



## Past or Present Medical Conditions

<input type="radio"/> None				
<input type="radio"/> Alzheimer's Disease	<input type="radio"/> Anemia	<input type="radio"/> Anxiety Disorder	<input type="radio"/> Arthritis	<input type="radio"/> Asthma
<input type="radio"/> Atrial Fibrillation	<input type="radio"/> Barrett's Esophagus	<input type="radio"/> Bipolar Disorder	<input type="radio"/> Blood Clots (Leg)	<input type="radio"/> Blood Clots (Lung)
<input type="radio"/> Bowel Obstruction	<input type="radio"/> Celiac Disease	<input type="radio"/> Cirrhosis	<input type="radio"/> Colon Cancer	<input type="radio"/> Colon Polyp, History of
<input type="radio"/> Congestive Heart Failure	<input type="radio"/> C.O.P.D.	<input type="radio"/> Coronary Artery Disease	<input type="radio"/> Crohn's Disease	<input type="radio"/> Dementia
<input type="radio"/> Depression	<input type="radio"/> Diabetes Mellitus Insulin Dependent (Type 1)	<input type="radio"/> Diabetes Mellitus, Non-Insulin Dependent (Type 2)	<input type="radio"/> Diverticulitis	<input type="radio"/> End Stage Renal Disease
<input type="radio"/> Frailty	<input type="radio"/> Gallstones	<input type="radio"/> Gastroesophageal Reflux Disease (GERD)	<input type="radio"/> Gout	<input type="radio"/> Hepatitis A
<input type="radio"/> Hepatitis B	<input type="radio"/> Hepatitis C	<input type="radio"/> Heart Attack	<input type="radio"/> High Blood Pressure	<input type="radio"/> High Cholesterol
<input type="radio"/> Hypothyroidism	<input type="radio"/> Irritable Bowel Syndrome	<input type="radio"/> Kidney Disease	<input type="radio"/> Kidney Stones	<input type="radio"/> Oxygen Dependence
<input type="radio"/> Pancreatitis	<input type="radio"/> Parkinson's Disease	<input type="radio"/> Peptic Ulcer Disease	<input type="radio"/> Seizure Disorder	<input type="radio"/> Sleep Apnea
<input type="radio"/> Stroke	<input type="radio"/> Transient Ischemic Attack	<input type="radio"/> Ulcerative Colitis	<input type="radio"/> Vascular Disease	<input type="radio"/> Wheel Chair Bound
<input type="radio"/> Other: _____		<input type="radio"/> Other: _____		

## Previous Procedures

<input type="radio"/> None				
<input type="radio"/> Abdominal aortic aneurysm (AAA) repair	<input type="radio"/> Appendectomy	<input type="radio"/> Bilateral Tubal Ligation (BTL)	<input type="radio"/> Cardiac Cath -with stent placement	<input type="radio"/> Colon Resection
When: _____	When: _____	When: _____	When: _____	When: _____
<input type="radio"/> Coronary Artery Bypass Graft (CABG)	<input type="radio"/> Defibrillator Placement	<input type="radio"/> Exploratory Laparoscopy	<input type="radio"/> Fundoplication -Nissen	<input type="radio"/> Gallbladder Removed
When: _____	When: _____	When: _____	When: _____	When: _____
<input type="radio"/> Gastric Bypass	<input type="radio"/> Gastric Lap Band	<input type="radio"/> Heart Valve Replacement	<input type="radio"/> Hemorrhoidectomy	<input type="radio"/> Hiatal Hernia Repair
When: _____	When: _____	When: _____	When: _____	When: _____
<input type="radio"/> Hernia Repair - Inguinal	<input type="radio"/> Hernia Repair - Umbilical	<input type="radio"/> Hernia Repair - Abdominal Wall	<input type="radio"/> Hysterectomy - Abdominal	<input type="radio"/> Joint Replacement Specify Site
When: _____	When: _____	When: _____	When: _____	When: _____
<input type="radio"/> Lung Lobectomy	<input type="radio"/> Lumpectomy, Breast	<input type="radio"/> Mastectomy Left	<input type="radio"/> Mastectomy Right	<input type="radio"/> Small Bowel Resection
When: _____	When: _____	When: _____	When: _____	When: _____
<input type="radio"/> Vasectomy	<input type="radio"/> Other: _____		<input type="radio"/> Other: _____	
When: _____	When: _____		When: _____	

## Diagnostic Studies/Tests

<input type="radio"/> None				
<input type="radio"/> Blood Tests	<input type="radio"/> Colonoscopy	<input type="radio"/> CT Abd/Pelvis	<input type="radio"/> CT Chest	<input type="radio"/> EGD
When: _____	When: _____	When: _____	When: _____	When: _____
<input type="radio"/> ERCP	<input type="radio"/> MRI Abd/Pelvis	<input type="radio"/> PET Scan	<input type="radio"/> Ultrasound Abd/Pelvis	
When: _____	When: _____	When: _____	When: _____	
<input type="radio"/> Other: _____		<input type="radio"/> Other: _____		
When: _____		When: _____		



## Review Of Systems

<b>Allergic/Immunologic</b>	Y N	<b>Eyes</b>	Y N	<b>Integumentary</b>	Y N
strong allergic reactions or urticaria	<input type="radio"/> <input type="radio"/>	Blurry Vision	<input type="radio"/> <input type="radio"/>	Itching	<input type="radio"/> <input type="radio"/>
		Vision Changes	<input type="radio"/> <input type="radio"/>	Rashes	<input type="radio"/> <input type="radio"/>
<b>Cardiovascular</b>	Y N	<b>Gastrointestinal</b>	Y N	<b>Musculoskeletal</b>	Y N
Chest Pain	<input type="radio"/> <input type="radio"/>	Abdominal Pain	<input type="radio"/> <input type="radio"/>	Joint Pain	<input type="radio"/> <input type="radio"/>
Difficulty Climbing Stairs	<input type="radio"/> <input type="radio"/>	Change in Bowel Habits	<input type="radio"/> <input type="radio"/>	Muscle Pain	<input type="radio"/> <input type="radio"/>
Chest Pain with Activity	<input type="radio"/> <input type="radio"/>	Constipation	<input type="radio"/> <input type="radio"/>		
Short of Breath - Exertion	<input type="radio"/> <input type="radio"/>	Diarrhea	<input type="radio"/> <input type="radio"/>	<b>Neurological</b>	Y N
		Heartburn	<input type="radio"/> <input type="radio"/>	Headaches	<input type="radio"/> <input type="radio"/>
<b>Constitutional</b>	Y N	Nausea	<input type="radio"/> <input type="radio"/>	Seizures	<input type="radio"/> <input type="radio"/>
Fatigue	<input type="radio"/> <input type="radio"/>	Vomiting	<input type="radio"/> <input type="radio"/>		
fever	<input type="radio"/> <input type="radio"/>	Black Tarry Stools	<input type="radio"/> <input type="radio"/>	<b>Psychiatric</b>	Y N
Chills	<input type="radio"/> <input type="radio"/>	Blood in Stool	<input type="radio"/> <input type="radio"/>	Anxiety	<input type="radio"/> <input type="radio"/>
		Hernias	<input type="radio"/> <input type="radio"/>	Depression	<input type="radio"/> <input type="radio"/>
<b>ENMT</b>	Y N	Swallowing Problems	<input type="radio"/> <input type="radio"/>	Suicidal Thoughts	<input type="radio"/> <input type="radio"/>
Sore Throat	<input type="radio"/> <input type="radio"/>				
Runny Nose	<input type="radio"/> <input type="radio"/>	<b>Genitourinary</b>	Y N	<b>Respiratory</b>	Y N
Throat Tenderness	<input type="radio"/> <input type="radio"/>	Frequent Urination	<input type="radio"/> <input type="radio"/>	Cough	<input type="radio"/> <input type="radio"/>
Thyroid Troubles or Mass	<input type="radio"/> <input type="radio"/>	urethral discharge or incontinence	<input type="radio"/> <input type="radio"/>	Breathing Problems	<input type="radio"/> <input type="radio"/>
		Trouble Urinating	<input type="radio"/> <input type="radio"/>		
<b>Endocrine</b>	Y N	<b>Hematologic/Lymphatic</b>	Y N		
Increased Thirst	<input type="radio"/> <input type="radio"/>	Anemia	<input type="radio"/> <input type="radio"/>		
Increased Hunger	<input type="radio"/> <input type="radio"/>	Bleeding Easily	<input type="radio"/> <input type="radio"/>		
Weight Gain	<input type="radio"/> <input type="radio"/>	Transfusion Reaction	<input type="radio"/> <input type="radio"/>		
Weight Loss	<input type="radio"/> <input type="radio"/>				

## Immunizations

None

Flu vaccine       Pneumonia vaccine

When: \_\_\_\_ / \_\_\_\_ / \_\_\_\_      When: \_\_\_\_
   
Month/ Day /Year      Year

## Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

Yes       No

X

Patient Signature/Responsible Party

Date

## Completed by/Reviewed with

Patient       Parent       Guardian       Not Present

# MAT-SU SURGICAL ASSOCIATES

FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_ LAST NAME \_\_\_\_\_

PREFERRED NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SEX: (circle) MALE FEMALE

MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SS # \_\_\_\_\_ E-MAIL \_\_\_\_\_ MARITAL STATUS: (circle) M S W D

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

RACE: \_\_\_\_\_ ETHNICITY: \_\_\_\_\_ PREFERRED LANGUAGE: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_ PRIMARY CARE PHYSICIAN: \_\_\_\_\_

PRIMARY INSURANCE \_\_\_\_\_ POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

SUBSCRIBER NAME \_\_\_\_\_ DOB \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_ POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

SUBSCRIBER NAME \_\_\_\_\_ DOB \_\_\_\_\_

PHARMACY \_\_\_\_\_

## EMERGENCY CONTACT AND CONSENT TO DISCLOSE HEALTH INFORMATION

We respect your right to privacy regarding medical information. Please list the names of individuals with whom we may share information, including the type of information, without additional written consent.

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Contact Number \_\_\_\_\_

Emergency Contact

Medical Health Information

Billing Information

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Contact Number \_\_\_\_\_

Emergency Contact

Medical Health Information

Billing Information

May we leave a confidential message on your voice mail: YES NO

## BENEFIT ASSIGNMENT / ACKNOWLEDGEMENT OF PRIVACY PRACTICES

\_\_\_\_ (Initial) I certify that the above insurance and demographic information is true and correct to the best of my knowledge. I authorize Garth LeCheminant, MD, David Morrow, MD, FACS, Iuliana Bobanga, MD, FACS, or Jennifer Lemert, NP, to administer medical treatment. The office has my permission to obtain or release medical records from outside sources that may be important for the continuation of my care (or in the best interest of my dependent if I am signing as a parent or guardian).

\_\_\_\_ (Initial) I understand that I have the right to receive and review a written description of how this practice will handle health information about me. This is known as a Notice of Privacy Practices and describes the use and disclosure of health information made and the information practices followed by the employees, staff, and other office personnel of the Providers, and my rights regarding my health information. The current version of the Notice of Privacy Practices is posted in the waiting/reception area and on our website @ matsusurgical.com.

\_\_\_\_ (Initial) I authorize payment of medical benefits to Mat-Su Surgical Associates. I understand that I am financially responsible for all charges, even if not paid by insurance. I authorize the release of any information necessary to secure the payment of benefits. I agree that all charges for medical services rendered that are not directly paid by my insurance will be my responsibility.

Patient Signature/Responsible Party

Date

# MAT-SU SURGICAL ASSOCIATES

## FINANCIAL POLICY

Thank you for choosing Mat-Su Surgical Associates for your healthcare needs. We are committed to providing you the best surgical healthcare available. You are required to read and sign our financial policy prior to any treatment. Please feel free to ask any questions. A copy of this policy will be provided to you upon request.

\_\_\_\_ (Initial) **INSURANCE** - As a courtesy to our patients, we bill and participate with most insurance types. It is your responsibility to know your insurance benefits. If you are unsure of your benefits, please contact your insurance carrier with questions. If you do not provide proof of insurance, you will be expected to pay in full at the time of service or make payment arrangements with our billing staff. You will be considered a self-pay patient until the insurance information is provided to our office.

- **PROOF OF INSURANCE** –We must obtain a copy of your insurance card(s) and a copy of a photo ID for billing. Failure to provide us with the correct information will result in the inability to assist you in filing insurance claims.
- **CLAIM SUBMISSION** –As a courtesy to our patients, we will submit claims. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their requests.
- **CO-PAYMENT/CO-INSURANCE/DEDUCTIBLE** – Co-pays are due at time of service. Co-pays, co-insurance, and deductibles are part of your contractual obligation with your insurance company and are patient responsibility.
- **SCREENING COLONOSCOPY**- Prior to scheduling a screening colonoscopy, you will have a pre-op exam in the office. The office exam is NOT part of the procedure and will be billed to your insurance carrier. This office visit may be subject to your deductible or co-insurance depending on your insurance plan.
- **NON-COVERED SERVICES** – Please be aware that some or all of the services provided may not be covered or not considered reasonable or necessary by some insurers. It will be your responsibility to pay for these services.
- **CHANGE IN COVERAGE** - If your insurance coverage changes, please notify us as soon as possible, so we can make the appropriate changes to help you receive your maximum benefits.
- **USUAL AND CUSTOMARY** – Our prices are representative of the usual and customary charges for our geographic area. You are expected to pay in full for any balance after insurance.

\_\_\_\_ (Initial) **NON-PAYMENT** – If your account is thirty days past due, you may be contacted by our billing department asking for payment in full or to make payment arrangements. If your balance is unpaid after three months, we may refer your account to Cornerstone Credit Services, a collection agency.

\_\_\_\_ (Initial) **CREDIT BALANCE** – A refund will be generated to the responsible party if an account has a credit balance over \$10.00. Balances less than \$10.00 will be retained and applied to future balances unless a refund is specifically requested.

\_\_\_\_ (Initial) **NO SHOW POLICY** – any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least a 24-hour notice will be considered a ‘No Show’ and charged a \$75.00 fee.

\_\_\_\_ (Initial) **SELF-PAY ACCOUNTS** – You are required to bring a minimum of \$200 toward the initial office visit. If the total balance due is more than you are able to pay at time of service, reasonable payment arrangements may be made by signing a self-pay financial agreement.

---

*I acknowledge that I have read and agree to the above Financial Policy.*

**X**

---

**Patient Signature/Responsible Party**

**Date**