Advanced Surgical Associates, P.A.

General, Advanced Laparoscopic and Breast Surgery

Michael Malik, MD FACS Sabah Hamad, MD FACS

Account# _____

New Patient Demographic Information

Last Name _____ First Name _____ Middle Initial _____ Age ____

Birthdate____/____/_____ Status: Married Single Divorced Widowed Separated Partnered Sex: ___M ___F

Street _____

City _____ State _____ Zip _____

Phone ( )_____ Cell ( )_____ SS# _____-_____-_____

Email Address _____

Referring MD _____ *Phone ( )* _____ *Fax ( )* _____

Primary MD _____ *Phone ( )* _____ *Fax ( )* _____

Employer _____ Phone ( ) _____

Address_____Occupation_____

Emergency Contact _____ Phone ( )_____

Relationship _____ Cell/Work ( )_____

Insurance Information

Insurance Subscriber Name _____ Birthdate___/___/____ Relationship _____

Subscriber Employer _____ Phone ( )_____

	Insurance Name	Subscriber ID #	Group#/ Name
1)	_____	_____	_____
2)	_____	_____	_____

Payment of Services

Payment is due at the time services are rendered. Your insurance company may be billed for covered services. If your insurance company is being billed for covered services the balance of the account will be due and payable within 45 days after the date the services were rendered. Any unpaid balance and/or noncovered services will be the responsibility of the undersigned. With regard to a minor patient the undersigned (parent or guardian) is responsible for payment.

530 New Waverly Place, Suite 304 Cary, NC 27518 phone (919) 851-9193 fax (919) 851-9223

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Authorization to release information and Authorization to Pay Insurance Benefits

I hereby authorize Advanced Surgical Associates, P.A. to release medical information to the insurance company(ies) listed above. Also by my signature and copies thereof, I authorize payment directly to Advanced Surgical Associates, P.A. of benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. If this account becomes delinquent and is turned over for collection, the undersigned agrees to pay all costs of collection, including reasonable attorney's fees. The undersigned agrees to pay interest on all unpaid balance at the rate of 1 ½% per month.

SIGNATURE_____

DATE_____

Rev 4/19

Advanced Surgical Associates Patient Worksheet

Name: _____ **Age:**_____ **Account #:** _____

Reason For Visit: _____

Medical History: check all that apply

High BP	Diabetes	Heart	Stroke	Thyroid Disease
Cancer	Asthma	Arthritis	Ulcers	Liver Disease
Bladder	Kidney	Pneumonia	Prostate	Gastrointestinal

Other_____

Other_____

Surgical History: check all that apply and write year of surgery

Gallbladder/Date:_____	Hernia/Date:_____	Breast/Date:_____
Colon/Date:_____	Hysterectomy/Date:_____	Kidney/Date:_____
Heart Bypass/Date:_____	Thyroid/Date:_____	Reflux/Date:_____

Other/Date:_____

Other/Date:_____

Medication/Dose:

1)_____	5)_____
2)_____	6)_____
3)_____	7)_____
4)_____	7)_____

Medication Allergies:

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No Drug Allergies
or

1)_____ 5)_____
2)_____ 6)_____
3)_____ 7)_____
4)_____ 8)_____

Social History:

Tobacco Packs/day_____ # of Years_____
Quit Y / N Year_____
Alcohol # of Drinks_____ per Day / Week / Month
Other Drug Use:_____

Occupation:_____

Account #: _____

Family Medical History:

Mother:_____
Father:_____
Sisters:_____
Brothers:_____
Children:_____
Grandparents:_____

Review of Systems: circle any that apply

Head/Neck	Blurred Vision	Ear Aches	Nosebleeds	Enlarged Lymph Node
Throat	Sore Throat	Ulcers	Loose teeth	
Chest	Cough	Sputum	Wheezing	Short of Breath
Heart	Chest Pain	Irregular heartbeat		

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Back	Sore Back	Shoulder Pain		
Abdomen	Bloating	Nausea	Diarrhea	Constipation
Rectal	Bloody Stools	Pain with BM		
Extremities	Leg Pain with Walking		Ulcers	Varicose veins
Neuro:	Headache	Seizures	Weakness	Paralysis
Skin:	Rashes	Abscess	Cysts	Enlarging moles
Urinary:	Bloody Urine	Painful Urination		
Other:	Fever	Chills	Vomiting	Night Sweats

This health information sheet is accurate to the best of my knowledge.

Patient Signature: _____

Date: _____

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ePrescribe Consent Form

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to your pharmacy. It has been determined that the ability to electronically send prescriptions is an important element in improving the quality of care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the prescription benefit plan.
- **Medication history transactions –** Provides the physician with information about medications the patient is already taking in order to minimize the number of adverse drug events.
- **Fill status notification –** Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patients prescription has been picked up, not picked up, or partially filled.

By signing the consent form, you are agreeing that **Advanced Surgical Associates** can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefits payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to **Advanced Surgical Associates** to enroll me in the ePrescribe Program. I have had the chance to ask questions and all my questions have been answered to my satisfaction.

_____ _____

Printed Name of Patient Patient Date of Birth

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Relationship to Patient Preferred Pharmacy Name/Phone #

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POLICIES AND PROCEDURES

Advanced Surgical Associates, P.A. (ASA) provides the best medical/surgical care possible to our patients. We have established policies with the intent to provide clarity through the business processes. We encourage you to discuss any questions you may have regarding our policies with our managing staff.

INSURANCE
We participate in a variety of insurance plans will directly bill your insurance carrier under these plans. In order to honor your insurance benefits, please provide insurance identification for verification of coverage by our office. We will accept assignment of benefits for those insurance companies with whom we are currently contracted. You may be requested to complete a waiver for those services that may not be covered by your insurance plan. We cannot accept responsibility for negotiating claims with insurance companies. You are responsible for payment of all co-payments, deductibles, and procedures not covered by your insurance carrier. All outstanding balances, regardless of insurance status, are to be paid within 45 days. By my signature and copies thereof, I authorize payment directly to Advanced Surgical Associates, P.A. of benefits otherwise payable to me. You will need to make payment for any claims submitted wherein you will be reimbursed directly from your insurance carrier. We cannot guarantee payment of your benefits. With regard to a minor patient, the undersigned is responsible for payment. We accept cash, check, MasterCard, Visa, American Express, Discover, and debit cards. Requests for duplicate forms or processing additional information such as life insurance and disability forms will be charged a few for professional time involved.

REFERRALS/AUTHORIZATIONS
If you are a member of a managed care plan that requires a prior referral to see a specialist, you are responsible for obtaining the initial and any subsequent referrals required. Our clinical staff will be happy to assist you with authorizations prior to treatment(s). Failure to obtain a valid referral/authorization may result in your financial responsibility for all changes incurred.

OUT-OF-NETWORK AND SELF PAY
Out-of-network and self-pay patients are responsible for payment in full at the time services are rendered for all procedures. With regard to a minor patient, the undersigned is responsible for payment. We accept cash, check, MasterCard, Visa, American Express, Discover, and debit cards.

INSUFFICIENT FUNDS
It is our policy to charge a fee of $25 for all returned checks due to insufficient funds or any stopped payment issued check.

BILLING

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You will receive a monthly statement showing your balance and indicating whether insurance has been filed. You will be responsible for any unpaid balance after 45 days. Should it become necessary for our office to seek legal assistance for any unpaid fees, you will be responsible for these additional charges and interest at a rate of 15%. You will be responsible for the provider's fee, plus expenses, should a court appearance become necessary. Unpaid balances older than 90 days will be subject to an interest rate of 1.5%. Services may be interrupted until payment is made.

REFUNDS

It is not our policy to issue refunds unless your account has a credit balance and all claims have been paid. Refund checks are cut at the end of the month.

CANCELLATION POLICY

Advanced Surgical Associates, P.A. understands that occasionally, you will be unable to attend your scheduled appointment. When this happens, we ask that you kindly notify our office as early as possible, so that we may open your appointment time to patients who may need more immediate care. We request that, when possible, you provide 24 hours notice.

Unfortunately, we have frequently experienced patients missing their appointments without any advance notice to Advanced Surgical Associates, P.A. Such occurrences are detrimental to both our business and to our other patients waiting for an appointment.

Please be notified that the following fees will be charged when an appointment is missed without advance notice.

Missed Appointment for a Scheduled Procedure

Each Occurrence:	$50.00

Missed Appointment for All Other Scheduled Office Visits

First Time:	Excused
Each Occurrence After:	$35.00

I have read and understand the Policy's and Procedures as stated above and agree to accept responsibility as described.

PATIENT NAME _____ DATE _____

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PATIENT SIGNATURE _____

PARENT/AUTHORIZED REPRESENTIVE _____

Revised 4/19

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement of receipt but we must keep a record of your refusal. If you refuse to sign this acknowledgement of receipt, we are required to treat you and we may still use and/or disclose your health information as HIPAA permits.
I acknowledge that I have received a copy of this office's Notice of Privacy practices.

Print name _____

Signature _____

Date _____

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FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement or receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- The patient refused to sign
- Due to an emergency situation it was not possible to obtain acknowledgement
- We were unable to communicate with the patient
- Other (provide specific details) _____

_____

_____

_____ _____

Employee signature Date

HIPAA Acknowledgement of receipt of the Notice of Privacy Practices

This form does not constitute legal advice and covers only federal, not state law.

Compound Authorization Form

Name of Patient: _____ **Date of Birth**: _____/_____/_____

The purpose of this authorization is to inform the patient or others with pertinent patient information. The patient has requested that _Advanced Surgical Associates, PA_ is to release the following information about the above named patient to the entities named below:

_____ **Voice Mail** and/or Answering Machine Phone number_____

_____ Appointments _____ Instructions (Pre/Post Procedure/Operation)

_____ Financial _____ Lab/test results _____ Medical_____

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_____ **Email** Email address_____

_____ Appointments _____ Instructions (Pre/Post Procedure/Operation)

_____ Lab/test results _____ NPP _____ Breach information details

_____ Financial _____ Medical_____

_____ **Spouse** Name_____

_____ Appointments _____ Instructions (Pre/Post Procedure/Operation)

_____ Financial _____ Lab/test results _____Medical_____

_____ **Other** Name_____

_____ Appointments _____ Instructions (Pre/Post Procedure/Operation)

_____ Financial _____ Lab/test results _____ Medical_____

Right of the Patient:
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to *Advanced Surgical Associates, P.A.* I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as result of this authorization may be subject to re- disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ Date_____
Signature of Patient or Legal Representative

_____
Description of Legal Representative Authority (provide supporting documentation)

Authorization for Credit Card On File

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Until further notice, I authorize Advanced Surgical Associates, P.A. to keep my signature on file and to apply charges to the credit card listed below for patient-responsible balances on my account.

I understand that once insurance has paid their portion for my care, I will receive an Explanation of Benefits detailing any remaining portion to be paid by me. I agree that Advanced Surgical Associates, P.A. may charge my credit card on file for the balance due once they receive the Explanation of Benefits from my insurance carrier. By signing below, I authorize my card to be for the full balance. I will receive a receipt via email for any transactions posted to my card.

I will contact Advanced Surgical Associates, P.A. if there are any changes to my credit card information to include, but not limited to, card expiration, lost/stolen cards, credit limit reached, card reissue, or any additional reason that might affect proper processing of the card on file.

Type of credit card: ☐ Visa ☐ Discover ☐ MasterCard ☐ Amex

Last 4 Digits: _____ Expiration Date (MM/YY): _____

Maximum Charge per Transaction for Balance Due (check one): ☐ $200 ☐ $500

Email Address_____

Printed Name _____

Billing address_____

Patient signature _____ Date_____

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