Patient Information

Patients Name: ______________________________ Social Security #: ______________________
Date of Birth: ________________ Sex:_____ Relationship Status: _________ Driver's License:__________
Home Address: _________________________ City:______________ State:______ Zip:______
Home Phone #:___________________ Work Phone #:________________ Cell Phone #:___________
Employer: ________________________________ Occupation:___________________________
Work Address: _________________________ City: ______________ State: ______ Zip: ______
In Case of Emergency, Notify: ____________________ Relationship: __________ Phone #: ________
Primary Care Physician: _________________________ Referred By: _________________________

E-Mail Address: __________________________________ Preferred Language: _________________
***(Please provide so we may invite you to use our Web-based Patient Portal)
Race: □ African American, □ American Indian, □ Asian, □ Hispanic, □ Native Hawaiian, □ Other Pacific Islander, □ White, □ Decline
Ethnicity: □ Not Hispanic or Latino, □ Hispanic or Latino, □ Decline

Insurance Information

Primary Insurance:_________________ HMO PPO Other Member ID#: _____________ Group #: ______
Subscriber Name:____________________________ Social Security #: ______________________
Date of Birth: ___________________ Relation to Patient: ________________________________
Subscriber's Employer: (Same as above) _____________________ Work Phone #: ________________
Claim Address: _________________________ City:______________ State:______ Zip:______

Secondary Insurance:_________________ HMO PPO Other Member ID#: _____________ Group #: ______
Subscriber Name:____________________________ Social Security #: ______________________
Date of Birth: ___________________ Relation to Patient: ________________________________
Subscriber's Employer: (Same as above) _____________________ Work Phone #: ________________
Claim Address: _________________________ City:______________ State:______ Zip:______

Is this a work related injury? Yes No

***If the patient has an HMO insurance, a referral from the PCP is required to allow the patient to be seen by our surgeons. If the patient does not have a valid referral at the time of the appointment, we will offer to reschedule the appointment until a referral is obtained or see the patient on self pay basis.**

Responsible Party Information (if other than patient)

Guarantor Name: ____________________________ Social Security #:______________________
Date of Birth: ________________ Sex: _____ Marital Status:__________ Driver's License:__________
Home Address: _________________________ City:______________ State:______ Zip:______
Home Phone #:___________________ Work Phone #:________________ Cell Phone #:___________
Employer: ________________________________ Occupation:___________________________
Work Address: _________________________ City: ______________ State: ______ Zip: ______

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Nicole Basa, MD and Alan R Abando, MD when she/he accepts assignment.

Authorization To Release Medical Information. I hereby authorize my Provider, Nicole Basa, MD and Alan R Abando, MD to release any information necessary for my course of treatment.

_______________________________ _________________

Patient /Guardian (If Patient is a minor) Signature **Date**

«PName»

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made:
Full Name: ____
Other Name(s) Used: ________________________ Date of Birth: _____________________
Address: ________________________ City: _____________ State:______ Zip Code:_______
Phone: (_____) _____________________ Email (*Optional*): __________________________

Information regarding health care provider or health care entity authorized to disclose this information:
Name: Cedar Park Surgeons, PLLC
Address: 1401 Medical Pkwy B, Suite 101 City: Cedar Park State: TX Zip Code: 78613
Phone: (512) 260-3444 Fax: (512) 260-3555

Information regarding person or entity who can receive and use this information:
Name: ____
Address: ________________________City:_____________ State:________ Zip Code:_______
Phone: (_____)_____________________ Fax: (_____)_____________________________

Specific information to be disclosed:
☐ Medical Record from (insert date) ________________ to (insert date) ________________
☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.
☐ Other: ____

Include: (*Indicate by Initialing*)
________ Drug, Alcohol or Substance Abuse Records
________ Mental Health Records (Except Psychotherapy Notes)
________ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)
________ Genetic Information (Including Genetic Test Results)

Reason for release of information:
(Choose all that Apply)
☐ Treatment/Continuing Medical Care
☐ Personal Use
☐ Billing or Claims
☐ Insurance
☐ Legal Purposes
☐ Disability Determination
☐ School
☐ Employment
☐ Other *(Specify)*: ________________

«PName»

<u>The individual signing this form agrees and acknowledges as follows:</u>

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date:
Month: ________ Day: ________ Year: _________.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative: ____ Date: ________________

If Legal Representative, relationship to Patient: ____

Witness (optional): ____ Date: _________________

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): ____________________________________Date: _________________

«PName»

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept VISA, MasterCard, Discover, and American Express.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. Patient will be responsible for copayment, coinsurance and deductible at the time of service.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- Our policy is to prepare an estimate for your surgery and collect the estimated amount prior to your surgery. Any balance due is your responsibility and is due upon receipt of a statement from our office.
- I understand that I will be legally responsible for all collection costs involved with the collection of this account if I default on this agreement.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

Disability/FMLA Forms, etc.

- For any form(s) that need to be filled out by the office staff other than a return to work/school note, there will be a fee of $25 collected when requested.

Medical Records

- A charge of $25.00 is required for the first 20 pages. Every page after 20 pages is an additional $0.50.

HIPAA- Patient Consent for Use and Disclosure of Protected Health Information

I have the right to review the Notice of Privacy Practices prior to signing this consent (posted in the waiting room). **Cedar Park Surgeons, PA** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: **Privacy Officer @ Cedar Park Surgeons**, **1401 Medical Parkway B, Ste. 101**, **Cedar Park, Texas 78613**

With this consent, **Cedar Park Surgeons, PLLC** may mail to my home or other alternative location any items that assist the practice in carrying out TPO (Treatment, Payment, and Operation) such as appointment reminders and patient financial statements.

With this consent, **Cedar Park Surgeons, PLLC** may speak with the person listed as the emergency contact to assist the practice in carrying out TPO, such as discussing any open or unpaid balances of my financial account, including visit reason and insurance related matters.

I have the right to request that **Cedar Park Surgeons, PLLC** restrict how it uses or disclosed my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Cedar Park Surgeons, PLLC** to use and disclose my PHI to carry out TPO.

If I do not sign this consent, or later revoke it, **Cedar Park Surgeons, PLLC** may decline to provide treatment for me. Restrictions to this consent could create situations which our practice is unable to maintain our standard TPO.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

____
Printed Name of the Patient

____ ____________________
Signature of Patient or Responsible Party if a Minor Today's Date (Required Renewal Yearly)

Patient's Name: _______________________________ DOB:______ Date: __________________________
Purpose of Visit: ____

Have you had any of the following done recently?:

X-ray: Yes No Date performed: _________ where was it performed? ____________________

Lab work: Yes No Date performed: _________ where was it performed? ____________________

** Hemoglobin A1C: Most Recent Date Performed: _______________ What was the Level: ____________________

Ultrasound: Yes No Date performed: _________ where was it performed? ____________________

MRI: Yes No Date performed: _________ where was it performed? ____________________

CT Scans: Yes No Date performed: _________ where was it performed? ____________________

Mammogram Yes No Date performed: _________ where was it performed? ____________________

Colonoscopy Yes No Date performed: _________ where was it performed? ____________________

List all Medical Conditions that you are currently being treated for or have been treated for in the past:

____

____

____

____

List all Surgeries or Procedures, and the year:

Surgery/Procedure	Year	Facility

Current Medications (please list over-the-counter medications) including Herbal Supplements and Multi Vitamins.
****You may also attach a list of your medications. **Please notify our office of any medication changes at each visit.**

Medication	Dose	Frequency	Medication	Dose	Frequency

**** Are you taking Aspirin, Ibuprofen, Coumadin, Beta Blockers, or any Blood thinners? Yes No Please List:**

____

Allergies to Medications: Yes No if yes, please explain reaction: ______________________________

____

Pharmacy: Name_________________________Location____

Do you smoke: Yes No How many packs a day_____ for______ years. Year you quit? ________________

Do you drink alcohol: Yes No How many drinks per day/week (circle one) ______________________

Do you use any illicit drugs Yes No If yes, please explain ____________________________________

List any medical illnesses that run in your family (include which family member): ____________________

____

If under 18 years old: Grade in school: ________ Are your immunizations up to date? Yes No

«PName»

CEDAR PARK
SURGEONS

Patient's Name: ______________________________ Date: __________________

Review of Symptoms: Have you recently had any of the conditions below? If so, please check **ALL** applicable boxes below:

General:
☐ Chills
☐ Fatigue
☐ Fevers
☐ Weight Gain
☐ Weight Loss

Skin:
☐ Bruising
☐ Changes in wart/mole
☐ Excessive Sweating
☐ New Lesions
☐ Skin Color Changes

Eyes/Ears/Nose/Throat/Mouth:
☐ Headache
☐ Head Injury
☐ Blurred Vision
☐ Double Vision
☐ Eye Pain
☐ Hearing Loss
☐ Deafness
☐ Spinning Sensation
☐ Nose Bleed
☐ Frequent Colds
☐ Nasal Congestion
☐ Seasonal Allergies
☐ Hoarseness
☐ Sore Throat

Neck:
☐ Neck Mass
☐ Neck Pain
☐ Neck Stiffness
☐ Swollen Glands

Respiratory:
☐ Chronic Cough
☐ Difficulty Breathing
☐ Snoring
☐ Wheezing

Cardiovascular:
☐ Calf Cramps
☐ Chest Pain
☐ Difficulty Breathing Lying Down
☐ Elevated Blood Pressure
☐ Fainting

Cardiovascular:
☐ Heart Attack
☐ Irregular Heart Beat
☐ Leg Pain/Swelling
☐ Palpitations
☐ Rapid Heart Rate
Date of occurrence ____________
☐ Varicose Veins
*Are you taking Aspirin for any of the above?*_____

Gastrointestinal:
☐ Abdominal Mass
☐ Abdominal Pain
☐ Bloating
☐ Black, Tarry Stool
☐ Bloody Stool
☐ Constipation
☐ Hemorrhoids
☐ Heartburn
☐ Nausea
☐ Rectal Bleeding
☐ Vomiting

Musculoskeletal:
☐ Back Ache
☐ Joint Pain
☐ Joint Swelling
☐ Leg Cramps
☐ Muscle Cramps
☐ Muscle Weakness
☐ Swelling to Extremities

Neurological:
☐ Decreased Memory
☐ Difficulty Speaking
☐ Numbness
☐ Headaches
☐ Seizures
☐ Stroke
☐ Visual Changes
☐ Weakness

Psychiatric:
☐ Anxiety
☐ Depression
☐ Hallucinations
☐ Insomnia
☐ Panic Attacks

Endocrine:
☐ Appetite Changes
☐ Excessive Thirst
☐ Excessive Urination
☐ Heat Intolerance
☐ Thyroid Problem

Hematology:
☐ Anemia
☐ Blood Clot
☐ Easy Bruising
☐ Enlarged Lymph Nodes
☐ Excessive Bleeding
☐ Spontaneous Bleeding

Immunologic:
☐ HIV/AIDS
☐ Hepatitis (A,B,or C)

Men Only:
☐ Prostate Disease
☐ Testicular Lump
☐ Testicular Pain
☐ Venereal Disease

Women Only:
Last Menstrual Period Started: ______
Number of Pregnancies: __________
Number of Deliveries: ___________
Last Pap Smear (date): ___________
☐ Menstrual Irregularities
☐ Menopause, age? ________
☐ Vaginal Discharge
☐ Venereal Disease

Breast:
☐ Breast Mass/Lump
☐ Breast Pain
☐ Monthly Self Exam
☐ Nipple Discharge

FOR OFFICE USE ONLY
Weight:
Height:
Temperature:
Pulse
Respiration:
O2:
Blood Pressure:

Risk Assessment for Common Hereditary Cancer Syndromes

Patient Name:____Physician Name____

Date of Birth:____Today's Date: ____

This is a screening tool for the common features of hereditary cancer syndromes. Please mark below if either **you or a family member** has a history of any of the following cancers. If yes, then indicate **who had the cancer** & **age of diagnosis** in the appropriate column (**i.e. Grandmother age 45**). Consider all the following relatives: Mother/Father, Sister/Brother, Children, Aunt/Uncle, Grandparents, Niece/Nephew, Great Grandparents, Great Aunt/Uncle, Cousin

			You	**Siblings/Children**	**Mother's Side**	**Father's Side**
	N	Breast Cancer				
Y	N	Ovarian Cancer				
Y	N	Breast Cancer in both breast OR multiple primary breast cancers				
Y	N	Male Breast Cancer				
Y	N	Triple Negative Breast Cancer (ER, PR, HER2 negative)				
Y	N	Pancreatic Cancer				
Y	N	Prostate Cancer				
Y	N	Uterine (endometrial) cancer				
Y	N	Colon Cancer				
Y	N	Stomach, kidney/urinary tract, brain, small bowel cancer, biliary tract OR intestine cancers				
Y	N	10 or more colon polyps found in a lifetime				
Y	N	Melanoma (not basal cell or squamous cell cancer)				

Are you of Ashkenazi Jewish descent? YES NO

Is there a known BRCA 1 or 2 mutation OR Lynch mutation in your family? YES NO

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Patient offered genetic testing: Accepted OR Declined

Patient's signature:____**Today's Date:**__________________

Healthcare Provider's signature: ____ **Today's Date:** _________________