The Surgery Clinic, LLC

Drs. Newman-C. Newman-Nordness

General Surgery

419 South 5th Street
Gadsden, AL 35901

Phone: (256)547-6331
Fax (256)547-1711

We are honored that you have chosen us as your healthcare provider. This is a reminder of your upcoming appointment with our practice. I have enclosed the registration packet for you to fill out in the convenience of your home. Please do not leave anything unanswered. Our goal is to provide the highest quality care for our patients in a timely and respectful manner.

Please bring the following information with you:

- **Patient Information Packet**
- **List of Current Medications with Dosages**
- **Driver's License**
- **Insurance Card/Copay**

If you have any questions, please feel free to contact our office.

Thank you,

The Surgery Clinic, LLC

(Vein Patients should wear/bring SHORTS for exam)

The Surgery Clinic, LLC
Drs. 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 & family medical leave forms that are presented to The Surgery Clinic. I authorize the physician to release & fax information & 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 & 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.

_____ _____
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):** _____

Primary Care Physician:_____ **Referring Physician:**_____

Preferred Pharmacy:_____

Medication (please list meds with the dosage**)**

◯ List Provided at Reception ◯ None

NAME:_____ **DOB:**_____

GENERAL REVIEW OF SYMPTOMS	YES	NO
FEVER		
WEIGHT LOSS/ WEIGHT GAIN		
MORBID OBESITY		
CHRONIC ANEMIA		
ANXIETY		
DEPRESSION		
SLEEP APNEA		
ARTHRITIS		
DIABETES		
H.E.E.N.T.		
PAIN/DIFFICULTY SWALLOWING		
RECENT CHANGE IN VOICE		
LUMPS/BUMPS IN THROAT		
GERD		
THYROID DISEASE		
CARDIOVASCULAR		
PREVIOUS HEART ATTACK		
CHEST PAIN		
IRREGULAR HEART BEAT		
HYPERTENSION (HIGH BLOOD PRESSURE)		
CORONARY ARTERY DISEASE		
HEART DISEASE		
STROKE		
LEG SWELLING/EDEMA		
LEG PAIN AFTER WALKING		
DEEP VEIN THROMBOSIS		
HYPERLIPIDEMIA (HIGH CHOLESTEROL)		
NEUROLOGICAL		
NUMBNESS/TINGLING EXTREMITIES		
GENITOURINARY		
PAIN/DIFFICULTY URINATING		
BLOOD IN URINE		
(MALES ONLY) TROUBLE STARTING/STOPPING		
(MALES ONLY) FREQUENT NIGHT TIME URINATION		
(FEMALES ONLY) VAGINAL DISCHARGE		
(FEMALES ONLY) URINE LEAKING		
BREAST		
BREAST LUMPS/ MASSES		
NIPPLE DISCHARGE		
BREAST CANCER		
BREAST PAIN		

ALLERGIES:

PULMONARY	YES	NO
CHRONIC COUGH		
COUGHING UP BLOOD		
PULMONARY EMBOLISM		
C.O.P.D.		
LUNG DISEASE		
GASTROINTESTINAL		
CHRONIC DIRRHEA		
BLOOD IN STOOL		
PAIN WITH BOWEL MOVEMENTS		
NAUSEA/VOMITTING		
CONSTIPATION		
RECENT CHANGE IN STOOL		
ABDOMINAL PAIN		
TROUBLE WITH SPICY/FATTY FOODS		
SKIN		
NEW SKIN LESIONS		
MOLES CHANGING IN COLOR/SIZE		
BLEEDING MOLES		
CANCERS		
HAVE YOU BEEN DIAGNOSED WITH CANCER		
(IF YES, PLEASE LIST WHICH TYPE)		

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

SURGICAL HISTORY	YES	NO		YES	NO
APPENDIX			GALLBLADDER		
BREAST			PANCREAS		
HEART			PROSTATE		
KIDNEY			SKIN LESIONS		
RECTUM			HYSTERECTOMY		
OVARY			COLON		

OTHER SURGERIES:

REVIEWING PHYSICIAN'S SIGNATURE: DATE:

_____ _____

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

Name of Hospital Facility	Date of hospitalization	Reason for hospitalization

FAMILY HISTORY	MOM	DAD	SIBLING	MATERNAL GRANDFATHER	PATERNAL GRANDFATHER	MATERNAL GRANDMOTHER	PATERNAL GRANDMOTHER
Asthma							
Cancer							
Diabetes Mellitus							
Heart Disease							
High Cholesterol							
High Blood Pressure							
Liver Disease							
Pulmonary Disease							
Renal Disease							
Seizure Disorder							
History of Blood Clots							
Thyroid Disease							
Medical History Unknown							
Other:							

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 FACILITY:

☐ **GADSDEN REGIONAL MEDICAL CENTER**

☐ **RIVERVIEW REGIONAL MEDICAL CENTER**

☐ **GADSDEN SURGERY CENTER**

Release of Medical Information

I allow the following person(s) to receive and/or discuss medical information at any time:
**Please include any individual (spouse/children/other guardians or caregivers of minor children/etc.) or organization with whom we have permission to speak as part of your care team. *You do not have to list referring or primary care physicians.*

THE SURGERY CLINIC, LLC

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.

The Patient Portal can provide the following services:

Update patient demographics	Request or look up appointments
Contact a nurse with a non-emergency call	View Clinical Summaries

We strive to keep all of the information in your records correct & 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 & correct information. Once you have signed the Patient Portal Consent Agreement & 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 & to communicate securely with our office. Keep your ID & password secure.

Patient Acknowledgement & Agreement

I acknowledge that I have read & fully understand this consent form. I acknowledge that using the Patient Portal in entirely voluntary & will not impact the quality of care I receive from The Surgery Clinic, LLC. I have been proactive about asking questions related to this consent agreement. All my questions have been answered with clarity.

E-mail Address: _____

_____	_____	_____
Print Patient Name	Patient or Parent/Guardian Signature	Date

Consent to the Use & 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 & maintains health records describing my health history, symptoms, examination & test results, diagnoses, treatment & 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 & 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 & reviewing the competence of healthcare professionals.

I understand & have been provided access with a **Notice of Privacy Practice** that provides a more complete description of information uses & 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 & 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 & 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.

_____	_____
Patient or Parent/Guardian Signature	Date

THE SURGERY CLINIC, LLC

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