

PATIENT IDENTIFICATION SECTION

Patient's Legal Name _____
(LAST) (FIRST) (MIDDLE)

Rex Healthcare will compare your Legal Name to your name as it appears on your insurance card.

Sex _____ Social Security # _____ Birth Date _____ Age _____

Reason for visit _____

PATIENT INFORMATION

Race _____ Non Hispanic _____ Hispanic _____ Marital Status _____

Mailing Address _____

Physical Address (if different from mailing address) _____

City _____ State _____ Zip Code _____

County _____ Country _____

Home Phone # _____ Cell Phone _____

Primary Spoken Language _____

Church/ Place of Worship _____ Religious Denomination _____

Email Address _____

Mother's Maiden Name (Last and First) _____

Referring Physician _____ Phone _____

Primary Care Physician _____ Phone _____

PATIENT'S EMPLOYMENT INFORMATION

Employment Status: Full-time _____ Part-time _____ Retired _____

Retirement Date (if applicable) _____

Employer's Name _____

Employer's Address _____

City _____ State _____ Zip Code _____

Phone # _____ Extension _____

GUARANTOR INFORMATION (Person Financially Responsible if different than patient)

Name of Guarantor _____ Relationship to Patient _____

Social Security # _____ Sex _____ Birth Date _____

Mailing Address _____

Physical Address (if different from mailing address) _____

City _____ State _____ Zip Code _____

Home Phone # _____ Employment Status _____

Employer's Name _____ Work Phone # _____

Full Time Student? Y / N

EMERGENCY CONTACT

Name of Emergency Contact _____ Relation to Patient _____

Mailing Address _____

Physical Address (if different from mailing address) _____

City _____ State _____ Zip Code _____

Home Phone # _____ Work Phone # _____

Cell Phone # _____

Patient Signature: _____ Date: _____

Patient's Name _____ Birth Date _____

PRIMARY INSURANCE

Name of Insurance Company _____

Insurance Plan Name as it Appears on Insurance Card _____

Policyholder's Name _____

Patient's Relation to Policyholder _____

Policyholder's Birth Date _____ Policyholder's Sex _____

Policyholder's Policy Number _____ Patient's Policy Number _____

Group Name (Employer Name) _____ Group Number _____

Customer Service Phone # _____

Claims Address _____

City _____ State _____ Zip Code _____

SECONDARY INSURANCE

Name of Insurance Company _____

Insurance Plan Name as it Appears on Insurance Card _____

Policyholder's Name _____

Patient's Relation to Policyholder _____

Policyholder's Birth Date _____ Policyholder's Sex _____

Policyholder's Policy Number _____ Patient's Policy Number _____

Group Name (Employer Name) _____ Group Number _____

Customer Service Phone # _____

Claims Address _____

City _____ State _____ Zip Code _____

MEDICAL INFORMATION

Are you enrolled in a Hospice Program? _____

If yes, is this service related to your hospice diagnosis? _____

If yes, which Hospice agency are you enrolled with? _____

ACCIDENT INFORMATION (Complete this section ONLY if your condition is accident related)

Type of Accident (Auto, Work, Other) _____

Accident Date and Time _____ State of Accident _____

Place of Accident and County _____

Description of Accident _____

Patient/Authorized Representative Signature _____

Date Signed _____

Patient's Name _____

Birth Date _____

I plan to make payment of my medical expenses as follows:

____ Cash/Check

____ Master Card/Visa

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:

I authorize treatment of the person named above and agree to pay all charges for such treatment. I agree to pay all charges for me and all dependents shown by statements, promptly upon presentation thereof, unless credit arrangements are agreed upon in writing. It is agreed that payment will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.)

Signature _____

Date _____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the physician to release any information acquired in the course of my examination or treatment to specific insurance carriers, third party payers or others involved in processing and collection of this claim.

Signature _____

Date _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES:

I hereby acknowledge that I have received a copy of Raleigh Surgical Specialists' Notice of Privacy Practices. This notice describes how information about me may be used or disclosed, in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Signature _____

Date _____

Past Medical History - please circle all medical problems you have had in the past:

EYES
 Blindness, Explain
 Glaucoma

EARS, NOSE & THROAT
 Deafness/Hard of Hearing

CARDIOVASCULAR
 Angina
 Heart Murmur
 Mitral Valve Prolapse
 Heart Attack, date:
 High Blood pressure
 High Cholesterol
 Congestive Heart Failure
 Stroke, date:
 Atrial Fibrillation
 AAA
 Coronary Artery Disease

RESPIRATORY
 Asthma
 COPD/Emphysema
 Tuberculosis, date:
 Bronchitis
 Sleep Apnea
 Pneumonia

GASTROINTESTINAL
 Colitis
 Colon Polyp
 Cirrhosis of Liver
 Diverticulosis/Diverticulitis (circle one)
 Gallstones
 Hepatitis, type:
 Stomach Ulcers
 Crohn's
 Hemorrhoids
 IBS
 Reflux

SKIN
 Skin Disorder, Explain:
 Melanoma, date:

URINARY
 Urinary Incontinence
 Kidney Failure
 Kidney Stones

NEUROLOGIC
 Epilepsy/Seizures
 Paraplegia/Quadriplegia
 Headache
 Parkinson's

PSYCH
 Depression
 Alzheimers

HEMATOLOGIC/LYMPHATIC
 HIV/AIDS, date:
 Poor Blood Clotting
 Anemia
 Sickle Cell Anemia
 Blood Clots legs/lungs

MUSCULOSKELETAL
 Arthritis
 Fibromyalgia
 Gout
 Osteoporosis

ENDOCRINE
 Lupus
 Thyroid Disorder, type:
 Diabetes, type:

CANCER
 Type & Date:
REPRODUCTIVE
 Is there a chance you could be pregnant?
 Endometriosis
 Pelvic Inflammatory Disorder

OTHER CONDITIONS NOT LISTED ABOVE:

Past Surgical History
 Please list all operations you have had in the past:
 None

Do you have a Pacemaker or Defibrillator:
 Yes No

Medications
 Please list all your current medications you are presently taking (include doses): None

Medication	Strength	Dose

Allergies
 Please list all medicines you are allergic to or have a reaction to:
 Latex None

Other: _____

Family Medical History
 Please list all medical problems which run in your family:

Will you accept blood or blood products?
 Yes No

Habits
 Do you smoke cigarettes?
 No
 Occasionally
 1/2 ppd
 1 ppd

If you smoked in the past, when did you quit?
 Caffeine intake
 Amount: _____

Do you drink alcohol?
 Never
 Occasionally
 a few times a week
 daily

IV Drug Use
 Never
 Occasionally
 a few times a week
 daily

Have you recently had any of the following symptoms? Please circle all that apply:

GENERAL
 weight loss - weight gain
 fever
 excessive thirst
 sweats
 chills
 decreased appetite
 enlarged lymph nodes
 fatigue

EYES
 loss of vision
 double vision

EARS, NOSE & THROAT
 hearing loss
 nose bleed
 sinus congestion
 hoarseness
 sore throat
 sinus problems
 trouble swallowing

LUNGS
 chronic cough
 coughing blood
 painful breathing
 recent cold
 shortness of breath
 coughing phlegm
 wheezing

HEART
 irregular heart beat
 chest pain
 palpitations
 swelling in feet

STOMACH/INTESTINES
 abdominal pain
 abdominal bloating
 constipation
 diarrhea
 change in stools
 heartburn
 nausea
 rectal bleeding
 vomiting

KIDNEY/GENITALS
 painful urination
 bloody urine

MUSCLES/BONES
 joint pain
 arthritis

NERVOUS SYSTEM
 headache
 numbness
 tingling
 dizziness

SKIN
 jaundice
 rash

BREAST
 breast discharge
 breast pain

PSYCHIATRIC
 depression
 insomnia

BLOOD
 easy bleeding

OTHER:

**MEDICARE SECONDARY PAYER
QUESTIONNAIRE**

**Place
Patient Identification
Label Here**

1. **Is the patient receiving Black Lung benefits?** Yes No Date Began: _____
2. **Are these services covered by a government program such as a research grant?** Yes No
3. **Has the Department of Veteran Affairs authorized and agreed to pay for these services?** Yes No
4. **Is this illness/injury accident related?** Yes No If yes, complete the accident information below
Type of accident: Auto Crime Employment Other
Accident Date: _____ Accident Time: _____ Place/Location of Accident: _____
Description of Accident: _____
5. **Was the illness/injury due to a work-related accident/condition?** Yes No
If, yes: Please complete questions sections
Worker's Comp Employer: _____ Worker's Comp Insurance: _____
Worker's Comp Policy #: _____ Claim's Address: _____
6. **Did an automobile accident cause the illness/injury?** Yes No
If, yes: Please complete sections below
No-Fault/Liability Insurance Name: _____ Policy #: _____
Name of Insured: _____ Claim's Address: _____
7. **Is the Patient entitled to Medicare based on (A)ge, (D)isability, or (E)SRD-End Stage Renal Disease?** _____
If Medicare is based on ESRD entitlement, complete questions below:
Has the patient received a kidney transplant? Yes No Transplant Date: _____
Has the patient received dialysis: Yes No Date Started: _____
Date Self Dialysis Training Program Started: _____
Is the patient within the 30-month coordination period? Yes No
Is patient entitled to Medicare based on ESRD and Age or ESRD and Disability? Yes No
Was the patient's initial entitlement to Medicare based on ESRD? Yes No
Does the working aged or disability MSP provision apply? Yes No
8. **Is the patient currently employed?** Yes No
Employer Name: _____
Employer Address: _____
9. **Is the patient retired?** Yes No Retired Date _____
10. **Patient's spousal information:** Married/Separated Divorced/Widowed/Single
If Married or Separated, complete the sections below
Is patient's spouse/family member currently employed? Yes No
Spouse's/Family member's Employer Name: _____
Employer Address: _____

If Retired, Retirement date: _____

**MEDICARE SECONDARY PAYER
QUESTIONNAIRE**

11. Does patient have group health plan coverage based on his own, or spouse's current employment? Yes No

Group Health Plan Name: _____

Policy Number: _____

Policy Holder: _____ Group#: _____ Relative: _____

12. If Entitlement is based on Age, (per question #7)

Does the group health plan employer employ 20 or more employees? Yes No

13. If Entitlement is based on Disability, (per question #7)

Does the group health plan employer employ 100 or more employees? Yes No

Patient's /Auth Rep. Signature

Date

Document date patient information was verified and updated.

Signature (employee)	Date	Signature (employee)	Date



Date _____

Authorization for Release of Patient Information

Name of Patient _____ Date of Birth _____

Wake Surgical Specialists is authorized to release protected health information pertaining to the above named patient to the entities below.

Entity to Receive Information (Initial each that is subject to this information)

____ Leave information on voice mail _____ Give information to spouse
____ Give information to the following persons: _____ Relationship
____ Employer FMLA/Disability Insurance

Description of Information to be Released (Initial each that is appropriate)

____ Financial Information
____ Results from tests and/or x-rays
____ Family Billing Information
____ Disability Insurance/FMLA Forms/Medical Insurance
____ Medical Information as follows: _____
____ Other information as described: _____
____ I do not authorize the release of any information at this time.

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected information to be disclosed as describe in this document by sending a written notification. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal and State Law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

Signature of Patient or Personal Representative

Date

Health Insurance Portability and Accountability Act

Confidentiality Policy

POLICY

Wake Surgical Center is entrusted by its patients and required by law to ensure the security of individually identifiable health information. This protected health information is preserved by law and regulatory requirements and these laws and regulatory requirements to be upheld by each individual involved with this organization.

- We are subject to the compliance of the law as we are a health care provider and we maintain and transmit health information in electronic form in connection with transactions referred to as claims, encounters, eligibility, referrals, payments, electronic remittance, coordination of benefits, claim status, first report of injury, health claim attachments and any other transactions as the Secretary may prescribe by regulation.
- We are permitted to use and disclose protected health information for the purpose of treatment, payment and health care operations.
- We shall make all reasonable efforts not to use or disclose more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use or disclosure.
- When making disclosures to public officials we will reasonably rely on the representations of such officials that the information requested is the minimum necessary for the stated purpose(s).
- We may use or disclose any de-identified protected health care information provided that the key or other devices designed to enable coded or otherwise de-identified information is not used or provided.
- We recognize all individually identifiable health information identifiers as created, received and used within our electronic computer systems and will make every reasonable effort to ensure they are secure in our environment. These identifiers are listed as:

Name, address (street, city, county, zip code, geocode), names of relatives, names of employers, birth date, telephone numbers, fax numbers, social security number, medical record number, account number, health plan beneficiary number, certificate or license number, E-mail address, IP address, vehicle or other device serial number, Web URL, finger or voice prints, photographic images, and any others added by the Secretary in future regulations

- The death of a patient does not terminate his rights to protection of health information. We shall apply all reasonable efforts to protect the individually identifiable health information of a deceased individual in the same manner we protect the living. This policy shall be in effect for two years following the death of the individual.
- I give my physician permission to communicate health information via my answering machine or voicemail.

Signature: _____ Date: _____

By signing above, I acknowledge receipt of the privacy policy as outlined by the Health Insurance Portability and Accountability Act. A general notice of privacy practices is available on request.