( ) New ( ) Update

Central New York Surgical Physicians, PC
Information & Authorization Form

Are you currently residing in a Skilled Nursing Home

Yes ( ) No ( )

If this visit is related to Workers' Comp or a Motor Vehicle Accident – Notify the Receptionist

Personal Information

PLEASE PRINT

Last Name: ________________________First Name:_______________________ MI_____

SSN: _______________ Birth Date: _______________ Sex: _______

Address:____

City/State/Zip: ____

Home Phone:_______________________ Work Phone:___________________ Cell Phone:________________

If known: Blood Type: _______ Optional: Race: _______________

Marital Status: ________ Spouse Last Name:__________________ First Name:________________MI:____

If Student/Minor: ( ) Mother_________________DOB:______ ( ) Father_______ _______DOB:_________

Employment Status: _____________ Employer:___________________ Occupation:________________________

Which Physician referred you to our practice: ____

Address: __________________________________City:__________________State/Zip:________________

Who is your Primary Care Physician:____

Address: __________________________________ City:_________________ State/Zip:_________________

Pharmacy Name: _______________________________Pharmacy Phone Number:__________________________

Pharmacy Address: ____

Emergency Contact Name: ____________________________________Phone Number:________________________

Address:________________________________ City:_________________ State/Zip:_________________

Patient Name: ____

INSURANCE INFORMATION

First Insurance:
Plan Name: ____________________________________ **ID Number:** ____
Address: ______________________________________ **Group Number:** _____________________________________
Policy Holder: __________________________________ **Effective Date:** ____________________________________
Policy Holders Date of Birth: _____________________ **Relationship:** _______________________________________

Second Insurance:
Plan Name: ____________________________________ **ID Number:** ____
Address: ______________________________________ **Group Number:** _____________________________________
Policy Holder: __________________________________ **Effective Date:** ____________________________________
Policy Holders Date of Birth: _____________________ **Relationship:** _______________________________________

Third Insurance:
Plan Name: ____________________________________ **ID Number:** ____
Address: ______________________________________ **Group Number:** _____________________________________
Policy Holder: __________________________________ **Effective Date:** ____________________________________
Policy Holders Date of Birth: _____________________ **Relationship:** _______________________________________

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? Yes _________ No _________
IF YES, PLEASE NOTIFY THE RECEPTIONIST

For patients under the age of 18 years old, the undersigned Parent/Guardian authorizes treatment and agrees that the policy holder will be named as the account guarantor unless noted otherwise in writing.

____________________________________	____
Print Name	**Signature**
____________________________________	____
Relationship	**Today's Date**

TO OUR MEDICARE PATIENTS: STATEMENT OF AUTHORIZATION FOR PAYMENT OF MEDICARE BENEFITS.
I certify that the information by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration, or its carrier any information about me to process my Medicare claim. I request that payment under the Medical Insurance Program be made whether to me or Central New York Surgical Physicians, PC for services rendered to me during the period of ________ to life.

MEDICARE BENEFICIARY SIGNATURE: ______________________________________ **DATE:** _________________________

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Private Insurance, and any other health plan to Central New York Surgical Physicians, PC.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all information necessary to secure payment. In the event my account is assigned for collection I agree to pay all costs of collection including a processing fee and attorney fees.

SIGNED: ____**DATE**____

Patient Name: ____

List all medications you are currently taking. This is to include any over the counter medications.

Medication	Dosage	Directions on how taken	Start Date

List all allergies and what your reaction has been ____

____

Any allergy to Latex? Yes ( ) No ( )

What is your problem? How don't you feel well?____
____
____
____

Height? _____________

Weight? _____________ How has it changed in the past two years? ______________________________

Patient Name: ____

Review of Systems

Check all that apply

Constitutional
( ) Fatigue
( ) Fever
( ) Night Sweats

HEENT
Eyes:
( ) discharge
( ) visual loss
Ears:
( ) discharge
( ) hearing loss
Nose:
( ) nasal drainage

Respiratory
( ) Cough
( ) Dyspnea (shortness of breath)
( ) Wheezing

Cardiovascular
( ) Chest Pain
( ) Dyspnea (shortness of breath)
( ) Irregular Heartbeat/Palpatations

Vascular
( ) Claudication (pain in legs when walking)

Gastrointestinal
( ) Abdominal Pain
( ) Constipation
( ) Diarrhea
( ) Vomiting

Genitourinary
( ) Dysuria (pain when urinating)
( ) Hematuria (blood in urine)

Reproduction
Female:
( ) Dysmenorrhea (menstral cramps)
( ) Menorrhagia (heavy period)
( ) Vaginal discharge
Male:
( ) Penile Discharge

Metabolic/ Endocrine
( ) Cold Intolerance
( ) Heat Intolerance
( ) Polydipsia (excessive thrist)
( ) Polyphagia (excessive eating)
( ) Polyuria (excessive urination)

Neuro/Psychiatric
( ) Gait Disturbances (changes in your walk)
( ) psychiatric/emotional problems

Dermatologic
( ) Pruritus (itchy skin)
( ) Rash

Musculoskeletal/
( ) Bone/Joint pain
( ) Muscle Weakness

Hematologic
( ) Easy Bleeding
( ) Easy Bruising

Immunologic
( ) Environmental allergies
( ) Food allergies

( ) NONE OF THE ABOVE

Recent X-rays done:
____
____
Where?____

FOR WOMEN ONLY:

Menstruation History: Age at onset____Date of Last period ____________ Are periods regular?__________
Heavy________________________ Medium ___________________ Light ________________
Length of cycle (from start to start) ___________________
Have you ever taken Hormonal Replacement Therapy?_________Type ____________________
Have you ever taken Birth Control pills? _______ Type__________________________________

Pregnancies: How many pregnancies? __________Age at first pregnancy? ___________
How many miscarriages? __________Any stillbirths? ________
Any Cesarean sections? _________ Any complications? ______________________________

Patient Name: ____

PAST MEDICAL HISTORY

CHECK ALL THAT APPLY:

( ) Alcoholism
( ) Allergies
( ) Anemia
( ) Anxiety
( ) Arthritis
( ) Asthma
( ) Atrial fibrillation
( ) Benign Prostatic Hypertrophy
( ) Bleeding Disorder
( ) Blood Clots
( ) Blood Transfusion

( ) Cancer
( ) Cardiac Arrest
( ) Cardiac dysrhythmias
( ) Cardiac Valvular Disease
( ) Cerebrovascular Accident
( ) COPD
( ) Coronary Artery Disease
( ) Crohn's Disease
( ) Dementia
( ) Depression
( ) Diabetes
( ) DVT

( ) Endocartis
( ) Gallbladder Disease
( ) GERD
( ) Hemoglobinopathy
( ) Hepatitis C

( ) Hyperlipidemia
( ) Hypertensiion
( ) Inflammatory Bowel Disease
( ) Liver Disease
( ) Malignant Hyperthermia
( ) Migraine Headaches

( ) MRSA/VRE
( ) Myocardial Infarction
( ) Osteoarthritis
( ) Osteoporosis
( ) Peptic Ulcer Disease
( ) Psychosis
( ) Pulmonary fibrosis
( ) Radiation
( ) Renal Disease
( ) Seizure Disorder
( ) Sleep Apnea
( ) Thyroid Disease

Have you ever been diagnosed with Tuberculosis? Yes ( ) No ( )

Have you ever had a Positive P.P.D? (TB Test) Yes ( ) No ( )

If Yes, When ____

Patient Name: ____

Have you had any operations?

Type	Year	Hospital	Surgeon

Have you had any serious injuries?

____
____
____
____

Have you ever been a patient in a hospital for anything other than the surgeries listed above?

Reason	Year	Hospital	Physician

When was your last tetanus shot? ____

Do you sleep well? _________________________________ How many hours? ________________________________

Patient Name: ____

FAMILY HISTORY

	Age	If Living Health	Age at Death	If Deceased Cause
Father				
Mother				
Brother				
Brother				
Brother				
Sister				
Sister				
Sister				
Husband				
Wife				
Child				
Child				
Child				

SOCIAL HISTORY

Tobacco Use Yes ( ) No ( ) ( ) Former Year Quit ________

If yes or former:

Type of tobacco: ___________Years smoked ______ Packs/day____ Pack year ______

Drinks Alcohol Yes ( ) No ( ) ( ) Former Year Quit ____

If yes or Former:

Type of Alcohol: __________ Frequency _______ Amount _______ Last Drink _____

Caffeine Use Yes ( ) No ( ) Type:_________________________________ Amount daily_______________

Confidential History

Have you ever been diagnosed with HIV/AIDS? Yes ( ) No ( )

Patient Name: ____

CENTRAL NEW YORK SURGICAL PHYSICIANS PAYMENT POLICY

Insurance: *You will be asked to present your current up-to-date insurance card along with picture identification at the time of your visit.* We participate in most insurance plans. If you are insured with a plan we do not do business with, payment may be required at each visit. If you are insured by a plan we do business with but do not have an up-to-date insurance card, you will be asked to sign a self-pay contract and payment in full for each visit may be required until you furnish us with a copy of both sides of your insurance card, you may also be asked to reschedule your appointment if you do not have a current insurance card. Knowing your insurance benefits is **your** responsibility. Contact your insurance company directly for any questions regarding your coverage. By signing this form you authorize CNY Surgical Physicians to release the necessary information in order to complete and process your insurance claims. <u>By signing this form you agree that if the information you provide is incorrect, you will be responsible for payment in full.</u>

Workers' Compensation: **If your visit is work related, notification must be made at the time your appointment is made and/or when you check in for your visit.** All your necessary compensation numbers along with name, address and telephone number of your employer; name, address and telephone number of your Workers' Compensation insurance carrier and the date of your injury must also be supplied at this time. Payment in full for each visit may be required until you can furnish us with all the above listed information. We will also need you to furnish us with your private health insurance, so please make sure you have that card with you at the time of your visit also.

No Fault: **Notification must be made at the time of your visit if this is a no fault related injury.** All the necessary no fault information and the date of your accident must be supplied at this time. Payment in full for each visit may be required until you can furnish us with all the above listed information. We will also need you to furnish us with your private health insurance, so please make sure you have that card with you at the time of your visit also.

Co-payments: All co-payments **must** be paid at the time of service. This arrangement is part of your contract with your insurance company. **A $20.00 processing fee will be added to your account for all co-pays not paid at the time of service.** ***This processing fee is in addition to your co-payment and it is not covered by insurance.***

Non-covered services: Some of the **elective services** you receive may not be covered by your insurance company, or not considered reasonable or necessary by other insurers. If you elect to proceed with the service, it will be your responsibility to pay for any services which have been determined by your insurance plan to be "non-covered". In these cases you will be asked to sign an *Advanced Beneficiary Notice of Non-Covered Elective Procedures.* Payment for these services may be asked for at each visit.

Updates: Our staff will ask you to verify your billing and personal information at each visit. Current information is essential in order to contact you regarding your treatment and for obtaining timely payment from your insurance company.

Claims Submission: We will submit your claims and assist you in any way we *reasonably* can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is **your** responsibility to comply in a timely manner with their request. Please be aware that the balance of your claim is **your** responsibility, whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company,

Patient Name: ____

Coverage changes: If your insurance changes, please notify us as soon as possible so we can make the appropriate changes to help you receive your maximum benefits. **Failure to notify our office of any insurance changes that result in incorrect billing and denial of payment by your insurance carrier will be your responsibility.**

Nonpayment: You will receive two statements from our office for any balances due. If this balance is not paid you will receive a third notice – Bad Debt letter. If the balance is not paid within 10 day of receipt of the Bad Debt letter, the account will be referred to our Collection Agency. In the event your account is assigned to our Collection Agency, you will be responsible to pay all costs of collection including a processing fee and any attorney fees.

Missed Appointments: A 24 hour notification is required for any appointment cancelled or changed. After two missed or no show appointments without notification to the office may result in a charge to you or possible dismissal from the Practice.

No Show Appointments: If your appointment has been confirmed and you do not show for the visit you will possibly be charged for the appointment. After two missed or no show appointments without notification to the office may result in a charge to you or possible dismissal from the Practice.

Returned Checks (NSF): You will be charged a $20.00 processing fee for any personal check returned for nonpayment.

I have read and understand the above Payment Policy:

____

Patients signature **Date**

Patient Name: ____

Part I

According to HIPPA regulations we must have your permission to speak to anyone, other than yourself, in regards to your Personal Health Information (PHI). Please list any person(s) below and their relationship that you give Central New York Surgical Physicians P.C. permission to discuss your Personal Health Information with.

____

____

____

____

Part II

Due to patient confidentiality, we need your permission to leave messages regarding appointments, tests, surgery, etc. If we cannot speak with you may we:

( ) Leave a message on your answering machine

and/or

( ) Leave a message with another person designated by you

Name of person ____

( ) You must speak with me personally

Signed: ____

Witness: ____

Date: ____