

**SURGICAL ASSOCIATES
OF EDMONDS**

A Division of Proliance Surgeons

7315 212th St. SW
Suite 201
Edmonds, WA 98026

Phone: 425-778-8116
Fax: 425-775-9526

Carol J. Cornejo, MD, FACS
Kurt E. Harmon, MD, FACS
Thomas J. Jurich, MD, FACS
Steven D. MacFarlane, MD, FACS
Michelle J. Sinnett, MD, FACS
Glenn O. Knight, PA-C
Dennis L. Loudenback, PA-C



Authorization to Leave Personal Health Information by Alternate Means

Patient Name: _____ Date of Birth: _____

Patient Mailing Address: _____

(Please check all that apply)

- May leave detailed message on voicemail at home #: () _____
- May leave detailed message on voicemail at work #: () _____
- May leave information with spouse (name): _____
- May leave information with other family member (name): _____
- May leave detailed message on cellular phone #: () _____
- May leave detailed message at a different location #: () _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

Patient or legally authorized individual signature Date

BMI: Ht: Wt: BP:

PLEASE LIST CURRENT MEDICATIONS: Mgs/Strength & How many times a day

ARE YOU TAKING ASPRIN? YES NO

PLEASE LIST CURRENT ALLERGIES: or REACTIONS YOU MAY HAVE:

WHAT IS YOUR PAST SURGICAL HISTORY:

Year: Operation:

PLEASE LIST PAST MEDICAL HISTORY:

CPAP?

PACEMAKER?

PERSONAL HEALTH HISTORY: PLEASE CIRCLE IF YOU HAVE ANY OF THE BELOW HEALTH CONDITIONS

WEIGHT LOSS/GAIN HIGH BLOOD PRESSURE GERD STROKE/SEIZURE/T.I.A.
GLASSES/DENTURES HIGH CHOLESTEROL KIDNEY STONES DEPRESSION/BIPOLAR
ASTHMA/COPD CORONARY ARTERY DISEASE PROBLEM VOIDING ARTHRITIS/GOUT
HEART RHYTHM PROBLEM INTESTINAL PROBLEMS DIABETES BLEEDING/CLOTS/DVT/PE

SOCIAL HISTORY AND HEALTH HABITS:

Relationship Status: Single Partnered Married Separated Divorced Widowed
Smoking No Packs/Day Packs-Yr Quit
Alcohol No Drinks/Day Drinks-Wk Drinks-Month
Quit
Drugs Marijuana IV Drugs

FAMILY HEALTH HISTORY:

Table with 4 columns: Family Member, Health Status, Other Family Members, Health Status. Rows include Father, Mother, Siblings, Aunt/Uncle, Children, Grandparents.

NAME: DATE:

System Review:

Check Box and give details

Constitutional Symptoms:

- Weight Loss/Gain: _____ lbs
- Fevers
- Night Sweats

Eyes:

- Glaucoma
- Macular Degeneration

Head and Neck:

- Sinus Infection
- Swollen Glands
- Dentures/Partial plate
- Radiation to face or neck

Heart:

- Chest Pain/Angina Pectoris
- Heart Attack/Myocardial Infarction
- Irregular Heartbeat
- Shortness of Breath lying down
- Swelling in your feet or legs
- Stents in heart
- Pacemaker

Lungs:

- Asthma/Wheezing
- COPD/Emphysema
- Respiratory Infections
- Sleep apnea

Gastrointestinal:

- Heartburn/GERD
- Ulcers
- Frequent Diarrhea
- Constipation
- Blood in Stool
- Hemorrhoids
- Hepatitis

Genitourinary:

- Difficulty voiding
- Frequent trips to urinate
- Kidney stones

Fertility/Reproduction:

Pregnancies: _____ Miscarriages: _____

- Menopause
- Tubal Ligation
- Vasectomy

Muscles/Joints:

- Arthritis
- Joint Replacement
- Back pain

Skin:

- Rashes
- Skin Cancer

Breasts:

- Breast Pain
- Breast Mass
- Nipple Discharge

Neurologic:

- Stroke
- Loss of Memory
- Seizures
- Migraines
- Depression
- Bipolar Disorder
- Anxiety

Endocrine:

- Thyroid Problems
- Diabetes

Blood Problems:

- Anemia
- Bleeding Problems
- Clotting Problems
- Transfusions

Allergies:

- Latex
- Iodine

FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you and by providing us with updated personal and financial information promptly following a change. The following is a summary of our written Financial Policy. We can provide you a copy of this Financial Policy upon your request. If you have questions regarding this Financial Policy, please speak with one of our Financial Coordinators.

New 'Self Pay' Patients

If you have no health insurance coverage and are a NEW patient, a minimum down payment of \$150 is required at the time of your first appointment. Payment must be made with cash or credit card only. No checks allowed. You will be contacted by our Business Office to establish a formal payment plan for your remaining balance. Your consult could cost less than \$150, in that case you may possibly be refunded at the time of your visit, or the money could go towards your next visit or surgery.

Payments are Due at the Time of Service

We will bill your health plan, for those in which we participate and are contracted. Copayments are due at the time services are rendered. We accept VISA, MasterCard, AMEX, Discover, Money Order, Cash and Personal Check. If you do not have insurance or a health plan in which we participate, you are responsible for the total charge, due at the time of services. We offer cash discounts upon request.

Outstanding Balances

We realize that our patients have financial difficulties. Patients with an outstanding balance must make arrangements for payment prior to scheduling appointments. There is a service fee of \$10.25 imposed on any balances thirty-one (31) days and older.

Referrals

If you are enrolled in a managed care insurance plan (i.e., HMO), you must receive a referral from your primary care physician before making an appointment.

Surgical Procedures

Prior to any surgical procedure, we will attempt to provide an estimate of amounts due to Surgical Associates of Edmonds. This is only an estimate based on information we receive from your health plan regarding your benefits and unmet deductibles and coinsurances. Your estimated portion is payable prior to your surgery date. After the procedure and once your health plan has paid its portion, any remaining

balance will be billed to you and is due and payable. Please keep in mind that estimated charges might change if findings during the procedure are more extensive than assumed at the time of estimate.

Returned Checks

There is a \$50.00 service fee for returned checks, after which we can no longer accept your check as a form of payment for a period of six (6) months.

Missed Appointments/Late Cancellations

Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment time. If you miss an appointment without providing 24 hour notice, we reserve the right to charge a missed appointment fee of \$25.00. Excessive missed appointments or late cancellations may result in discharge from the practice.

Refunds

If we have over-collected a payment, we will send you a refund after any other outstanding account balance is paid.

Non-Covered Services

Your insurance plan may not cover all of the services we can provide to you. If a service you received is not a covered benefit, you will be financially responsible. We will use our best efforts to attempt to inform you in advance. If your procedure is cosmetic, an excision of a lesion, lump, and skin neoplasm etc, we may ask you to sign an Advance Beneficiary Notice (ABN) prior to receiving services.

Assignment and Agreement

I have read and understand Surgical Associates of Edmonds/ Proliance Surgeons Financial Policy, and agree to its terms. I hereby assign all medical/surgical benefits to Surgical Associates of Edmonds and Proliance Surgeons who may bill certain insurance companies as a courtesy to me, and authorize a release of all information necessary to secure the payment of benefits. I understand that I am responsible for the bill for all services rendered to me or my dependents by Surgical Associates of Edmonds/Proliance Surgeons regardless of whether I have insurance and regardless of how much my insurance might pay. Any copayments, deductibles and non-covered charges that might apply will be paid at the time services are rendered unless other arrangements are specifically made in advance and late fees will be imposed on any balances older than sixty (60) days.

Signature of

Patient / Responsible Party: _____

Date: _____

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Signature of patient OR patient's authorized representative

Date signed

Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

THIS AREA FOR STAFF NOTES:

THIS FORM WILL BE RETAINED IN YOUR MEDICAL RECORD.