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**

Patient's Name_____ **Patient Date of Birth** _____

Address_____ **Height** _____ **Weight** _____

City/Zip_____ **Home Phone**_____

Social Security Number _____ **Cell Phone**_____

Employer_____ **May we text appointment reminders? Y/N**

Work Phone_____ **May we contact you at work? Y/N**

Primary Emergency Contact Name: _____

Relationship: _____ **Contact Number(s):** _____

Second Emergency Contact Name: _____

Relationship: _____ **Contact Number(s):** _____

Medication (please list meds with the dosage) **Preferred Pharmacy:** _____

○ List Provided at Reception ○ None

_____

_____

_____

_____

The Surgery Clinic, LLC

Drs. Newman, Jr. - Newman III - C. Newman - Nordness

419 South 5th Street, Gadsden, AL 35901

Name: _____ Date of Birth: _____ Date: _____

Primary Care Phys. _____ Referrring Phys. _____

CHECK HERE IF YOU HAVE ANY OF THESE SYMPTOMS:

	YES	NO
GENERAL REVIEW OF SYMPTOMS		
FEVER		
WEIGHT LOSS / WEIGHT GAIN		
H.E.E.N.T.		
PAIN/DIFFICULTY SWALLOWING		
RECENT CHANGE IN VOICE		
LUMPS/BUMPS IN THROAT		
CARDIOVASCULAR		
PREVIOUS HEART ATTACK		
CHEST PAIN		
IRREGULAR HEARTBEAT		
HYPERTENSION (HIGH BLOOD PRESSURE)		
LEG SWELLING / EDEMA		
LEG PAIN AFTER WALKING		
RATE YOUR PAIN (MILD) 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE)		
DURATION OF PAIN:		
NEUROLOGICAL		
NUMBNESS/TINGLING EXTREMITIES		
GENITOURINARY		
PAIN/DIFFICULTY URINATING		
RATE YOUR PAIN (MILD) 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE)		
DURATION OF PAIN:		
BLOOD IN URINE		
GENITOURINARY (MALE)		
TROUBLE STARTING/STOPPING		
FREQUENT NIGHTTIME URINATION		
GENITOURINARY (FEMALE)		
(FEMALE) VAGINAL DISCHARGE		
(FEMALE) LEAK URINE		
BREAST		
BREAST LUMPS OR MASSES		
NIPPLE DISCHARGE		
BREAST CANCER		
BREAST PAIN		
RATE YOUR PAIN (MILD) 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE)		
DURATION OF PAIN:		

	YES	NO
PULMONARY		
CHRONIC COUGH		
COUGHING UP BLOOD		
GASTROINSTESTINAL		
CHRONIC DIARRHEA		
BLOOD IN STOOLS		
PAIN WITH BOWEL MOVEMENT		
NAUSEA / VOMITTING		
CONSTIPATION		
RECENT CHANGE IN STOOLS		
ABDOMINAL PAIN		
RATE YOUR PAIN (MILD) 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE)		
DURATION OF PAIN:		
TROUBLE WITH SPICY/FATTY FOOD		
SKIN		
NEW SKIN LESIONS		
MOLES CHANGING COLOR/SIZE		
BLEEDING MOLES		
LOCATION(S):		

ALERT		
UNDER PAIN MANAGEMENT		
SMOKING/TOBACCO USE		
DRUG USE		
ALCOHOL USE		
PACEMAKER		
TAKING ASPRIN / BLOOD THINNERS		
PREGNANT / PLANNING PREGNANCY		
AIDS / HIV POSITIVE		
HEPATITIS (please circle) A B C		
ALLERGY TO LATEX		
ALLERGY TO ADHESIVE		

M.D. SIGNATURE: _____

DATE REVIEWED

The Surgery Clinic, LLC

Drs. Newman, Jr. - Newman III - C. Newman - Nordness
419 South 5th Street, Gadsden, AL 35901

Patient Name: _____ *Date of Birth:* _____

Past Medical History (please check all that apply)

	YES	NO
Chronic Anemia		
Anxiety		
Depression		
Breast Cancer		
Heart Disease		
High Blood Pressure		
Coronary Artery Disease		
Irregular Heartbeat		
Deep Vein Thrombosis		
Pulmonary Embolism		
Diabetes		
Kidney Disease		

	YES	NO
GERD		
Colon Cancer		
Other Colon Issue		
Hepatitis		
Thyroid Disease		
COPD		
Lung Cancer		
Lung Disease		
Morbid Obseity		
Arthritis		
Sleep Apnea		
Stroke		

OTHER MEDICAL CONDITIONS :

Allergies

_____

_____

_____

_____

Past Surgical History (please check all that apply)

	YES	NO
Appendix		
Breast: _____		
Heart: _____		
Kidney: _____		
Skin / Benign lesion removal		
Skin / Basal or Squamous cell		
Skin / Melanoma		

	YES	NO
Gallbladder		
Pancreas		
Prostate		
Rectum		
Hysterectomy		
Ovary		
Colon: _____		

OTHER SURGICAL HISTORY :

Name: _____ **Date of Birth:** _____ **Today's Date:** _____

FAMILY HISTORY	MOM	DAD	BROTHER	SISTER	GRANDPARENTS (MATERNAL OR PATERNAL)	AUNT	UNCLE
Asthma							
Cancer							
Depression							
Diabetes Mellitus							
Heart Disease							
Hyperlipidemia							
Hypertension							
Liver Disease							
Pulmonary Disease							
Renal Disease							
Seizure Disorder							
Thromboembolic Disease							
Thyroid Disease							
Medical History unknown							
Other:							

Have you had any recent hospitalizations with-in the past 6 months? Yes No
If you answered yes, please give additional details

Name of Hospital Facility	Date of hospitalization	Reason for hospitalization

Recent Routine Diagnostics:

When was your last Colonoscopy: _____ Mammogram: _____

Have you had a recent fall? Yes No

Are you a current smoker? Yes No
If YES _____# Packs/Day for Approx. _____# Yrs

Preferred Hospital: □ Riverview Regional □ Gadsden Regional □ Gadsden Surgery Center

Release of Medical Information

I hereby authorize the release of medical information to the following person(s).
(Please include any individual/organization with whom we have permission to speak as part of your care team.)

_____ _____

_____ _____

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 in 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 _____ _____
atient or Parent/Guardian Signature Date

E-mail Address: _____

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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

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.

Patient's Signature X _____ 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 waivers all claims or rights of exemption allowed by The Constitution of the State of Alabama or any other State of the United States."

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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