PATIENT REGISTRATION

Demographics

Name (First, MI, Last):______________________________ Preferred Name: ____________________

Date of Birth: ______/ ______/ ___________

Social Security #: ______ - ______ - ___________

Driver's License #: ________________________________

Sex Assigned at Birth (circle one): M F Gender Identity: ______________________________

Marital Status (circle one): Single Married Divorced Widowed Other (specify): ______________

Contact Information

Mailing Address: ______________________________ City: ____________ State: ______ Zip: _________

Email Address: ____

Cell Phone: (_____) _____-_________ Home Phone: (_____) _____-_________ Work Phone: (_____) _____-_________

May we leave a detailed message on your voicemail (circle one): Yes No

With whom may we speak regarding your health information?

Name: ______________________ Relationship: __________________ Phone #: (_____) _____-_________

Name: ______________________ Relationship: __________________ Phone #: (_____) _____-_________

For Minors Only, please indicate with whom child lives: ______________________________

Occupation

Employer Name: ____

Employer Address: ____

Job Title: ____

Insurance Information

Primary Insurance Company______________________

Policy/ID#______________________

Group #______________________

Policyholder's name______________________

Policyholder's SS#______________________

Policyholder's DOB______________________

Employer name ______________________

Secondary Insurance Company______________________

Policy/ID#______________________

Group #______________________

Policyholder's name______________________

Policyholder's SS#______________________

Policyholder's DOB______________________

Employer name ______________________

msa PRIMARY CARE

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care. To avoid any questions or problems, we need your assistance and understanding of our financial policy.

1. All co-pays are due at the time of service. There is a $5.00 fee for any co-pay not paid on the date the services are provided. Even if you have a secondary insurance that picks up your co-pay, you are responsible for paying the co-pay. We will abide by the contract we have with your primary insurance company.
2. There is a $50.00 fee for any appointment that is not cancelled 24 hours before your scheduled appointment time. Two "NO SHOW" appointments will be grounds for dismissal from the practice. A $50.00 "NO SHOW" fee will be applied for any missed appointment.
3. Insurance is a contract between you and your insurance company. We will file your insurance claims as a courtesy to you. You agree to pay any portion of the charges not covered by insurance. We will file your insurance claims on time. If no payment is made, the balance is your responsibility. We emphasize that as a medical provider, our relationship is with YOU and NOT your insurance company. We cannot be responsible for any loss of benefits. It is YOUR responsibility to know your policy.
4. Not all services are covered benefits in all insurance contracts. Some insurance companies select certain services they will not cover and regardless of our participation with a plan, payment for any non-covered services will be the patient's responsibility.
5. In the case of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for any charges or co-pays. It is the authorizing parent's responsibility to collect from the other parent if necessary.
6. There is a $40.00 fee for any returned check. Payment will need to be made by cash, credit card, or cashier's check within 14 days for the amount due, and the returned check fee.
7. Accounts over 60 days old are subject to a billing fee.
8. Accounts over 90 days old are subject to a $5.00 delinquent fee. Balances will need to be paid in full at this time to avoid dismissal from the practice and the account being sent over to collections.
9. Accounts over 120 days old or accounts for whatever reason are dismissed from the practice are subject to a $15.00 dismissal fee.
10. Accounts that are sent to collections are subject to the collection agency's fees that are charged to Medical and Surgical Associates, which is usually 30% of the balance sent to collections. The balance includes any interest added, delinquent and dismissal fees,
11. There is a $10.00 fee for any records transferred to another physician. The fee increased to $25.00 if you have an unpaid balance at the time of transfer or if you have been dismissed from the practice. Once your records have been transferred, no further appointments will be made with our office. This aforementioned clause is applicable if you have been dismissed from our practice.
12. There may be a $20.00 fee for any medication prior authorization your insurance requires.
13. There may be a charge for forms filled out by a physician.

Signature of Patient or Guardian: ______________________________ Date: ____________________

If guardian, please print name and relationship to patient: ______________________________

AUTHORIZATIONS

(1) We participate in one or more Health Information Exchanges. Your Healthcare providers can use this network to securely provide access to your health records for a better picture of your health needs. We and other healthcare providers may allow access to your Health Information through the Health Information Exchange for treatment, payment, or other healthcare operations. This is a voluntary agreement. You may opt out at any time by notifying Medical and Surgical Associates Staff or the office Administrator.

Signature of Patient or Guardian: ______________________________ Date: ________________
If guardian, please print name and relationship to patient: ______________________________

(2) I hereby authorize Medical and Surgical Associates, Inc. and/or any of its representatives to disclose medical or other information obtained in the course of my diagnosis and treatment to any government and/or third party (insurance) payer, or any other entity required by law. I permit a copy of this authorization to be used in place of the original, and request payment of any insurance benefits to Medical and Surgical Associates, Inc. or myself. I further authorize the disclosure of my diagnosis and treatment records, including the charges for the same to any billing service, attorney, or debt collection agency selected by Medical and Surgical Associates, Inc. Said disclosure shall be solely for the collection of charges incurred for treatment provided by Medical and Surgical Associates, Inc. to me and/or my spouse and children. I will notify you of any changes made in my health status or insurance information.

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware I may be responsible for all charges that are incurred.

Signature of Patient or Guardian: ______________________________ Date: ________________
If guardian, please print name and relationship to patient: ______________________________

(3) This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your healthcare information.

I hereby give my consent to Medical and Surgical Associates, Inc. to use and disclose my protected health information for the purpose of treatment, payment and operations of my healthcare at this practice.

Consent for treatment: I, with my signature, authorize (this practice), and any employee working under the direction of the physician, to provide medical care for me, or this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not be limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other healthcare professionals for care and treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice. This release may include information about drug use/abuse, alcohol use/abuse, mental health issues or concerns, AIDS or HIV status as pertinent to my medical care.

Consent related to the Privacy Notice: I have had a chance to review the Privacy Practice Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time. If I revoke this consent, the revocation does not take effect until the practice receives it.

Signature of Patient or Guardian: ______________________________ Date: ________________
If guardian, please print name and relationship to patient: ______________________________

IF REVOKING THE ABOVE CONSENT, PLEASE SIGN/DATE BELOW:
Signature of Patient or Guardian: ______________________________ Date: ________________
If guardian, please print name and relationship to patient: ______________________________

Practice Privacy Statement

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION: PLEASE REVIEW IT CAREFULLY

I.

- This is a formal notification, as required by the government concerning the privacy policy of this practice. This practice has an obligation to maintain all medical information in the strictest of confidence. Our practice cannot release information without your written consent, including conversations, reminder calls, test results and other confidential issues. Patient information about health care is identified as "PHI" or protected health information. This new policy requires that you, the patient, identify at the time of registration with us specific information about release of information. You can change this information at any time with either written notification or verbal notification, followed up in writing. Changes can only impact the care or information from that point in time forward.
- We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying [the Health Information Management Services/Medical Records Department [ ] OR [the office administrator].

II. Your protected health information (PHI) is a part of your medical care, and can be used or disclosed as follows:

- For your treatment in this practice and other locations under the immediate care for care needs. This may include any referral for services; diagnostic tests or treatment related to your medical care needs.
- For obtaining payment for treatment with your identified health care program. This would include any documentation related to this care, including history forms, progress notes or operative notes. This would include eligibility verification, prior authorization and claim submission.
- For operations of this practice, such as enrolling with insurance programs, hospital privileges, accounting and compliance with federal and state laws and regulations.
- Appointment reminders and health related benefit services only with your consent identified on the registration form
- Disclosure to your family and friends concerning any related health care information with your on the registration form which can be modified at any time orally, followed by written consent.
- Consent is not required for emergency care and treatment. An emergency is identified as a medical condition that in the judgment of the physician requires information for care on your behalf.

Certain disclosures can be made without our consent and they are as follows:

- Disclosure required by the government or law enforcement agencies. An example would be victims of abuse
- Information used for public health purposes, medical examiners or related to a person's death or for the health department for disease tracking. Specific governmental functions
- Information used for health care oversight, such as a site review by an insurance program,

III. Yours rights for your health information include: The right to request limits on the uses and disclosure at registration or any time during your care. The right to choose how we send this information to you, including an alternate address.
The right to see and obtain copies of your PH, but there may be copy and postage fees. The right to get a listing of which we have made disclosures to about your PHI. The right to correct your file through an amendment process if appropriate.

IV. This practice reserves the right to modify or change this Privacy Statement and process at any time. Revision to the Notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Privacy Notice. An updated Privacy Notice will be posted in the office within 60 days of the revision.

V. If you have a concern or complaint about how your protected health information is being used, from this time forward you should first contact our Practice Administrator at our Business office to resolve your concerns or you may contact the Office of Civil Rights or the Ohio Medicare Carrier, GBA Palmetto.

Office of Civil Rights - Regional Manager
Department of Health & Human Services
233 N. Michigan Avenue, Suite 240
Chicago, Illinois 60601

Palmetto GBA
Part B Operations — HIPAA Compliance Concerns
PO Box 18957
Columbus, Ohio 43218

Patient signature on receipt of Privacy Notice:______________________________

PEDIATRIC HISTORY WORKSHEET

1. Child's Name: ____
Last First MI

2. Male / Female / Identifies as ______________________________________

- Preferred Pronoun: She/Her He/Him They/Them (circle one)

3. Date of Birth: ______________________ If delivered early, how early? ____________
Month Day Year

4. Was the child delivered on time, late, or early? (circle one)
Did the child stay in the hospital after birth for any treatment? Yes / No (circle one)
Were there any pregnancy complications with this child? Yes / No (circle one)
Did child receive Hepatitis shot in the hospital? Yes / No (circle one)

5. Does the child have any allergies? Yes / No.
If yes, please list) ____

6. Diet: Breastfed yes/no (circle one) Formula______________ oz/day______________

7. Please list any medical problems the child has had in the past and approximate date it was discovered.

Problem	Date

8. Is the child taking any medications regularly? Please list with the dosage and frequency.
(Include over the counter medications also)

Name	Dose	Frequency

9. Please record child's family medical history:

	Age	Living/Deceased	Health Problems	Custody Y/N
Mother:				
Father:				

Brother(s):

Age	Living/deceased	Health problems	Lives in home Y/N

Sister(s):

Age	Living/deceased	Health problems	Lives in home Y/N

10. Has the child ever been hospitalized, had surgery, or had a major injury?

Date	Reason/ Type of injury	Surgeon/Hospital

11. Social History

Child lives with whom at home? ____

Apartment / House (circle one)

City water /Well water (Circle one)

Exposure to old home/old paint (Circle one)

Are their animals in the home? Yes / No. If yes, Cat / Dog / Other_____________________

Does anyone in the child's home smoke? Yes/ No (circle one)

Medical and Surgical Associates, Inc., 1930 Tamarack Road Rd, Newark Ohio 43055

Authorization for Release of Medical Records

Patient Name: ____

Date of Birth: ____

Records to be Released to:

Medical and Surgical Associates, Inc.

1930 Tamarack Rd.

Newark, Ohio 43055

Ph. 740-522-7600

Fax 740-522-6399

I hereby authorize ____

Previous Physician Name, Address & Phone/Fax

____

____

Furnish complete copy of the medical record, medical information, also known as PHI, and related data for the above identified person for all the following dates of service:

____

____

*****Please note that if record is larger than 50 pages, preferred method would be mail. *****

By initialing below, I am authorizing release of confidential information. If I do NOT want this information included, I will write DO NOT DISCLOSE in the space below and initial.

Substance Abuse: ________ Mental Illness: ________ HIV/Aids: ________

Signature of patient/legal guardian: Date:

______________________________ ______________________