General Surgery at Northpointe, LLC

Review of Systems_____
Date

Patient Name: _____ Date of Birth: _____

Primary Care Physician: _____

Pharmacy: _____

CHIEF COMPLAINT: _____

PLEASE ANSWER ALL QUESTIONS

Are you <u>currently</u> experiencing any of the following?

<u>Constitutional:</u>			**<u>Respiratory:</u>**		
Good general healthy	Yes	No	Frequent coughing	Yes	No
Recent weight change	Yes	No	Shortness of breath	Yes	No
Fever	Yes	No	Asthma/wheezing	Yes	No
<u>ENT:</u>			**<u>Neurological:</u>**		
Hearing loss	Yes	No	Seizures	Yes	No
Nose bleeds	Yes	No	Strokes	Yes	No
<u>Cardiovascular:</u>			**<u>Genitourinary</u>**:		
High Blood Pressure	Yes	No	Frequent urination	Yes	No
Heart attack/Heart	Yes	No	Burning/pain urination	Yes	No
Leg swelling	Yes	No	Blood in urine	Yes	No
<u>Gastrointestinal</u>:			**<u>Skin:</u>**		
Trouble swallowing	Yes	No	Rash or itching	Yes	No
Change in bowel	Yes	No	Change in skin color	Yes	No
Nausea/vomiting	Yes	No	Chronic sores on legs	Yes	No
Chronic diarrhea			Varicose veins	Yes	No
Blood in stool	Yes	No	**<u>Hematological/Lymphatic</u>**		
Heart burn	Yes	No	Easily bruise or bleed	Yes	No
			History of blood clot	Yes	No

<u>Endocrine:</u>

Diabetes Yes No If yes type: _____

Have you had any abdominal surgeries? Yes No If yes, please list below:

_____

Any other health issues we need to know about?

_____

<u>Medication List with dosage (all currently taking):</u>

_____

_____

_____

_____ _____

Patient Signature Date

GENERAL SURGERY AT NORTHPOINTE, LLC
PATIENT REGISTRATION FORM

Patient Information

Date: _____ Home Phone: (____)_____ Cell Phone: (____)_____

Name: _____ E-mail: _____
Last Name First Name Middle Initial

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Sex: ☐ **M** ☐ **F** Age: _____ Date of Birth: _____ Race: _____

Responsible Party (If patient is a minor): _____

Relationship to Patient: _____

In case of an emergency who should we notify?

Name: _____ Phone: _____

⇨ (Relationship to patient) _____

Primary Insurance - Yes No

Please provide copy of card

Name of Primary Insurance: _____

If your insurance ID isn't listed on your card, please provide: _____

Secondary Insurance - Yes No

Please provide copy of card

Name of Secondary Insurance: _____

If your insurance ID isn't listed on your card, please provide: _____

Assignment and Release

I, the undersigned certify that I (or for my dependent) assign all insurance benefits to General Surgery at Northpointe, LLC. If any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the name facility to release all information necessary to secure payment of benefits. I authorize the use of my signature on all insurance submissions.

_____ _____ _____

Patient/Responsible Party Signature Relationship Date

General Surgery at Northpointe, LLC

General consent for test, treatment, photo, video and services

I consent to examinations, blood tests (including blood test for communicable diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and /or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments rendered by my physician(s), fellow(s), resident(s) or intern(s).

I agree and understand that all physicians (including fellows, residents and interns) dentists, oral surgeons and podiatrists involved in my care in any way are responsible or liable for the acts or omission of the aforementioned. Service may be performed by independent contractors who are not employed by the facility. I am aware that the practice of medicine is not an exact science; and further understand that no guarantee has been or can be made as to the results of the treatments, care or examination in the facility.

I have been informed of the treatment procedures considered necessary for me and that the treatments/procedures will be directed by a physician and may be performed by such physician and/or one or more additional physicians, fellows, residents, interns and employees or the facility. I understand that one or more physicians, fellows, residents, and /or interns at the facility may treat me or participate in my treatment. I understand that no guarantee or assurance has been made regarding (1) which physician and/or fellows, residents, or interns will treat me or participate in my treatment and/or (2) the results that may be obtained from treatment.

I consent to the photography or video recording, including appropriate portions or my body, for medical and medical records documentations purposes, provided said photographs or video recordings are maintained and released in accordance with protected health information regulations (HIPAA).

The undersigned certifies that she/he has read the forgoing, understands it, accepts its terms, has received a copy of it and is the patient or is duly authorized by the patient as their agent to execute the above.

Patient's Signature or Legal Representative	Date	Time
Relationship to Patient		Interpreter, if utilized
Witness Signature		If Telephone Consent, 2nd Witness Signature

General Surgery at Northpointe, LLC

Financial Agreement Form

Thank you for choosing us as your health care facility. We are committed to excellent patient care. The following is an explanation of our Financial Policy and Agreement, which you must read and sign prior to any current and future medical treatment. All patients must also complete the medical history and insurance form before being seen. The content of this document may not be changed.

RELEASE OF INFORMATION: I agree that General Surgery at Northpointe, LLC (GSNP) may disclose my "protected health information" (PHI) in compliance with HIPAA Privacy Provisions which may include my medical records, to any third-party payers, including, but not limited to health insurers, health care service plans, state and federal agencies, workers' compensation carrier, manufacturers required by FDA to track medical devices. This includes appropriate release and disclosure of my medical records in compliance with privacy provisions when necessary for my treatment and general health. While receiving treatment and/or care, GSNP has permission to disclose pertinent information to family members, friends or designated caregivers who may be present with me. I understand that if I am no present, my personal health information will not be disclosed unless I agree to disclosure.

FINANCIAL AGREEMENT: P**ayment of all insurance co-pays, co-insurance and deductibles are required at the time of service.** Patients who have no insurance are required to pay 100% of service at time of service. If this is impossible, you will need to make payment arrangements with our office prior to any medical services. We accept: cash, checks and major credit cards.

TERMS: Net 30 days from date of invoice unless otherwise indicated above. (If applicable, GSNP will not invoice patient until payment from insurances are received).

- Monthly payments are required on all accounts with outstanding balances. A monthly finance charge of 1.75% per month (21% ANNUAL RATE) will be charged to the amount not paid after 30 days, with a minimum charge of .50¢ per month.
- A **$65.00** fee will be charged on all returned checks
- The undersigned specifically agrees to pay all reasonable attorney fees and court costs in the event legal action is taken to collect on the account. The undersigned further agrees to pay an additional amount representing up to 40% of the principal balance if the amount is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with said collection action processing.

ASSIGNMENT OF INSURANCE BENEFITS: You are responsible for knowing what your insurance covers and the providers and network(s) covered under your health insurance plan. Any service provided, but not covered by your insurance company, will be your responsibility to pay. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and charges to our office. Your bill is your responsibility whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim. I authorize direct payment to GSNP of any insurance benefit. I agree to pay any unpaid balances on my account no more than 30 days after date of service.

MEDICARE CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUESTS: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf.

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES: I understand that there are several types of advance directives; the two most common forms are living wills and durable power of attorney designation. I understand that in the ambulatory care setting, if I suffer a cardiac or respiratory arrest or other life-threatening situation, signing this document grants consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with Federal law, GSNP is notifying you that it will NOT HONOR previously signed advanced directives. If this is not acceptable to you, you must address this issue with our management prior to preforming the procedure.

CANCELLATION/NO SHOW FEES: I acknowledge and understand, that if I do not show for an appointment or cancel within 24 hours of my scheduled appointment, I will be charged a $50.00 fee, that is not covered by insurance and will be paid personally by myself/responsible party.

I certify that I have read this document and am the patient or duly authorized to execute it and accept is terms.

_____ _____

Patient/Responsible Party (Print Name) Relationship to Patient (Self, Parent, etc.)

_____ _____

Signature of Patient/Responsible Party Date

General Surgery at Northpointe, LLC

HIPAA Compliance Patient Consent Form

HIPPA PRIVACY NOTICE: I acknowledge that I have received GSN's HIPPA PRIVACY notice and have had the opportunity to review its content. _____ (please initial)

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Name the member(s) allowed, to discuss your medical condition/billing:

Name	Relationship to patient	Phone Number	Medical/Billing or both
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If other than patient, please state relationship to patient: _____

Signature: _____ Date: _____