MERIDIAN SURGICAL, P.C.

PATIENT QUESTIONAIRE

PLEASE ANSWER ALL QUESTIONS BELOW

Date: _____

Patient Name: _____

Age: _____ Occupation: _____

Primary Care Physician: _____

Referring Physician: _____

What problem brought you here today? _____

How long have you had this problem? _____

Have you ever had the following?

Yes	No		Yes	No	
___	___	Heart Disease	___	___	Ulcers
___	___	Rheumatic Fever	___	___	Arthritis/Joint Problems
___	___	Mitral Valve Prolapse	___	___	Artificial Joints
___	___	Artificial Heart Valve/Pacemaker	___	___	Gastroesophageal Reflux
___	___	High Blood Pressure	___	___	Thyroid/Endocrine Disease
___	___	Stroke	___	___	Sleep Apnea
___	___	Vascular Disease	___	___	Gallbladder Disease
___	___	Blood Clots	___	___	Depression
___	___	Cancer	___	___	Seizures
___	___	Emphysema	___	___	Glaucoma
___	___	Asthma	___	___	HIV / AIDS
___	___	Breast Disease	___	___	Liver Disease
___	___	Infectious Disease (TB, HIV, Hepatitis)	___	___	Diabetes (NIDDM)
___	___	Other Illness or Medical Problems: _____			

List any surgery you have had and when/where performed:

_____

_____

_____

Have you taken cortisone / steroids in the past six months? _____ If yes, what type? _____

Are you taking any blood thinners (ie, Coumadin, Lovenox, etc.)? _____

List all medications you are taking:

_____

_____

_____

List any allergies: _____

Current/Previous tobacco use? _____ How much per day? _____

Do you drink alcohol? _____ How much per day? _____

Are you currently having any of the following?

Yes	No		Yes	No	
___	___	Marked weight change	___	___	Persistent fever
___	___	Night sweats	___	___	Skin rash
___	___	Vision changes	___	___	Difficulty hearing
___	___	Frequent nosebleeds	___	___	Bleed / bruise excessively
___	___	Hoarseness	___	___	Numbness / tingling
___	___	Coughing up blood	___	___	Vomiting up blood
___	___	Difficulty breathing when lying down	___	___	Chest pain
___	___	Ankle swelling	___	___	Abdominal pain
___	___	Black, bloody, or pale stools	___	___	Bloody urine

For women:

___ ___ Are you pregnant? LMP: _____

_____ _____

Physician's Signature **Date**

MERIDIAN SURGICAL, P.C.

PATIENT REGISTRATION

Welcome to our office. In order to serve you properly, we will need the following information. (Please print)
All information will be kept strictly confidential.

Patient Demographic Information

Patient's Full Name:	Sex: M F	Marital Status: S M D W O Birth Date: ___/___/___	Social Security Number: ___-___-___
Address: City St Zip			Home Phone:
Person responsible for this account: Self Spouse Parent Other:___		Responsible Party's Date of Birth: ___/___/___	Responsible Party's Social Security # ___-___-___
Email Address:			Cell Phone ( )
Patient's Employer:	Address: City St Zip		Work Number:
Name of Spouse / Parent:	Birth Date: / /	Social Security Number: ___-___-___	Business Phone:
Person to contact in case of an emergency:	Relationship to Patient:	Phone Number:	Other Phone Number:
Name of Referring / Primary Care Physician:	Address: City Zip		Office Phone Number:

Insurance Information

Primary Insurance Company Name:	Address: City St Zip		Phone Number:
Insured's Name:	Insured's Date of Birth: ___/___/___	Insured's Social Security Number: ___-___-___	Relationship to Patient:
Secondary Insurance Company Name:	Address: City St Zip		Phone Number:
Insured's Name:	Insured's Date of Birth: ___/___/___	Insured's Social Security Number: ___-___-___	Relationship to Patient:

Internal Use

Consent signed ___Y ___N Authorization ___Y ___N ___N/A Privacy Policy ___Y ___N

CS Sig:_____ Date: _____

MERIDIAN SURGICAL, P.C.

FINANCIAL POLICY

We recognize the need for a definite understanding between the patient and the doctor concerning health care and the financial arrangements for this medical care. The following is a statement of our Financial and Office Policy. Please read and sign that you fully understand your responsibilities regarding all services rendered for Meridian Surgical P.C.

OFFICE FORMS

All forms must be completed and signed prior to seeing the doctor.

We understand that some people may have some concerns providing specific information requested on our forms. Note that all information requested is required for payment, treatment or operations. Should this be of concern to you and you, for some reason, do not want to provide information requested, please be prepared to pay for all services required in full at the time of service or prior to any scheduled visits or procedures. Should you have any questions regarding this matter, please ask to speak with the office manager.

FEES

ALL COPAYS, DEDUCTIBLES AND CO-INSURANCE FEES REPORTED BY INSURANCE COMPANIES ARE DUE PRIOR TO SERVICES RENDERED

A $25 Penalty Fee Will Be Applied To Any "No Shows" or CoPays Not Paid On The Date Of Service.

For your convenience, we accept Cash, Checks, Visa, Discover, and Mastercard

Return Check or Charge Back Fee is $35.00

A $15 Monthly Rebilling Fee Will Be Included On All Statements With Patient Balances Over 30 Days.

OTHER MEDICAL FORMS

The completion of disability forms, FMLA forms, attending physician statements, and other supplemental insurance forms all require office supplies, physician and staff time to complete, therefore a $35 fee for each form will be charged and must be pre-paid. Note, there will be a 14 day turnaround time for completion, so make arrangements accordingly. Non-standard or multiple page forms may result in a higher rate.

REFERRALS

If your insurance plan is a plan that requires a referral to be seen by a specialist, we ask that you obtain that referral directly from your primary care physician and bring it with you. This will prevent any appointment rescheduling or delays. Due to certain managed care requirements we are unable to request or obtain patient referrals directly from the primary care physicians.

Patient Initials: _____

Assignment of Benefits Form
Meridian Surgical, PC

I, _____ (Print Name) with insurance benefits through (Employer Name) _____ (Medicare, Medicaid or Individual Plan), as well as my governing Health and Welfare Plan, hereby authorize all entitled benefits under my governing Plan / Policy to be paid directly to the provider listed above for all services rendered. I understand that I am entitled to all benefits that my Health and Welfare Plan is legally obligated to provide, including any legal claim to benefits under the governing Plan. I understand that my Plan Sponsor and Health Insurance Issuer are both required to accept and honor this agreement for all services rendered, in full compliance of all governing state and federal laws. This authorization includes any and all rights permissible under my governing Health and Welfare Plan; applicable Social Security Act; Federal, City or State Government program; as well as state and federal law related to all services rendered. I understand this authorization also covers any and all other providers of service directly associated with services rendered and requested by the above provider, including but not limited to all providers involved with surgical related services, including surgical assistants, anesthesiology services, diagnostic testing, labs, pathology, radiology, implants, tissues, or any other services as ordered or requested by the provider above and entitled under my governing Plan. I appoint and authorize the above provider and business associate appointed by the provider as my duly authorized and personal representative relating to all services rendered, rights of appeal, rights of disclosure and remedy due me under law.

I hereby certify that all insurance information provided is true and accurate and that I am responsible for keeping it updated. I understand that failure to provide accurate insurance information and coordination of benefit coverage at the time of service or any failure to cooperate with the provider to the fullest extent requested to obtain full entitled reimbursement for all services rendered will result in my full financial responsibility of all services rendered. I hereby authorize the Provider listed above to submit claims, on my behalf, to the insurance company responsible for administering entitled benefits for all services rendered in good faith. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure the claim is paid in full and in full compliance of applicable state and federal laws. I also understand I may be responsible for any and all amounts not payable by my insurance company including any portion paid and not applied to in network benefits for any out of network services, non covered services, services determined by the insurer as not medically necessary, or any failure by my insurer to comply with all governing and applicable laws. I agree to cooperate with all providers listed in this agreement in any attempts by such provider to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with provider against such insurers and/or employee health care plan for failure to pay all entitled benefits or provide all protected rights.

I hereby irrevocably designate, authorize and appoint Provider listed above as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of receiving all payments, rights and remedies due under my governing Health and Welfare plan or Policy to include all medical services rendered or to be rendered as ordered by the provider listed above. This power of attorney shall automatically terminate, without formal action being taken, as soon as the above listed healthcare provider/s has received payment in full as entitled under my governing Plan and in full compliance of governing federal and state laws. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. I hereby authorize my Plan and insurer unequivocal assignment and transfer of all entitled plan benefits, all rights under the Plan and federal law of appeal, disclosure, remedies and litigation due me to the Provider listed above and any appointed business associates working with them for the sole purpose of making sure all protected rights and entitled benefits under my specific health and welfare plan of governing law are administered in full compliance and extent of governing law. This authorization includes all protected rights under applicable governing law of entitled benefit administration, submittal of evidence, any request made, to give or receive any notice, receive copies of all relevant documents or data pertaining to my claim or appeal submittals, receive governing plan documents, remedies, request administrative reviews, litigation, or make any statement of fact and law on my behalf to the extent consistent with Federal and state law. This is a direct unequivocal assignment of all rights and benefits under the governing plan/policy/Social Security Act. I understand this payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment where entitled benefits are not paid applicable to governing federal and state laws.

I hereby instruct and direct my Plan or Health Insurance Issuer to pay all entitled plan benefits as required by the governing Plan/Policy directly to any applicable Provider(s) listed above and rendering services following all terms, conditions and requirements of the governing Health and Welfare Plan. I understand under applicable governing law that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I under my protected rights pursuant to applicable state, federal or ERISA law hereby instruct and direct my Insurance Company to provide specific SPD documentation stating such non-assignability clause to myself and the applicable Provider, along with the regulatory guideline that allows for such non-assignability. Upon proof of specified non-assignability documentation, I then instruct that the insurer make out the check to me and mail it directly to the Provider and address listed on the submitted claim for the professional or medical expense benefits, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. I agree and understand that any funds received by my insurance company due for services rendered by any and all healthcare providers listed in this assignment of benefits will be immediately signed over and sent directly to such provider. Upon receipt of said check, I authorize Provider listed above to receive any such checks, endorse them for deposit only, and to deposit and apply all the proceeds toward payment due on my account. I authorize the release of any information pertinent to my case including any and all medical records required for a full and fair review to any business associate, insurance company, adjuster, Plan Sponsor, governmental agency or attorney involved or responsible for making sure all protected rights and entitled benefits are provided pursuant to the governing Plan, state and federal laws. I authorize all applicable Providers listed providing medical services or appointed business associates to be my personal representative, which allows them as my duly authorized representative to: (1) submit any and all claims and appeals when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information, appeals, remedies and protected disclosures from my Plan or insurance company, and (3) initiate formal complaints to any State or Federal agency that has jurisdiction over my insurer and/or plan benefits. Should the account be referred to an attorney or outside agency for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. I understand that all delinquent accounts bear interest or administrative fees at the legal rate. I also agree that any penalties or fines levied against my insurance company will be paid to Provider acting as my personal representative. I understand this assignment will remain in effect until revoked by me in writing except to the extent that the covered entity has already used or disclosed information under the authorization or (b) if the authorization was obtained as a condition of insurance coverage, or other law that provides the insured with the right to contest a claim under the governing Plan/policy. A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ _____

Signature of Patient / Guarantor Date

MERIDIAN SURGICAL, P.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Meridian Surgical, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Meridian Surgical, P.C.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Meridian Surgical, P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Meridian Surgical, P.C., Attn: Privacy Officer at 3655 Sixes Rd, Suite 203, Canton, GA 30114.

With this consent, Meridian Surgical, P.C. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Meridian Surgical, P.C. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Meridian Surgical, P.C. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Meridian Surgical, P.C. restrict how it uses or discloses my PHI to carry out TPO.

However, 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 Meridian Surgical, P.C.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Meridian Surgical, P.C. may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

MERIDIAN SURGICAL, P.C.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I,_____, have had the opportunity to review a copy of Meridian Surgial,
Patient Name

P.C.'s Notice of Privacy Practices.

_____ _____

Signature of Patient Date