SURGICAL GROUP OF JOHNSON CITY, MPC

2333 Knob Creek Road • Suite 16 • Johnson City, TN 37604 • (423) 975-0764 • Fax (423) 975-0141

Scott D. Watson, M.D., F.A.C.S. Michael J. Hodge, M.D., F.A.C.S.

PLEASE PRINT

PATIENT INFORMATION

ACCT. # _____

(LAST) (FIRST) (MIDDLE)

PATIENT NAME: _____

ADDRESS: _____

CITY, STATE: _____ ZIP: _____

HOME PHONE NO.: ____/____

CELL PHONE NO.: ____/____

EMERGENCY PHONE: _____
(NEAREST RELATIVE OR FRIEND)

PATIENT SOCIAL SEC. NO.: _____

EMAIL ADDRESS: _____

PATIENT SEX: ❑ MALE ❑ FEMALE

BIRTH DATE: _____ AGE: _____

PATIENT STATUS: ❑ SINGLE LANGUAGE: _____

❑ MARRIED RACE: _____

❑ DIVORCED ETHNICITY: _____

❑ OTHER

❑ WIDOW(ER)

REFERRING PHYSICIAN: _____

PATIENT'S EMPLOYER: _____

EMPLOYER'S PHONE NO.: ____/____

INSURANCE HOLDER'S INFORMATION (IF INSURANCE NOT THROUGH PATIENT'S EMPLOYMENT)

NAME: _____

ADDRESS: _____
(IF DIFFERENT FROM PATIENT)

CITY, STATE: _____

ZIP CODE: _____

TELEPHONE NO.: ____/____

EMPLOYER: _____

EMPLOYER'S PHONE NO.: ____/____

GUARANTOR'S SOCIAL SEC. NO: _____

GUARANTOR'S BIRTH DATE: _____

RELATION TO GUARANTOR: SELF ❑ SPOUSE ❑ CHILD ❑ OTHER ❑

INSURANCE INFORMATION

ORDER OF CLAIM SUBMISSION:

1. INS. CO.: _____ 2. INS. CO.: _____ 3. INS. CO.: _____

(IF INSURANCE NOT IN PATIENT'S NAME)

INSURED'S NAME: _____ INSURED'S NAME: _____ INSURED'S NAME: _____

IS PATIENT'S CONDITION RELATED TO:

A. EMPLOYMENT? YES ❑ NO ❑

B. AUTO ACCIDENT? YES ❑ NO ❑

❑ SELF PAY ❑ CO-PAY_____

IF YES, SEND BILL TO: _____

HMO: ❑ YES ❑ NO

IF YES, NAME OF MEDICAL DOCTOR _____

ASSIGNMENT AND RELEASE

I hereby authorize and direct my insurance benefits to be paid directly to the Physician. I am financially responsible for all services to me, including the balance remaining after payment of possible insurance benefits and including all costs connected with the collection of this account. I also authorize release of any medical information necessary to process this claim. To the best of my knowledge, the information given is correct.

PATIENT SIGNATURE _____ DATE _____
(PARENT OR GUARDIAN IF MINOR)

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED

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HIPAA PATIENT PRIVACY ACKNOWLEDGEMENT

I acknowledge that I have received notification that access to a copy of **S**urgical **G**roup of **J**ohnson **C**ity, **MPC**, Notice regarding Privacy of Personal Health Information is available upon request. In order to ensure that your health information remains confidential and to protect the staff of **S**urgical **G**roup of **J**ohnson **C**ity, **MPC**, we require authorization to speak to or leave messages with anyone other than the patient.

Patient/Guardian Signature:_____ Date:_____

I give my permission for the Practice of **S**urgical **G**roup of **J**ohnson **C**ity, **MPC**, including the staff, to speak with the contacts listed below (Please include the area code with all phone numbers):

Name:_____Phone #:_____Relationship to Patient:_____

Name:_____Phone #:_____Relationship to Patient:_____

Name:_____Phone #:_____Relationship to Patient:_____

May we leave test results on your answering machine/voicemail? Yes_____ No_____

May we contact you at work? Yes_____ No_____ Phone #:_____

I authorize any staff member of **S**urgical **G**roup of **J**ohnson **C**ity, **MPC**, to send correspondence to me by mail regarding appointments, any test results, treatments, account balances, and office updates.

Yes_____ No_____ Mailing Address:_____

If **S**urgical **G**roup of **J**ohnson **C**ity, **MPC**, needs to call in or e-Prescribe medication for me, I would like to use the following pharmacy:

Pharmacy Name:_____ Pharmacy Street/City:_____
Pharmacy Phone #:_____

I authorize Surgical Group of Johnson City to verify my electronic medicine history **Y** **N**

Please note that if the patient is a minor and parents are separated/divorced, both parents have a legal right to the minor child's healthcare information unless otherwise prohibited by a court of law. If this is the case, documentation will need to be provided. Additionally, if the patient has a Power of Attorney, that person must sign all paperwork at each visit as necessary and a copy of the documentation must be on record with us prior to the patient being seen by our physicians.

This authorization will remain in effect until revoked by me in writing.

Patient/Guardian Signature:_____ Date:_____

Witness Signature:_____ Date:_____

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FINANCIAL PAYMENT POLICY

Thank you for choosing the Surgical Group of Johnson City as your health care provider. We are committed to providing successful treatment. Please understand that prompt payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to treatment.

ALL PATIENTS MUST PAY THE APPLICABLE COPAY AND DEDUCTIBLE BEFORE SEEING THE PHYSICIAN.

All patients must complete our information sheets before seeing the physician.

INSURANCE: We may accept assignment of insurance benefit from your health care plan. It is your responsibility to determine if we are a provider for your insurance. We will be glad to provide help with this when possible. The physician's service is provided directly to you and not the insurance company, the contract is between you and the insurance company and does not relieve you of financial responsibility for the bill. Any unpaid balance is due from you and you will be held responsible for collecting from your insurance company. We will file claims for you (up to two claims per company). You will be responsible for any follow-up regarding their payment.

If we are not participating providers with your insurance company, please refer to the above statement.

METHODS OF PAYMENT: We accept cash, check, VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS. We will also offer an extended payment plan in the event of special needs. If your insurance plan has not paid your balance in full in 60 days, the balance must be paid in full by you or transferred to a credit card. If you do not have insurance or we are not a participating provider with your insurance plan, the full payment will be due prior to treatment.

RETURN CHECK FEE IS $30

USUAL AND CUSTOMARY RATES: Our practice is committed to the best treatment for our patient and our fees are usual and customary for this area. Please be aware that some insurance companies determine that our fees are above reasonable and customary. You are responsible for payment regardless of any insurance company's arbitrary determination of usual, responsible or customary fees.

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SELF PAY BALANCES AND COLLECTION AGENCY: We ask that you pay all self pay balances once the insurance has paid. If you have not paid your balance, you will need to clear that balance before seeing the physician again. If your account remains unpaid 60 days after the insurance has paid, then it will transfer to our collection agency for processing. Once an account has gone to the collection agency, you may not be seen in our office until the balance is paid in full.

MISSED APPOINTMENT: Please cancel any appointment that you are unable to keep at least 24 hours in advance. We reserve the right to charge for missed appointments at the rate of a normal office visit.

REMEMBER, WE ARE HERE TO HELP!!!

Thank you for understanding our financial policy. Please let us know if you have questions or concerns.

I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY

_____ _____

SIGNATURE DATE

Surgical Group of Johnson City

Name: _____ Age: _____Date: _____ Referring Doctor: _____

MEDICAL HISTORY: Please check if you have or have had any of the following:

- ❑ High Blood Pressure
- ❑ Heart Failure
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Rheumatic Fever
- ❑ Angina
- ❑ Stroke
- ❑ Transient Ischemic Attack
- ❑ Seizure
- ❑ Vascular Disease
- ❑ Anemia
- ❑ Disc Disease
- ❑ Veneral Disease
- ❑ Aneurysm
- ❑ Urinary Stress Incontinence
- ❑ Bleeding Disorder
- ❑ Kidney Stone
- ❑ Kidney Infection
- ❑ Prostate Trouble
- ❑ Emphysema
- ❑ Asthma
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Anesthetic Problem
- ❑ Collapsed Lung
- ❑ Diabetes
- ❑ Thyroid Problems
- ❑ Lupus
- ❑ Polycystic Ovarian Syndrome
- ❑ Phlebitis
- ❑ Breast Problems
- ❑ Cancer of any Kind
- ❑ Hodgkins Disease
- ❑ Leukemia
- ❑ Fibroids
- ❑ Pelvic Infections
- ❑ Adrenal Gland Problem
- ❑ Varicose Veins
- ❑ Hernia
- ❑ Irritated Bowel
- ❑ Ulcer Disease
- ❑ Pancreatitis
- ❑ Hepatitis
- ❑ Hyperlipidemia
- ❑ Cirrhosis
- ❑ Gallbladder Problem
- ❑ Ulcerative Colitis
- ❑ Crohns Disease
- ❑ Bowel Obstruction
- ❑ Rectal Problem
- ❑ Hemorrhoids
- ❑ Arthritis
- ❑ Blood Clots
- ❑ Depression
- ❑ Head Injury
- ❑ Eye Disease
- ❑ Sleep Apnea
- ❑ Hypercholesterolemia
- ❑ GERD (Reflux)
- ❑ Fibromyalgia

Are you pregnant or any possibility of being pregnant? _____
Number of Pregnancies: _____ Number of Children: _____ Number of Miscarriages: _____
Age of First Period: _____ Last Period: _____ Last Pap Smear: _____
Last Mammogram: _____
Previous Surgeries: _____
_____
_____
Medications: _____
_____
_____
Allergies: _____
Social History: Smoke: Yes _____ No _____ Alcohol: Yes _____ No _____
History of Family Health Problems: Father _____ Brothers _____
History of Family Health Problems: Mother _____ Sisters _____
History of Family Health Problems: Grandparents _____

REVIEW OF SYSTEMS: Please check if you have or in the past have had any of the following:

SKIN:
- ❑ Easy Bruising
- ❑ Changing Moles

LYMPH:
- ❑ Enlarged Node
- ❑ Gland Swelling

ENDOCRINE:
- ❑ Increased Thirst
- ❑ Intolerance To Temp.
- ❑ Increased Urination
- ❑ Weight Loss

HEENT:
- ❑ Convulsions
- ❑ Severe Headaches
- ❑ Vision Changes
- ❑ Nose Bleeds
- ❑ Speech Difficulty
- ❑ Hoarseness

BREAST:
- ❑ Lumps
- ❑ Nipple Discharge
- ❑ Pain or Enlargement

CHEST:
- ❑ Pain
- ❑ Shortness of Breath
- ❑ Wheezing
- ❑ Cough, Dry Mucus/Blood
- ❑ Night Sweats
- ❑ Fever or Chills
- ❑ Irreg. Heart Beat

G.I.:
- ❑ Abdominal Pain
- ❑ Indigestion
- ❑ Nausea or Vomiting
- ❑ Decreased Appetite
- ❑ Jaundice
- ❑ Change in Bowels
- ❑ Rectal Trouble
- ❑ or Bleeding

G.U.:
- ❑ Bulge in Groin
- ❑ Impotence
- ❑ Problem with urination
- ❑ Abn. Vag. Bleeding

EXT:
- ❑ Leg Pain w/Walking
- ❑ Cold Feet
- ❑ Swelling

Have you ever received a Blood Transfusion? Yes _____ No _____
Do you take Aspirin daily? Yes _____ No _____
Do you take Hormones or Birth Control Pills? Yes _____ No _____
Do you have Dentures? Yes _____ No _____