

PATIENT INFORMATION**Surgical Specialists of Jackson, PLLC**New Patient

DIPLOMATES-AMERICAN BOARD OF SURGERY

Updated Info.

PLEASE PRINT

Name	Social Security Number	Marital Status				Sex		Birthdate
		S	M	D	W	M	F	
Address	City, State, Zip	Home Phone	Cell Phone	Email:				
Employer	Employer's Address (include city, state, and zip)		Work Phone	Employment Status	Part Time <input type="checkbox"/>			
					Full Time <input type="checkbox"/>			
Race	<input type="checkbox"/> African American/Black, <input type="checkbox"/> American Indian / Alaska Native, <input type="checkbox"/> Asian, <input type="checkbox"/> Asian/Pacific Islander, <input type="checkbox"/> Caucasian/White, <input type="checkbox"/> Hispanic/Latino, <input type="checkbox"/> More than one race, <input type="checkbox"/> Native Hawaiian, <input type="checkbox"/> Other Pacific Islander							
Ethnicity	<input type="checkbox"/> Hispanic/Latino, <input type="checkbox"/> non-Hispanic							
Preferred Language	<input type="checkbox"/> English <input type="checkbox"/> 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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>
SECONDARY INSURANCE: Company Name	Identification Number	Group Number
Insurance Company Address (include city, state, and zip)		
Name of Policyholder	(Date of birth)	Relationship, Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>

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.

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 OR 16% 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

Surgical Specialists of Jackson

971 Lakeland Drive, Suite 656

Jackson, MS 39216

Office: (601) 366-6606

Fax: (601) 366-6647



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
Bariatric Surgery
Hernia Surgery*

*Laparoscopic Surgery
Gallbladder & Liver
Cancer Surgery*

*Intestinal Surgery
Vascular 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? _____

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.