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.

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

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	*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: _____

HISTORY AND PHYSICAL DATE_____

NAME_____ AGE_____ SEX_____

FAMILY DOCTOR_____WHO REFERRED YOU HERE_____

PHARMACY NAME AND NUMBER_____

PERSONAL MEDICAL HISTORY (check ALL that apply, if none apply check none)

NONE_____ HEPATITIS_____ STROKE_____
HIGH BLOOD PRESSURE_____ DIABETES_____ HIV/AIDS_____
HEART DISEASE/HEART ATTACK_____ COPD/ASTHMA_____ KIDNEY DISEASE_____
CANCER(if yes, what type)_____ OTHER NOT LISTED ABOVE_____
_____

PREVIOUS SURGERIES:

_____ _____ _____
_____ _____ _____
_____ _____ _____

CURRENT MEDICATIONS YOU ARE TAKING:

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

MEDICATION ALLERGIES (if yes, what meds)_____

DO YOU CURRENTLY SMOKE OR CHEW TOBACCO? Y/N IF NO, QUIT DATE_____
IF YES, HOW MANY PACKS/CANS A DAY?_____ FOR HOW LONG_____
DO YOU DRINK ALCOHOL? Y/N IF SO, HOW MUCH_____

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

OFFICE USE ONLY

HPI_____
_____

PHYSICAL EXAMINATION:

HT_____WT_____BP_____T_____P_____R_____
GEN:_____ABD:_____
EYES:_____G/U:_____
ENT:_____LYM:_____
NECK:_____M/S:_____
RESP:_____SKIN:_____
CV:_____NEURO:_____
BREASTS:_____PSY:_____

Surgical Specialists of Jackson

Patient Name: _____ Date: _____

Please CIRCLE any symptoms you are experiencing, FILL IN all applicable blanks.

Constitutional: Fever Chills Night Sweats Extreme Fatigue
Weight LOSS / GAIN of _____ lbs. over _____months.

EYES: Blindness – (R) (L) (Both) Transient visual loss or disturbance?

ENT: Sinusitis/ nose bleeds Dental problems Hoarseness
Seasonal allergies Mouth ulcerations Sore throat

Respiratory: Wheezing Asthma Shortness of breath at rest
Chronic cough Emphysema Use of oxygen at home
Coughing up blood Pneumonia Sleep apnea
History of TB Asbestosis CPAP at night

Cardiovascular: Chest pain when exercising Unusual or irregular heartbeat

Gastrointestinal: Poor appetite Constipation Difficult or painful swallowing
Reflux Diarrhea Blood in stools
Nausea Hepatitis Painful bowel movements
Vomiting Other liver disease

Urology: Frequent urination Difficult or painful urination History of kidney stones
Blood in urine Recurring urinary infections Urinary incontinence

Women: Number of spontaneous/induced abortions ____
Number of pregnancies _____ Number of live births _____
Last menstrual period _____
Age when menstruation began _____; age ended _____
Pregnant: Yes/No Possibility you are pregnant: Yes/No

Men: Pain or mass in testicles

Musculoskeletal: Arthritis Bone pain Muscle pain/weakness
Toe/foot ulcerations Night leg cramps Leg swelling

Skin: Unusual rash/itching Psoriasis History of jaundice
Brittle hair/fingernails Skin cancer Other skin disorder: _____

Neurological: Migraine Headaches Episodes of paralysis/numbness
Strokes Slurring/Difficulty with speech Tremors/Seizures

Psychological: Depression/Schizophrenia History of Drug/Alcohol Abuse

Endocrine: Intolerance to heat Slow healing wounds
Increased urination with increased hunger/thirst

Hematology/Lymph: Prolonged bleeding of cuts HIV/AIDS History of blood clots in legs
Bruise easily/anemia Enlarged lymph node: N*eck Axillary(arm) Groin*

Allergies: Latex Allergies_____ Food allergies: _____
Drug Allergies: _____

Colon Cancer is the 3rd most common cancer in the United States

According to the Center of Disease Control a screening colonoscopy is recommended beginning age 50 and continuing until age 75, if you have no indications to have one sooner (ie, rectal bleeding, rectal pain, chronic constipation or diarrhea, etc).

Also, if you have an immediate family member (parent, sibling, grandparent, etc) who has been diagnosed with colon cancer, you could be at increased risk for developing colon cancer as well, therefore it is recommended that you have a screening colonoscopy beginning age 40.

Most cancers can be prevented by early detection and removing any polyps before they enlarge and become malignant.

Most all insurance companies require a screening colonoscopy and cover the cost if you meet some of the above criteria.

Please answer the following questions to determine if you may need to schedule a screening colonoscopy, or know someone who may need to be evaluated.

Have you ever had a colonoscopy? YES NO

If so when?_____

Were the results cause for concern: YES NO

Are you 50 years of age or more and have not had a screening colonoscopy? YES NO

Do you have a family member that has been diagnosed with colon cancer? YES NO

Are you having any bowel problems that may require evaluation? YES NO

If you answered yes to any of the questions above, please discuss your situation with me to determine your need for a screening colonoscopy.

Date:_____

Thank you,

DOB:_____

Dr. David S. Miller, MD FACS

Print Name:_____

General Surgery including:
- Abdominal Surgery
- Intestinal Surgery
- Gallbladder and Liver
- Hernia Surgery
- Surgery of the Breast

Laparoscopic Surgery
Bariatric Surgery
Vascular Surgery
Cancer Surgery

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.