*For office staff use only:

Temp: _____ HR: _____BP: _____ HT: _____WT:_____

NEW PATIENT MEDICAL INFORMATION SURVEY

Today's Date: _____ **Augusta Surgical Group**

We are glad you chose the Augusta Surgical Group to meet your surgical needs. Please take a few minutes to fill out this form, as it will help us provide you with optimal care .Please circle choices or fill in blanks where appropriate. Thank you for your time.

Name: _____ **Date of Birth:** _____ **Sex: M / F** **Age:** _____

Social history: Occupation_____ **Married / Single / Divorced / Widowed**

Preferred contact numbers: _____

Primary Medical Doctor: _____ **Referring Doctor:** _____

Cardiologist: _____ **Nephrologists:** _____ **Dialysis Center:** _____

Other Doctors & their specialties: _____

What brings you to the office today? _____

Allergies: (drug, food, tape, latex/rubber and reaction):_____

List Medications that you are taking:

1._____ 4._____ 7._____ 10._____

2._____ 5._____ 8._____ 11._____

3._____ 6._____ 9._____ 12._____

Date of Recent Mammo: _____ **Colonoscopy:** _____ **Hospitalizations:** _____ **X-rays:** _____

Surgeries: * Cardiac Catheterization. *Hernia Repair *Pacemaker *Gallbladder *Bowel Surgery * Reflux/hiatal Hernia *Appendectomy * Weight Loss Surgery **Other*** _____

Medical Conditions (PLEASE CIRCLE THOSE THAT APPLY TO YOU): *Arthritis *Asthma * COPD *Bleeding Disorder *Blood Clots *Cancer *Stroke *Diabetes *GERD *Hepatitis *HIV/AIDS *Heart Disease *High Cholesterol *High Blood Pressure *MRSA *Kidney Disease * Seizures *Thyroid Disease *OTHER_____

Family Medical History: (List medical conditions affecting your immediate family)
Mother- ALIVE - DECEASED Father- ALIVE - DECEASED Other

Tobacco: Current Smoker YES or NO, Packs Per day_____ Former Smoker: Years quit _____
Years Smoked: _____ Alcohol YES or NO Type: _____ Amount per Week: _____
Other recreational drugs: _____

Obstetrical/gynecologic history: Last menstrual period: _____ Age at first childbirth: _____ Age at first period: _____ Are you pregnant: ____ Number of deliveries: _____ Number of pregnancies:_____
Have you had: natural menopause/hysterectomy/still menstruating (circle one)

Personal / Religious preferences that you would like us to consider or that may impact your care_____

Do you CURRENTLY or have you RECENTLY had any of the conditions listed below?
Please circle N for NO or Y for YES

Constitutional

Fever	N	Y
Chills	N	Y
Weight Loss	N	Y
Fatigue	N	Y
Sweating Episodes	N	Y

Skin

Rash	N	Y
Wound	N	Y
Masses	N	Y

Heent

Headaches	N	Y
Dental Problems	N	Y
Hearing Loss	N	Y
Congestion	N	Y
Sore Throat	N	Y

Eyes

Visual Disturbance	N	Y
Eye Pain	N	Y

Cardiovascular

Chest Pain	N	Y
Palpitations	N	Y
Shortness of Breath Lying Flat	N	Y
Leg Swelling	N	Y
Irregular Heartbeat	N	Y

Respiratory

Coughing	N	Y
Shortness of Breath	N	Y
Wheezing	N	Y

Gastrointestinal

Heartburn	N	Y
Nausea	N	Y
Vomiting	N	Y
Abdominal Pain	N	Y
Diarrhea	N	Y
Constipation	N	Y
Blood in Stool	N	Y

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Painful Urination	N	Y
Urgency	N	Y
Frequency	N	Y
Blood in Urine	N	Y
Difficulty Urinating	N	Y
Pelvic Pain	N	Y

Musculoskeletal

Muscle pain	N	Y
Back Pain	N	Y
Joint Pain	N	Y

Endocrine/hematoma

Easy bruising/bleeding	N	Y
Allergies	N	Y
Swollen lymph node	N	Y

Neurological

Dizziness	N	Y
Numbness	N	Y
Focal Weakness	N	Y
Seizures	N	Y
Loss of Consciousness	N	Y

Psychiatric

Depression	N	Y
Substance Abuse	N	Y
Nervousness Anxiety	N	Y
Memory Loss	N	Y

***For office staff use only:**

History:

A/P:

PE:

Augusta Surgical Group

New Patient Information

Name: _____ SSN: _____ DOB: _____ Male / Female

Address_____ City: _____ ST: _____ Zip: _____

Home #._____ Work #: _____ Cell: _____

Primary Number I wished to be contacted on. HOME / WORK / CELL (CIRCLE) Email: _____

Need Interpreter? YES or NO Primary Language _____ Marital Status M S W D

Ethnicity_____ Religion _____ Race _____

Referring Doctor_____ Primary Care Doctor_____

Preferred Pharmacy Name and Location: _____ Preferred Laboratory: _____

EMPLOYMENT / INSURANCE

Employer _____

Employment Status _____ Employer Phone No: _____

Guarantor of Account: SELF / OTHER Relationship: _____ Phone No:_____

Address_____ City: _____ ST: _____ Zip: _____

PRIMARY INSURANCE:

Insurance Company: _____ ID: _____ SSN: _____

Group No: _____ Subscriber: SELF / OTHER Relationship: _____ DOB: _____

SECONDARY INSURANCE:

Insurance Company: _____ ID: _____ SSN: _____

Group No: _____ Subscriber: SELF / OTHER Relationship: _____ DOB: _____

All Information given is accurate. I give my permission for Augusta Surgical Group- (ASG) to contact me regarding practice information by the above methods.

Print Name: _____ **Signature:** _____ **Date:** _____

Patients Medical Approval List

Augusta Surgical Group, P.C.

Date: _____

Patients Name: _____

Please List anyone that we may discuss your Medical information with. If their name is not on this list, we cannot disclose any of your medical information.

Emergency Contact

Name: _____**Relationship**_____ **Phone no.**_____

Hipaa List Below

Name: _____ Relationship: _____ Phone No: _____

Name: _____ Relationship: _____ Phone No: _____

Name: _____ Relationship: _____ Phone No: _____

Name: _____ Relationship: _____ Phone No: _____

Signature: _____

augustasurgical GROUP

PAYMENT POLICY

James C. Sherman, M.D., P.C., F.A.C.S.
J. Newton Bates, Jr., M.D., P.C., F.A.C.S.
Gregory T. Ellison, M.D., P.C., F.A.C.S.
Chris C. Carlson, M.D., P.C., F.A.C.S.
Matthew M. Mondi, M.D., P.C., F.A.C.S.

IMPORTANT MESSAGE TO OUR PATIENTS

Insurance Coverage and reimbursement is a very confusing issue. We would like to help clarify some of the most common misconceptions so that you, the patient, will understand what is expected of your insurance companies and you regarding visits to our office and subsequent procedures performed here or at the hospital.

Most Insurance policies pay for office visits and surgical Procedures (or operations). We will file a claim to your insurance company for any procedures. They will pay a percentage (after you have met your deductibles) of the fee and, unless, you have a secondary insurance, you will be responsible for the remaining portion of the fee. You will be asked to pay your office visit Co-Payment before you are seen. If you do not have a Co-Payment, We will check on your insurance to see what you will owe.

Self-Pay patient must pay at the time of the visit. If surgery is needed, we will have our patient accounts representative discuss this with you before surgery.

Medicare operates by a different set of rules. Since your physicians participate in the Medicare program, we are required to file for all services provided to you. Medicare allows a specific fee for each visit or procedure and pays 80% of this allowance. We are then required to bill you for the additional 20% (through either supplemental insurance or your payment) and we are required to write off the difference between our normal fee and the fee Medicare allows. The new Medicare Advantage plans operate mainly with a co-pay and/or coinsurance. This may not apply if we do not participate in your particular Medicare Advantage Plan.

Each Insurance Company is unique so we need as much information as possible about your present coverage. Many companies are now requiring precertification or preauthorization before they will allow any charges.

Please help up help you by providing our staff as much detail as you have regarding your insurance coverage. Remember, you the patient, are responsible for charges incurred through our office-regardless of insurance coverage.

Patient Signature: _____ Date: _____

James C. Sherman, M.D., P.C., F.A.C.S.
J. Newton Bates, Jr., M.D., P.C., F.A.C.S.
Gregory T. Ellison, M.D., P.C., F.A.C.S.
Chris C. Carlson, M.D., P.C., F.A.C.S.
Matthew M. Mondi, M.D., P.C., F.A.C.S.

Patient Registration From

Your signature below indicates your consent for treatments, and hereby authorizes the release of any information acquired in the course of your examination or treatment to your insurance company.

Signature: _____ **Date:** _____

I hereby assign, transfer, convey and authorize all payments to the physicians for medical services rendered to my dependents or myself. I understand and that I am responsible for any amount not covered by insurance.

Signature: _____ **Date:** _____

Privacy practices acknowledgment: I hereby, acknowledge that Augusta Surgical Group, P.C., has provided me with the notice of its privacy practices as is required by the Federal health insurance portability and accountability act of 1996 (HIPPA). I understand that Augusta Surgical Group, P.C., will upon request, provide me with a copy of the notice of privacy practices.

Signature: _____ **Date:** _____

A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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