PATIENT INFORMATION

Surgical Specialists of Jackson, PLLC

DIPLOMATES-AMERICAN BOARD OF SURGERY

New Patient ☐
Updated Info. ☐

PLEASE PRINT

Name	Social Security Number	Marital Status S M D W	Sex M F	Birthdate

Address	City, State, Zip	Home Phone	Cell Phone	Email:

Employer	Employer's Address (include city, state, and zip)	Work Phone	Employment Status	Part Time ☐ Full Time ☐

Race ☐ African American/Black, ☐ American Indian / Alaska Native, ☐ Asian, ☐ Asian/Pacific Islander, ☐ Caucasian/White, ☐ Hispanic/Latino, ☐ More than one race, ☐ Native Hawaiian, ☐ Other Pacific Islander

Ethnicity ☐ Hispanic/Latino, ☐ non-Hispanic

Preferred Language ☐ English ☐ Spanish

Emergency Contact Name

Relationship Phone Number

PARENT/GUARANTOR INFORMATION

Complete this section only if the patient is not responsible for this account.

Name	Relationship of Patient to Responsible Party		
	Spouse	Child	Other

Address	City, State, Zip	Home Phone	Social Security Number

INSURANCE INFORMATION

Please present insurance cards to Receptionist.

PRIMARY INSURANCE: Company Name	Identification Number	Group Number

Insurance Company Address (include city, state, and zip)

Name of Policyholder (Date of birth) Relationship, Self ☐ Spouse ☐ Child ☐ Other ☐)

SECONDARY INSURANCE: Company Name	Identification Number	Group Number

Insurance Company Address (include city, state, and zip)

Name of Policyholder (Date of birth) Relationship, Self ☐ Spouse ☐ Child ☐ Other ☐)

ADDITIONAL INFORMATION

Were you injured on the job?	Yes	No	Date:
Were you injured in an automobile accident?	Yes	No	Date:
When did you first consult us for this condition?			Date:

STATEMENT OF POLICY

I UNDERSTAND THAT I AM PERSONALLY AND DIRECTLY RESPONSIBLE FOR ALL HEALTH CARE BILLS SUBMITTED BY SURGICAL SPECIALISTS OF JACKSON, PLLC FOR SERVICES RENDERED TO ME AND THAT I HAVE THE PRIMARY DUTY AND OBLIGATION TO PAY MY DOCTOR FOR THESE SERVICES NOT WITHSTANDING ANY CONTRACT THAT I MAY HAVE WITH ANY THIRD PARTY, SUCH AS AN INSURANCE COMPANY, EMPLOYER, UNION OR GOVERNMENT. IF MY ACCOUNT IS DELINQUENT OVER 60 DAYS, A PERCENTAGE RATE OF 1.33% MONTHLY (16% ANNUALLY) WILL BE ADDED TO MY BILL AND, IF MY ACCOUNT MUST BE TURNED OVER FOR COLLECTION, THE COST OF COLLECTION WILL BE ADDED TO MY BILL AS A DIRECT EXPENSE TO ME.

I GIVE THIS OFFICE MY CONSENT TO RENDER MEDICAL TREATMENT AND CARE, AND TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM TO THIRD PARTY PAYORS, INSURANCE CARRIERS, OR HEALTH CARE OPERATIONS. I ALSO REQUEST PAYMENT OF MEDICAL BENEFITS BE ASSIGNED TO THE TREATING PHYSICIAN.

SIGNATURE ______________________________

Thank you for choosing Surgical Specialists of Jackson, PLLC for your health needs. Please let any of the staff know if we can answer any questions or be of any assistance.

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Surgical Specialists of Jackson
971 Lakeland Drive, Suite 656
Jackson, MS 39216
Office: (601) 366-6606
Fax: (601) 366-6647

STATEMENT OF POLICY

I UNDERSTAND THAT I AM PERSONALLY AND DIRECTLY RESPONSIBLE FOR ALL HEALTH CARE BILLS SUBMITTED BY DAVID R. CARROLL, MD AND PLLC FOR SERVICES RENDERED TO ME. I HAVE THE PRIMARY DUTY AND OBLIGATION TO PAY MY DOCTOR FOR THESE SERVICES NOT WITHSTANDING ANY CONTRACT THAT I MAY HAVE WITH ANY THIRD PARTY SUCH AS AN INSURANCE COMPANY, EMPLOYER, UNION OR GOVERNMENT. IF MY ACCOUNT IS DELIQUENT OVER 60 DAYS, A PERCENTAGE RATE OF 1.33% MONTHLY OR16% ANNUALLY WILL BE ADDED TO MY BILL. IF MY ACCOUNT MUST BE TURNED OVER FOR COLLECTION, THE COSTS OF COLLECTION WILL BE ADDED TO MY BILL AS A DIRECT EXPENSE TO ME.

I AUTHORIZE THIS OFFICE TO RENDER MEDICAL TREATMENT AND CARE, AND RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF MEDICAL BENEFITS BE ASSIGNED TO THE UNDERSIGNED PHYSICIAN

Signature: ________________________________ Date: ______________

Dr. David R. Carroll ***Dr. David S. Miller*** ***Dr. Jeffrey H. Glover*** ***Karen Ransom, CFNP***

General Surgery including:

Abdominal Surgery
Bariatric Surgery
Hernia Surgery
Laparoscopic Surgery
Gallbladder & Liver
Intestinal Surgery
Vascular Surgery
Breast Surgery

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TO WHOM IT MAY CONCERN:

I give my permission to release any or all of my records, which may include x-rays and lab reports to Surgical Specialists of Jackson, PLLC.

Patient Signature: ______________________________ ***Date:*** ____________

David R. Carroll, MD   David S. Miller, MD   Jeffrey H. Glover, MD

General Surgery including:

Abdominal Surgery	*Laparoscopic Surgery*	*Intestinal Surgery*
Bariatric Surgery	*Gallbladder & Liver*	*Vascular Surgery*
Hernia Surgery	*Cancer Surgery*	*Breast Surgery*

Surgical Specialist of Jackson
971 Lakeland Drive, Suite 656
Jackson, MS 39216

Authorization for Release of Medical Information to Designated Party

Some patients prefer that other individuals, especially family members, be allowed access to their medical information. In order to comply with strict legal standards, a written release is required to allow another person access to your medical records.

This release grants permission to individual(s) listed below to: Make or confirm appointments, have access to x-ray and laboratory findings, pick up sample medications, be made aware of your diagnosis, prognosis, and treatment plans, serve as your emergency contact, and discuss financial aspects of your account.

If you do not agree, or would like only partial disclosure, please give other instructions:

_______ Other Conditions of Disclosure: ____

____

Designated Party Name	Telephone Number	Relationship

I understand that this consent may be revoked by me at any time by written notice to the practice.

Patient Signature: ______________________________

Print Name of Patient: ______________________________

Date of Signature: ______________________________

Authorization to Leave Voice Mail

There may be times when our office is not able to reach you by telephone. In order to comply with strict legal standards, a written release will allow us to leave a message on your answering machine or voice mail. By signing below you are authorizing us to leave messages on your answering machine or voice mail at the telephone numbers you have given us in your record.

Patient Signature: ______________________________ Date: ____________________

Surgical Specialists of Jackson

Patient History

____ David R. Carroll, MD
____ Jeffrey H. Glover, MD
____ David S. Miller, MD
____ Karen Ransom, CFNP
______Update ______New

PT NAME: ____________________________ DOB/AGE: _____________/_____ SEX: M/F DATE: ____________________

WHO REFERRED YOU HERE? ____

REASON FOR TODAY'S VISIT: ____

FAMILY DOCTOR: __________________________ PHONE/CITY-STATE: ______________________________

PHARMACY LOCATION: ____

PERSONAL HISTORY: *Have you had any of the following, please circle*

High Blood Pressure   Diabetes   Stroke   Heart Trouble   Heart Attack   Kidney Failure/Disease
HIV/AIDS   Cancer (type of cancer)____________________

PLEASE LIST ANY OTHER HEALTH PROBLEMS NOT LISTED ABOVE :

____

PREVIOUS SURGERIES: ____

____

____

CURRENT MEDICATIONS & DOSAGES: ____

____

____

MEDICATION ALLERGIES: ____

LATEX OR ADHESIVE ALLERGIES: ____

FAMILY MEDICAL HISTORY: (please circle) or write none: ______________________________

CANCER:	MOTHER/FATHER	SISTER/BROTHER	SON/DAUGHTER
DIABETES:	MOTHER/FATHER	SISTER/BROTHER	SON/DAUGHTER
HEART TROUBLE:	MOTHER/FATHER	SISTER/BROTHER	SON/DAUGHTER
HIGH BLOOD PRESSURE:	MOTHER/FATHER	SISTER/BROTHER	SON/DAUGHTER
STROKE:	MOTHER/FATHER	SISTER/BROTHER	SON/DAUGHTER

SOCIAL HISTORY:

HAVE YOU EVER SMOKED? Yes/No   DO YOU SMOKE CURRENTLY? yes / no

IF YES: How much daily? ________________ For how many years? ________________

IF NO: When did you quit?________________ How many years did you smoke?____________

DO YOU CHEW TOBACCO? yes / no How much daily? __________________ For how many years? ________________

DO YOU DRINK ALCOHOL? yes/ no How often? _______________ How much? ______________ How many years?__________

DAVID R. CARROLL, M.D.
JEFFREY H. GLOVER, M.D.
DAVID S. MILLER, M.D.

Review of Systems

Please circle any of the following symptoms you experience:

Constitutional

good general health
significant weight loss
significant weight gain
fever
night sweats
fatigue
other________________

Eyes

blindness
eye pain
vision loss
other________________

Ears, nose, & throat

hearing loss
sore throat
swelling or mas in throat
difficulty swallowing
hoarseness of voice
other________________

Cardiovascular

chest pains
ankle, leg, or foot swelling
high blood pressure
toe, foot, or leg ulcerations
other________________

Pulmonary

shortness of breath
cough
wheezing
other________________

Gastrointestinal

nausea/vomiting
abdominal pain
rectal bleeding
constipation
diarrhea
other________________

Musculoskeletal

muscle cramps
muscle cramps when sleeping
joint pain
other________________

Genitourinary

Male
inguinal hernia
genital warts
pain or mass in testicles
other________________

Female
breast lump/mass
breast pain/ tenderness
nipple discharge
other________________

Integumentary

hair loss
change in mole
non-healing wounds
suspicious skin lesions
rash
other________________

Neurological

stroke
syncope (fainting)
vertigo (dizziness)
weakness
other________________

Endocrine

excessive hunger/thirst
recent weight change
slowly healing wounds
other________________

Hematologic/Lymphatic

anemia
prolonged bleeding when cut
enlarged lymph nodes
other________________

Immunological

HIV exposure
persistent infections
other________________

To the best of my knowledge the above information is accurate and complete.

____

Patient Signature | Date | Date of Birth

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT FORM

I, ______________________________, have received a copy of Surgical Specialists of Jackson Notice of Privacy Practices.

______________________________ ______________________________

Signature of Patient Date

Effective: October 31, 2013

Surgical Specialist of Jackson's Notice of Privacy Policy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As our patient, you have entrusted your medical information to our care. We know that your relationship with us is based on trust, and that you expect us to act in your best interests. As your personal medical history is your private information, we hold ourselves to the highest standards in its safekeeping.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. HIPAA provides penalties for covered entities that misuse personal health information. We are required by law to maintain the privacy of your protected healthcare information and to provide you with this notice of our legal duties and our privacy practices. HIPAA gives you, the patient, the right to understand and control how your protected health information ("PHI") is used.

Under HIPAA regulations, we may use and disclose your Protected Health Information (PHI) without written consent for treatment, payment and health care operations (TPO)

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is communicating with your referring physician, pharmacy or laboratory
- Payment means activities related to obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include verifying insurance coverage or sending you a billing statement
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. Examples of this would be patient survey cards or contacting you, by phone or in writing, to remind you of an appointment
- We may also be required or permitted to disclose your PHI for law enforcement, matters of public health and safety and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We will not use your information for marketing or fundraising. We will not sell your information.

In compliance with federal and state privacy laws, ***written authorization by the patient or legal guardian*** **is required before we can release records for reasons other than treatment, payment and healthcare operations**. If you give authorize to release your records, you may revoke such authorization in writing and we will honor your request from the date we receive your written request forward.

Protecting Your Privacy Online

Our concern for your privacy naturally extends to our online communication. We transfer your data over the Internet to submit health insurance claims and send electronic prescriptions to your pharmacy via a secure server. We do NOT use Electronic Medical Records so your chart is not accessible over the internet.

We will file an insurance claims to your private insurance, Medicare or Supplement if you authorize us to do so. If you ask us not to give details about services to an insurance company that they will not be pay for, such as cosmetic services, we will honor your request.

You may have the following rights with respect to your PHI:

- The have the right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you notify us in writing.
- You can advise us of the best location to contact you to protect your private information.
- You can request a copy of medical record in writing.
- You can request an amendment of your PHI. This request must be done in writing and will be honored at our discretion.
- We keep a log of disclosures of your medical information for the past six years and you can request a copy
- We will notify you if a breach of your protected health information occurs.

Please let us know if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with our practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Contact information: Feel free to contact our office if you have any concerns regarding the privacy of your personal information. Please contact our Practice Compliance Officer, Kristen Humphrey (601-366-6606)

A copy of our privacy policy is available at our office.

This notice is effective as of **11/01/2013**, and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. A copy of the revised Notice of Privacy Practices is posted on our website and a copy of the written policy is available at our office and can be mailed upon request.