

PATIENT HISTORY SHEET

NAME _____

DATE _____

OCCUPATION _____

DATE OF BIRTH _____

MARITAL STATUS-M/S/W

OF CHILDREN _____

PRESENT WEIGHT _____

HEIGHT _____ FT _____ IN

LAST MENSTRUAL PERIOD _____

FAMILY PHYSICIAN _____

REFERRING PHYSICIAN _____

PLEASE LIST THE REASON FOR TODAY'S VISIT

MEDICAL PROBLEMS

_____	_____
_____	_____
_____	_____
_____	_____

SURGERIES (OPERATIONS)

_____	_____
_____	_____
_____	_____

MEDICATION (PRESCRIPTION AND NONPRESCRIPTION)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

DRUG ALLERGIES

_____	_____
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MD SIGNATURE & DATE

Patient DOB: _____

SOCIAL HISTORY
(Please circle below)

- YES NO DO YOU SMOKE OR USE TOBACCO PRODUCTS? IF YES, HOW MANY PACKS A DAY? _____ FOR HOW MANY YEARS? _____ (305.1 V15.82)
- YES NO DO YOU DRINK ALCOHOL? _____ IF YES, HOW MUCH? _____ (305.0)
- YES NO HAVE YOU EVER USED MARIJUANA, COCAINE OR IV DRUGS? _____ (304.90)

FAMILY HISTORY

PLEASE CIRCLE ANY DISEASES THAT RUN IN YOUR FAMILY

- HEART DISEASE _____ (V17.3)
- HIGH BLOOD PRESSURE _____ (V17.49)
- ASTHMA _____ (V17.5)
- CANCER _____ (V16.8 - V16.9)
- BLEEDING DISORDERS _____ (V18.3)
- LUNG DISEASE _____ (V17.6)
- KIDNEY PROBLEMS _____
- DIABETES _____ (V18)
- PROBLEMS WITH ANESTHESIA _____ (V19.8)
- OTHER _____

SYSTEM REVIEW
(Please circle below)

GENERAL

- YES NO HAVE YOU RECENTLY HAD A FEVER? HOW HIGH? ___ FOR HOW MANY DAYS? ___
- YES NO HAVE YOU RECENTLY LOST WEIGHT? ___ HOW MUCH? _____ (783.21)
- YES NO HAVE YOU RECENTLY GAINED WEIGHT? ___ HOW MUCH? _____ (783.1)
- YES NO DO YOU HAVE ANY BLEEDING TENDENCIES?
- OTHER? _____

H.E.E.N.T.

- YES NO HAVE YOU NOTICED A YELLOWISH TINT IN THE WHITES OF YOUR EYES? (782.4-277.4)
- YES NO DO YOU HAVE ANY PAIN OR DIFFICULTY SWALLOWING? (787.20)
- YES NO HAS YOUR VOICE CHANGED RECENTLY? (478.5)
- YES NO HAVE YOU NOTICED ANY LUMPS OR BUMPS IN YOUR THROAT? (784.2)
- OTHER? _____

CARDIOVASCULAR

- YES NO HAVE YOU EVER HAD A HEART ATTACK? ___ IF SO WHEN? _____ (412)
- YES NO DO YOU HAVE CHEST PAIN? (786.50)
- YES NO DO YOU HAVE HIGH BLOOD PRESSURE? (401.1)
- YES NO DO YOUR LEGS SWELL? (729.81)
- YES NO DO YOUR LEGS HURT AFTER WALKING CERTAIN DISTANCES? (440.21)
- YES NO DOES LEG PAIN WAKE YOU UP AT NIGHT? (327.52)
- OTHER? _____

MD INITIALS _____

RESPIRATORY

Patient DOB: _____

YES NO DO YOU HAVE A CHRONIC COUGH?
YES NO HAVE YOU COUGHED UP BLOOD? (786.3)
OTHER? _____

GASTROINTESTINAL

YES NO DO YOU HAVE CHRONIC DIARRHEA? (787.91)
YES NO DO YOU HAVE BLOOD IN YOUR STOOLS?
YES NO DO YOU HAVE PAIN WITH BOWEL MOVEMENTS?
YES NO DO YOU HAVE ANY NAUSEA OR VOMITTING? ANY BLOOD IN YOUR
VOMIT? YES NO (787 787.01)
YES NO ARE YOU CONSTIPATED?
YES NO HAVE YOUR STOOLS CHANGED RECENTLY?
YES NO DO YOU HAVE ABDOMINAL PAIN? (789.00)
YES NO DO YOU HAVE TROUBLE EATING FATTY OR SPICY FOOD?
OTHER? _____

GENITOURINARY

YES NO DO YOU HAVE PAIN OR DIFFICULTY URINATING? (788.1)
YES NO DO YOU HAVE BLOOD IN YOUR URINE? (599.7)

MALE

YES NO DO YOU HAVE DIFFICULTY STARTING OR STOPPING YOUR STREAM? (788.64)
YES NO DO YOU WAKE UP AT NIGHT TO USE THE RESTROOM? (788.43)

FEMALE

YES NO DO YOU HAVE ANY VAGINAL DISCHARGE?
YES NO DO YOU LEAK URINE? (788.3)
OTHER? _____

BREAST

YES NO HAVE YOU FELT ANY BREAST LUMPS OR MASSES? (611.72)
YES NO HAVE YOU HAD ANY NIPPLE DISCHARGE?

NEURO

YES NO DO YOU HAVE NUMBNESS OR TINGLING IN YOUR HANDS, FEET OR TOES?
OTHER? _____

SKIN

YES NO HAVE YOU NOTICED ANY NEW SKIN LESIONS? (709.9)
YES NO HAVE ANY MOLES RECENTLY CHANGED COLOR OR GROWN OR STARTED TO
BLEED AT TIMES?

IN ORDER TO MAINTAIN PATIENT CONFIDENTIALITY OUR DOCTORS AND STAFF DO NOT DISCUSS
YOUR MEDICAL CARE WITH ANYONE OTHER THAN YOU. IF YOU WISH TO AUTHORIZE US TO DISCUSS YOUR
MEDICAL CARE WITH ANYONE ELSE PLEASE LIST THEM BELOW.

CONTACT NAME _____ RELATIONSHIP _____

CONTACTS PHONE# _____

Patient or Parent/Guardian Signature: _____

MD INITIALS _____

The Surgery Clinic, LLC
Drs. Newman Jr., Newman III, C. Newman & Nordness
419 S. 5th Street Gadsden, AL 35901 (256)547-6331

Assignment of Benefits

I hereby assign all medical/surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, Blue Cross & Blue Shield, Medicaid, Medigap or any other health plan to The Surgery Clinic, LLC. I understand that I am financially responsible for all charges including non-covered charges.

Authorization to Release Information

I hereby authorize the release of all medical information necessary to secure payment for claims, complete disability forms, cancer policies and family medical leave forms that are presented to The Surgery Clinic. I authorize the physician to release and fax information and also request/receive information pertaining to the treatment of my health.

Medicare/Medigap Authorization (Crossover Claims)

I authorize release to the Social Security Administration & Health Care Financing Administration or its intermediaries or carriers and information needed for this or related Medicare claims. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act & 31 U.S.C.3801-3812 Providers penalties for withholding this information.) I authorize any holder of medical or other information needed, to be released to The Surgery Clinic for this or any related Medigap claim. I request payment of medical insurance benefits to either myself or to the party who accept assignment.

X

Patient or Parent/Guardian Signature

Date

Name _____

Social Security # _____

Address _____

City/Zip _____

Home Phone _____

Work Phone _____

Employer _____

Cell Phone _____

May we text appointment reminders? Y/N If so, cell phone carrier? _____

May we contact you at work? Y/N May we leave a message on your answering machine? Y/N

Spouse/Primary Contact Name/Phone _____

Emergency Contact Name/Phone _____

Preferred Hospital: Riverview Regional Gadsden Regional Gadsden Surgery Center Cherokee Medical

Preferred Pharmacy _____

Release of Medical Information

I hereby authorize the release of medical information to the following person(s) only.

This order will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original.

THE SURGERY CLINIC, L.L.C.

North Alabama Vein Center

DRS. NEWMAN-NEWMAN-NEWMAN-NORDNESS

GENERAL SURGERY

419 SOUTH FIFTH STREET
GADSDEN, ALABAMA 35901

TELEPHONE (256) 547-6331
FAX (256) 547-1711

Patient Portal User Agreement

The Surgery Clinic, LLC provides a patient portal to enhance patient-physician communications. All users must be established by a previous office visit. We strive to keep all of the information in your records correct and complete. If you identify any discrepancy on your record, you agree to notify us immediately. Additionally, by using the Patient Portal, the user agrees to provide factual and correct information.

The Patient Portal can provide the following services:

- Update patient demographics
- Request or look up appointments
- Contact a nurse with a non-emergency call (example: Prescription Refill or ask her a question)
- View Clinical Summaries

The Patient Portal is not intended to provide internet based diagnostic medical services. Also, the following limitations apply:

- No internet based triage and treatment request. Diagnosis can only be made and treatment rendered after the patient schedules and SEES the Doctor.
- No Emergent communications or services.
- No requests for narcotic pain medication will be accepted.

The Patient Portal is provided as a courtesy to our patients. We are focused on providing the highest level of service and health care. However, if abuse or negligent usage of Patient Portal persists, we reserve the right at our own discretion to terminate Patient Portal offering, suspend user or modify services offered through the Patient Portal. The Patient Portal is provided in partnership with Greenway Health, our EHR software vendor, who electronically houses the software. The data is on HIPAA compliant VPN with high level encryption that exceeds HIPAA standards. While we believe that the IT infrastructure and data are safe and secure, it does not guarantee that unforeseen, adverse events cannot occur. All new and established patients have signed a HIPAA Agreement form and have been offered a copy of our HIPAA policy. If you do not recall having signed the HIPAA Agreement form or need to reacquaint with our HIPAA policy, a print will be provided for your review. Once you have signed the Patient Portal Consent Agreement and have provided us with a legitimate e-mail address that is secure, you will be e-mailed a welcome invite with a link to our portal with a generated temporary password for you to create a new password. You will then be able to use this information to access portions of your medical records and to communicate securely with our office. Keep your ID and password secure.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I have been given the risks and benefits of Patient Portal and agree that I understand the risks associated with online communications between my physician and patient, and consent to the conditions outlined herein. I acknowledge that using the Patient Portal is entirely voluntary and will not impact the quality of care I receive from The Surgery Clinic, LLC should I decide against using the Patient Portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for online communications. I have been proactive about asking questions related to this consent agreement. All my questions have been answered with clarity.

Print Patient Name

X _____
Patient or Parent/Guardian Signature

Date

E-mail Address: _____

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my healthcare this practice (The Surgery Clinic, LLC) originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- ❖ A basis for planning my care & treatment.
- ❖ A means of communication among the many healthcare professionals who may contribute to my care.
- ❖ A source of information for applying my diagnosis and treatment information to my bill.
- ❖ A means by which a third-party payer can verify that services billed were actually provided.
- ❖ A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided access with a Notice of Privacy Practice that provides a more complete description of information uses and disclosures. I understand that I have the right to review the Notice prior to signing this consent. I understand the organization (The Surgery Clinic, LLC) reserves the right to change its notice and practices. I understand that I have the right to object to the use of my healthcare information for directory purposes. I understand that I have the right to request restrictions as to how my healthcare information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization (The Surgery Clinic, LLC) is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to the use of my health information:

I fully understand and accept decline the terms of this consent.

X

Patient or Parent/Guardian Signature

Date

THE SURGERY CLINIC, L.L.C.

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GENERAL SURGERY

419 SOUTH FIFTH STREET
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**I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED ACCESS TO NOTICE
OF PRIVACY PRACTICE OF THE SURGERY CLINIC, LLC.**

Print Name of Patient or Personal Representative

X _____
Signature of Patient or Personal Representative

Date

If Patient is not signing, please list relationship

OFFICE / FINANCIAL POLICY

Welcome to the practice of Drs. Newman Jr., Newman III, Charles Newman & Nordness. We understand that visiting a surgeon's office can be an especially anxious time. Our doctors, nurses and office staff work very hard to deliver quality care to each patient. Your health and well being are our first priority. The Surgery Clinic, LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Our office hours are Monday thru Friday from 9:00 a.m. to 5:00 p.m. Our doctors see patients by appointment. Referral from another physician is not necessary unless it is required by your insurance company. We understand that there are times when you may need to see your doctor for an unscheduled visit. If such a need arises we recommend you first call the office. Doing so will allow us to give you an appointment time that will decrease your wait. We understand that time is valuable and we will always strive to see you at your scheduled time. Because we see patients by appointment, we suggest that you do not arrive more than fifteen minutes before your appointment time. Because of the nature of the practice, there are times when emergencies arise resulting in the doctor's late arrival to the office. If we are notified of this in time, we will make appropriate arrangements. Your patience is always appreciated.

Our doctors operate at Gadsden Regional Medical Center, Riverview Regional Medical Center, Gadsden Surgery Center & Cherokee Medical Center. Surgery is scheduled Monday thru Friday. Patient's may choose the place for surgery and often may also choose the date for surgery.

Telephone calls during office hours will be handled according to their urgency. If you feel that you have a problem needing medical attention or have questions related to your surgical care, please feel free to call. These calls are generally handled by our nursing staff. Unfortunately, they are not always available at the time of your call. In this case, please leave a message with the receptionist and your call will be returned as soon as possible.

If you develop a problem after office hours, there is always a doctor on call. In this case you should call our answering service and give as much information as possible. You can reach the answering service by dialing our office.

Fee information is open and available to all patients. Our physicians are PMD providers and participate with several PPO plans, Medicare and Medicaid. We will be happy to bill your insurance company for our services whether it is an office visit for surgical procedure. However, your co-pay is due when services are rendered.

Our insurance department will bill your insurance company. After insurance payment, a statement will be sent to the patient for any outstanding balance. For major surgeries, where no insurance is involved, a percentage of the charge must be paid in advance and a promissory note will need to be signed by the responsible party. Accounts over 30 days past due are considered past due. It is our policy if an account is over 90 days past due to turn this information over to collections. Our billing department will gladly assist you with any questions that you may have at any time. Financial arrangements are required before scheduling surgery.

I hereby authorize the physician to release and fax information and also request and receive any information required in the course of my examination or treatment.

Thank you for entrusting us with your surgical care.

DRS. NEWMAN JR., NEWMAN III, CHARLES NEWMAN & NORDNESS

I hereby agree to the terms and conditions of the above office/financial policy.

X Patient's Signature _____ Date _____

Responsible
Party/Guarantor _____ Date _____

"In consideration of services rendered or to be rendered, the undersigned agrees to pay all costs of collection and/or reasonable attorney fees, should the account be turned over to enforce collection of said charges. The undersigned hereby waives all claims or rights of exemption allowed by The Constitution of the State of Alabama or any other State of the United States."

The Surgery Clinic, LLC
Drs. Newman Jr., Newman III, C. Newman & Nordness
419 S. 5th Street Gadsden, AL 35901 (256)547-6331

**If your visit was due to an automobile, no fault or liability injury,
Please fill out the following information.**

Type of Accident Auto Other Date of Accident: _____

If other, please explain _____

Insurance Situation Liability Not Liability

Name of Policy Holder: _____

Policy Holder's Address: _____

Policy/Claim Number: _____

Name of Insurance Company: _____

Insurance Company Address: _____

Legal Representation Name: _____

Phone Number: _____

**If your visit is due to Worker's Compensation, please fill out the following
information.**

Date of Accident: _____

Is Patient Working? Yes No If yes? Full-Time Part-Time

Employer Name: _____

Employer Address: _____

Name of Worker's Comp. Insurance Company: _____

Policy Number: _____

Contact Name: _____ Contact Phone Number: _____

Patient or Parent/Guardian Signature

Date