PATIENT INFORMATION

First Name: _____ **Last Name:** _____

Date of Birth: _____ **Sex:** Male Female

Social Security # _____ **Marital Status:** Single Married Divorced Widowed

Ethnicity: Non-Hispanic Hispanic

Race: White African American Asian Pacific Islander American Indian Unknown Decline to Say

Preferred Language: English Spanish Other: _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Communication Preference: Home Phone Cell Phone Mail Email

Employer: _____ **Work Phone:** _____ **EXT:** _____

Which Doctor Are You Seeing Today? _____

Referring Doctor: _____ **Phone:** _____

Family Doctor: _____ **Phone:** _____

Emergency Contact or Next of Kin: _____ **Relation:** _____ **Phone:** _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Name of Insured: _____ **DOB:** _____

I.D. # _____ **Group #:** _____ **SS #:** _____

Effective Date of Coverage: _____ **Relationship to Patient:** _____

Employer: _____

Secondary Insurance Company: _____

Name of Insured: _____ **DOB:** _____

I.D. # _____ **Group #:** _____ **SS #:** _____

Effective Date of Coverage: _____ **Relationship to Patient:** _____

Employer: _____

PATIENT AUTHORIZATION

_____ _____ _____

Patient Signature Date (Power of Attorney or Authorized Signature if Minor)

I understand that I am responsible for my payment of services to Columbia Surgical Associates, Inc. and The Vein Center of Mid-Missouri, L.L.C. I authorize the release of any and all medical records information necessary to process claims and requests for payment from my Insurance Company in compliance with HIPAA regulations.
Further, I understand that certain procedures may be considered cosmetic by my insurance company and/or not covered by my insurance company. In such situations I understand I will be responsible for payment for such services.

Patient Name: _____ **Date of Birth:** _____

Workers Compensation/Auto Accident Liability Information

Is your visit today related to a work injury? [Y] [N]

Is your visit today related to an auto accident? [Y] [N]

Is your visit today related to any other liability claim? [Y] [N]

If you have answered "NO" to all of the questions above, please sign below:

_____ _____

Patient Signature Date

If you answered "YES" to any of the questions above, please complete the rest of this form and sign below:

Do you have authorization from the insurance carrier for today's visit : [Y] [N]

Has this claim been filed with the Missouri State Department of Workers Compensation: [Y] [N]

If "yes" please provide the Report of Injury Number: _____

I authorize Columbia Surgical Associates, Inc. and/or its representatives to release my medical records information and/or discuss continued treatment of care with the designated insurance company or Workers Compensation carrier or its representatives as necessary to process claims and requests for payment.

_____ _____

Patient Signature Date

Patient Name: _____ Date of Birth: _____

HISTORY OF PRESENT ILLNESS

Reason for today's visit: _____

What makes this better or worse: _____

Date illness started: _____ Severity of pain 1-10 (10 being worst) _____

Quality of pain (stabbing/pressure-like/etc.) _____

VITALS (will be completed by nursing staff)

Height: _____ Weight: _____ Pulse: _____ BP: _____

MEDICAL HISTORY

Please list all surgeries:

	Surgery	Year	Complications/Details
	Hernia		
	Gall Bladder		
	Appendectomy (Appendix)		
	Hysterectomy		
	Heart Catheterization		
	Heart Bypass		
	Any Vascular Surgeries (Please Explain)		
	Other		
	Other		

Please list all Hospitalizations:

Hospitalization Reason	Date	Hospital

Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY (*continued*)

Please circle "Y" for any medical conditions YOU suffer from. Circle "N" if you do not suffer from the condition.

Anemia	Y	N	Epilepsy/Seizures	Y	N	Liver Disease/Jaundice	Y	N
Arthritis	Y	N	Freq. Headache/Migraine	Y	N	Meningitis	Y	N
Asthma	Y	N	Gallbladder	Y	N	Multiple Sclerosis	Y	N
Bladder Incontinence	Y	N	Head Injury	Y	N	Pneumonia	Y	N
Blood Clots	Y	N	Hearing Loss	Y	N	Rheumatic Fever	Y	N
(Had a) Blood Transfusion	Y	N	Heart Attack	Y	N	Stroke	Y	N
Cancer – Breast	Y	N	Heart Disease	Y	N	Thyroid Disorder	Y	N
Cancer – Colon	Y	N	Hepatitis	Y	N	Tuberculosis	Y	N
Cancer – Other _____	Y	N	Hiatal Hernia/Reflux	Y	N	Ulcers – Leg	Y	N
Colon/Rectal Polyps	Y	N	High Blood Pressure	Y	N	Ulcers - Stomach	Y	N
Diabetes	Y	N	High Cholesterol	Y	N	Varicose Veins	Y	N
Emphysema	Y	N	Kidney Disorder	Y	N	Weakness or Paralysis	Y	N
PVD Peripheral Vascular Disease	Y	N						

Please list any major or chronic illnesses not listed above: ☐ NONE

_____

_____

_____

FOR WOMEN ONLY

Do you think you may be currently be pregnant: ☐ Y ☐ N How many times have you been pregnant: _____

How many children do you have: _____

Have you had a mammogram: ☐ Y ☐ N If yes, when: _____ Results: ☐ Normal ☐ Abnormal

FOR MEN ONLY

Do you have any prostate issues: ☐ Y ☐ N If yes, explain: _____

Have you had a prostate exam: ☐ Y ☐ N If yes, when: _____

Have you had a PSA (Prostate Specific Antigen) test: ☐ Y ☐ N If yes, when _____ Level _____

Patient Name: _____ Date of Birth: _____

SOCIAL HISTORY

Who lives in your home: _____

Are you currently working: Y N Reason (if no) ☐ Unemployed ☐ Retired Other _____

Your Occupation: _____ ☐ Full-Time ☐ Part-Time ☐ Student

Do you smoke: Y N Quit *(when:* _____) Packs Per Day: _____ How Long: _____

Do you use other tobacco products: Y N Quit *(when:* _____) How Long: _____

Do you Drink Alcohol: Y N How Often: ☐ Rarely ☐ Daily ☐ Weekly ☐ Monthly

Do you drink more than 6 cups of caffeinated beverages per day: Y N

FAMILY HISTORY

Please circle "Y" and list the relation if any family members suffer from any of the conditions below. Circle "N" if no family members suffer from any of the listed conditions.

			Family Member				Family Member
Anemia	Y	N		Heart Surgery or Stents	Y	N	
Asthma	Y	N		Hepatitis	Y	N	
Abdominal Aneurysm	Y	N		High Blood Pressure	Y	N	
Blood Clots	Y	N		High Cholesterol	Y	N	
Blood Transfusion	Y	N		Kidney Disorder	Y	N	
Cancer – Breast	Y	N		Liver Disease/Jaundice	Y	N	
Cancer – Colon	Y	N		Multiple Sclerosis	Y	N	
Cancer – Other_____	Y	N		Problems with Anesthesia	Y	N	
Colon/Rectal Polyps	Y	N		PVD Peripheral Vascular Disease	Y	N	
Diabetes	Y	N		Varicose Veins	Y	N	
Emphysema	Y	N		Stroke	Y	N	
Gallbladder	Y	N		Thyroid Disorder	Y	N	
Heart Attack	Y	N		Tuberculosis	Y	N	

The above information is completed to the best of my knowledge

_____ _____

Patient Signature **Date**

Patient Name: _____ Date of Birth: _____

Do you now or have you recently had any problems related to the following systems? Circle YES (Y) or NO (N). If you mark YES to any of the following, please indicate which doctor is treating you for that problem. If you haven't seen a physician yet, please contact your Internist or Family Physician to address those issues.

REVIEW OF SYSTEMS

Cardiovascular:			**Hematological/Lymphatic:**			**Respiratory:**		
Chest Pain	Y	N	Swollen Glands	Y	N	Wheezing	Y	N
Palpitations/Murmur	Y	N	Blood Clotting Problems	Y	N	Frequent Cough	Y	N
Leg Swelling	Y	N	Bleeding Problems	Y	N	Chronic Cough	Y	N
Irregular Heartbeat	Y	N	Other:			Shortness of Breath	Y	N
Other:						Other:		
			Musculoskeletal:					
Constitutional Symptoms:			Joint Pain	Y	N	**Gastrointestinal:**		
Fever	Y	N	Neck Pain	Y	N	Abdominal Pain	Y	N
Chills	Y	N	Back Pain	Y	N	Nausea/Vomiting	Y	N
Headache	Y	N	Assistive Devices	Y	N	Indigestion/Heartburn	Y	N
Weight Loss	Y	N	Other:			Stomach Ulcer	Y	N
Weight Gain	Y	N				Intolerance to Greasy Foods	Y	N
Other:			**Neurological:**			Blood in Stool	Y	N
			Seizures	Y	N	Colon/Rectal Polyps	Y	N
Endocrine:			Tremors	Y	N	Jaundice	Y	N
Excessive Thirst	Y	N	Dizzy Spells	Y	N	Difficulty Swallowing	Y	N
Too Hot/Cold	Y	N	Numbness/Tingling	Y	N	Have you had a Colonoscopy	Y	N
Tired/Sluggish	Y	N	Other:			When:		
Other:						Results: Normal	Abnormal	
			Psychological:			Other:		
Genitourinary:			Do you suffer from Depression	Y	N			
Urine Retention	Y	N	Do you feel Anxious/Nervous	Y	N			
Painful Urination	Y	N	Other:					
Urinary Frequency	Y	N						
Difficulty Urinating	Y	N						
Other:								

Patient Name: _____ Date of Birth: _____

CURRENT MEDICATION LIST

Pharmacy:	Street and City:	Phone Number:

Medication Allergies:			Reaction:
Do you suffer from a Latex Allergy/Sensitivity:	Y	N	

Prescription/Over the Counter Medication Name:	Dosage:	Frequency:	Route/Topical Site:

Herbal Medication Name:	Dosage:	Frequency:	Route/Topical Site

Columbia Surgical Associates

To: Our Patients

Thank you for choosing Columbia Surgical Associates, Inc as your health provider.

With today's rising cost of health care, we are making every effort to keep your costs to a minimum. In order to do this, we need your help. Please read and sign the following Financial Policy statement.

IF YOU HAVE HEALTH INSURANCE COVERAGE:

- Please supply us with a copy of your current insurance card.
- Please notify our office of any changes in your address, telephone number, or insurance coverage.
- ALL CO-PAYMENTS MUST BE PAID AT THE TIME OF YOUR VISIT. Failure to do so will result in the rescheduling of your appointment.
- ALL referrals are the responsibility of the patient and must be current at the time of your visit.
- When scheduling surgery, you will be asked to pay co-insurance and/or deductible amounts in order to confirm your surgery date. Our Business Office staff will discuss these payment arrangements with you.

IF YOU DO NOT HAVE HEALTH INSURANCE COVERAGE:

- Payment in full will be expected at the time of service unless prior payment arrangements are made.
- We accept payment by cash, check, credit card (Visa or MasterCard), cashier's check or money order.
- Our Business Office staff will be happy to discuss payment arrangements at your request.

We will gladly assist you by filing an insurance claim to your insurance company. If you have questions, our Business Office staff is available from 8:00 a.m. to 5:00 p.m. Monday – Friday. If you receive a bill from our office indicating a "balance due from patient", we will expect a payment from you. If you disagree with the bill for any reason, please call our office immediately at 573-443-8775.

We utilize the services of Account Management Services in the event payment is not received according to the agreed upon terms. AMS reports to the Credit Bureau upon placement of any account.

I HAVE READ AND AGREE TO THIS FINANCIAL POLICY:

_____ _____

Signature of Patient or Responsible Party Date

Columbia Surgical Associates

3220 Bluff Creek Drive, Suite 100
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Shachar Laks, M.D.
Scott A. Gard, M.D.
Kimberly C. Suppes, M.D.
Nicole C. Nelson, D.O.
Erica H. Salinas, M.D.
Jane A. Vaughn, APRN, FNP-BC

Patient Portal Registration

In order to provide our patients with online access to their medical information we have partnered with Intuit Health and their MedFusion Patient Portal to provide protected electronic health information to our patients. This is in compliance with American Recovery and Reinvestment Act of 2009 which created the Health Information Technology for Economic and Clinical Health Act.

Once the Patient Portal is launched you will be able to:

- Complete Registration Paperwork
- Update your Demographic and Insurance information
- Complete your Health History information
- Request an Appointment
- Receive Appointment Reminders
- Communicate with our Doctors, Nurses, Billing Staff and Schedulers
- View Summaries of Previous Visits
- Pay your Bill

Patient Name: _____ Date: _____

☐ I am interested in accessing my medical information online, please

Use the following email address to grant me access:

_____

☐ I am not interested in accessing my medical information online.

If in the future, your interest or your email address changes, please let us know.

Privacy Policy

Columbia Surgical Associates are committed to keeping your email address confidential. We do not sell, rent, lease, or share our information with any other parties. We will not provide your personal information to any third party individual, government agency, or company at any time without your expressed written permission or in the case of a court order.

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Medicare Billing Authorization

Patient Name(Please Print) _____ **Medicare Number** _____

Secondary Insurance _____ **Insurance ID/Group Number** _____

Third Insurance _____ **Insurance ID/Group Number** _____

I request that payment of authorized Medicare benefits or my health insurance benefits be made either to me or on my behalf to Columbia Surgical Associates, Inc. for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid Services (formally Health Care Financing Administration) and its agents, or other insurance carrier as directed by me, any information needed to determine these benefits payable for related services.

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.

Signature _____ **Date Signed** _____

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HIPAA Authorization

I have been informed by Columbia Surgical Associates that the **"Notice of Information Practices "is** available in their waiting room for review. I understand that I have the right to ask questions in order to seek clarification and/or request a copy of this document.

Any medical or billing information may be discussed with the following:

_____
Name (s)

_____

_____

_____ _____
Patient Signature Date