Advanced Surgical Associates, P.A.

Patient Information ***Account #_________________***

Name ____Age_____Birthdate___/___/___

Status: Married Single Divorced Widowed Separated Partnered Sex: __M __F

Street______________________________City______________State_____Zip______

SS #_____-____-_____ Phone# ( )_____________Cell# ( )_________________

Employer _________________________________Phone # ( ) _________________

Address___________________________________Occupation____________________

Referring MD__________________________ Primary MD_____________________

Insurance Information

Insurance Subscriber Name ___________________________ Birthdate___/___/____

Subscriber Employer _________________________Phone#( )_________________

Emergency Contact __________________________Phone #( )________________

Relationship ______________________________ Cell/Work #( )________________

Insurance Name	Plan	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.

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 3/07

Advanced Surgical Associates Patient Worksheet

Name:_______________________________ Age:______ Acct#:__________________

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:

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:____

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		
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:____

Rev 2/08

Advanced Surgical Associate, PA

Michael Malik, MD FACS
Sabah Hamad, MD FACS

530 New Waverly Place Suite 304 Cary, NC 27518

Phone (919) 851-9193 Fax (919) 851-9223

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.

NO SHOWS/MISSED APPOINTMENTS

It is our policy for patients who no show to their appointments to be charged $35. Patients who repeatedly miss appointments may be asked to pursue treatment on a non-scheduled time, as available.

BILLING

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.

PROTECTED HEALTH INFORMATION (PHI)

The documents and materials contained in the patient's medical record witch may include, but are not limited to, paper, digital, or electronic correspondence, photographs/radiographs are confidential. ASA will retain the ownership rights to these photographs, digital, or electronic correspondence, or other images and the patient will be allowed access to view them or obtain copies. Reasonable copy fees will be charged. These images will be stored in a secure manner that will protect privacy and they will be kept for the time period required by law or outlined in ASA's policy.

All documents and materials in the medical record that identify the patient will be released and/or used in accordance with the Notice of Privacy policy. The Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" (PHI) is information about you (including demographic information that may identify you) and relates to your past, present, or future physical/mental health and related health care services.

You may obtain the Notice of Privacy Practice by accessing our web site, **advancedsurgicalassociates.com**, at the time of your office visit or by request any time. In-office laminated copies can be viewed by requesting them at the reception desk.

I acknowledge that I have read (or had the opportunity to read if I so chose) the Notice of Privacy Practice.

I also have read, understood, and agree to comply with the above policies. I recognize and accept full financial responsibility for all professional services rendered.

PATIENT NAME___________________________________DATE_____________

PATIENT SIGNATURE____

PARENT/AUTHORIZED REPRESENTIVE______________________________________

Rev 12/07

Consent to Use or Disclose Information For Treatment, Payment, Health Care Operation, or Other Uses Permitted Under HIPAA

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information (“protected health information”) by Advanced Surgical Associates, P.A. in order to carry out treatment, payment, or health care operations. The Patient should review our Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

Advanced Surgical Associates, P.A. reserves the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If we do change the terms of the Notice of Privacy Practices, a copy of the revised Notice will be mailed to you.

Patient retains the right to request that Advanced Surgical Associates, P.A. further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. Advanced Surgical Associates is not required to agree to such requested restrictions; however, if we do agree to the Patient’s requested restrictions, such restrictions are then binding on Advanced Surgical Associates, P.A.

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to Advanced Surgical Associates, P.A. in writing. The revocation shall be effective except to the extent that Advanced Surgical Associates, P.A. has already taken action in reliance on the Consent.

Advanced Surgical Associates, P.A. may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that the Facility is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent, Advanced Surgical Associates has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the Facility is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Print
Name:________________________________Date:_____________Time:_______am/pm

Signature:____
(Patient or Authorized Representative)

Advanced Surgical Associates, P.A.

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 cancellation policy stated above and agree to accept responsibility as described.

Print Name:____
Date:___________________

Signature:____
Date:___________________
(patient or responsible party)

CARY, NORTH CAROLINA 27518
(919) 851-9193 FAX (919) 851-9223

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Check the appropriate boxes to indicate how we may release your health information.

□Answering Machine/Voice Mail

Information to be disclosed: **□ Medical Information**

□ Date/Time of Office Visit **□ Office visit Instructions**

□ Date/Time of Surgery **□ Surgery Instructions**

□ Request for additional information **□ Financial**

□ Visit my waiting party after my surgery and give a status report

Or

□ Do not visit anyone in the waiting area after my surgery to give a status report.

□ Spouse

Information to be disclosed:

□ Medical **□ Financial** **□ Exceptions________________________________**

□ Parent

Information to be disclosed:

□ Medical **□ Financial** **□ Exceptions________________________________**

□ Other (name/relationship):____

Information to be disclosed:

□ Medical **□ Financial** **□ Exceptions_______________________________**

Advanced Surgical Associates, P.A. is authorized to release health information about the patient listed below as directed by the information filled out in this form. Release of information is for the direct purpose of informing the patient and/or others designated by the patient about the patient's health status as per the patient's instructions.

PRINT NAME____ DOB_____/_____/_____

I understand that I have the right to revoke this authorization at any time. I have the right to inspect or copy my health information. To receive a copy of my health information I must submit a written request to Advanced Surgical Associates, P.A. Information redisclosed by myself or others I have designated may no longer be protected under Federal or State law. I may refuse to sign this authorization without any consequences to my health care treatment. Once signed, the authorization will remain in effect until a written request that it be revoked is submitted to Advanced Surgical Associates, P.A.

SIGNATURE____DATE_______________________

REV. 3/07