ No When? _____	Do you drink? ☐ Yes ☐ No Frequency _____ Do you take drugs for any reasons that are not medical? ☐ Yes ☐ No If yes, please list _____

FAMILY HEALTH HISTORY								
	MOTHER	**FATHER**	**SIBLINGS** **BRO / SISTER**	**GRANDMOTHER** **MOM SIDE/DAD SIDE**	**GRANDFATHER** **MOM SIDE/DAD SIDE**	**CHILDREN**	**AUNT** **MOM/DAD SIDE**	**UNCLE** **MOM /DAD SIDE**
Issues with Anesthetic								
CANCER TYPE								
Breast								
Colon								
Pancreatic								
Prostate								
Other Cancer **List type**								
Diabetes								
Heart Disease								
High Blood Pressure								
Stroke								

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Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**

ALLERGIES TO MEDICATIONS	
Name the Drug	**Reaction you had**
OTHER ALLERGIES	
Allergy to:	**Reaction you had**
☐ Latex	
☐ Adhesive tapes	
☐ Betadine	
☐ Foods	

MEDICATIONS
(INCLUDE TYLENOL, ASPIRIN, VITAMINS, OVER THE COUNTER MEDS, HERBAL REMEDIES, SUPPLEMENTS, ETC…)

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength/ Frequency Taken	Reason for Medication

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Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**

MENTAL HEALTH		
Do you have anxiety?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you hallucinate?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY			
Number of pregnancies:	Number of live births:	Are you pregnant or breastfeeding?	
Have you ever had a Mammogram?		Date of last Mammogram or Breast Exam?	
Experienced any recent breast tenderness, lumps, or nipple discharge?		☐ Yes	☐ No
Date of last pap and rectal exam?			
☐ Painful urination	☐ Irregular periods	☐ Discharge	
☐ Frequency	☐ Urgency	☐ No Problems	

MEN ONLY		
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?		
☐ Testicular mass	☐ No problems	

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