CAPITAL SURGICAL ASSOCIATES

PLEASE FILL OUT EACH SECTION COMPLETELY- THANK YOU

PATIENT'S LEGAL NAME		DATE OF BIRTH	SEX M F	AGE	MARITAL STATUS
MAILING ADDRESS		CITY	STATE/ZIP CODE		
PRIMARY PHONE#	CELL PHONE#	WORK PHONE #	PREFERRED CONTACT METHOD		
PATIENT'S EMPLOYER	EMPLOYER ADDRESS	SOCIAL SECURITY #			
RACE	ETHNICITY HISPANIC NON HISPANIC	LANGUAGE			
WHO IS YOUR REFERRING PHYSICIAN?	WHO IS YOUR PRIMARY CARE PROVIDER?	EMAIL			

SPOUSE'S NAME (if married)	SPOUSE'S SSN #	DATE OF BIRTH
SPOUSE'S EMPLOYER	SPOUSE'S PHONE#	
FATHER'S NAME (if minor)	FATHER'S SSN #	DATE OF BIRTH
FATHER'S EMPLOYER	FATHER'S CONTACT PHONE#	
MOTHER'S NAME (if minor)	MOTHER'S SSN #	DATE OF BIRTH
MOTHER'S EMPLOYER	MOTHER'S CONTACT PHONE#	

PLEASE CIRCLE ONE: INSURANCE WORKER'S COMP AUTO OTHER SELF-PAY MEDICARE MEDICAID

WERE YOU INJURED AT WORK? YES NO	WERE YOU INJURED IN AN AUTO ACCIDENT? YES NO
DATE OF INJURY OR ONSET SYMPTOMS	BODY PART INVLOVED

INSURANCE COMPANY NAME (PRIMARY)			**INSURANCE COMPANY NAME** (SECONDARY)		
ADDRESS	PHONE#		ADDRESS	PHONE#	
ID#	GROUP#		ID#	GROUP#	
POLICYHOLDER	BIRTH DATE	RELATIONSHIP	POLICYHOLDER	BIRTH DATE	RELATIONSHIP

EMERGENCY CONTACT INFORMATION

NEAREST FRIEND/RELATIVE NOT LIVING WITH YOU	
RELATIONSHIP	PHONE#

I authorize Capital Surgical Associates to render treatment. I authorize Capital Surgical Associates to release/obtain any medical records/x-rays from any medical care providers and my insurance carrier to facilitate processing of my claims. I authorize my insurance carrier to pay all benefits directly to Capital Surgical Associates. This authorization shall continue to be in force and effect until revoked in writing by me. By signing, I acknowledge that I am ultimately responsible for any and all charges incurred by this office.

SIGNATURE (PATIENT, OR PARENT/GUARDIAN IF UNDER 18)	DATE

CAPITAL SURGICAL
ASSOCIATES

FINANCIAL POLICY

Thank you for choosing us for your healthcare needs. We are committed to providing the best possible care and believe your understanding of your financial responsibilities is an important element of the treatment process.

Your health insurance policy is a contract between you and your insurance company. It is your responsibility to know the specifics of your insurance coverage and benefits, and if you have any questions to inquire before services are rendered.

NEW PATIENTS: You have been asked to fill out our patient information sheet. The accuracy of the information is very important. Please print clearly. Please give us your given name and initial as they appear on your insurance card. If you go by a different name, put it in ( ) by your name. Please bring a current copy of your personal identification and insurance card with you to your appointment. Please bring your referral information.

PAYMENT OF SERVICES: You and your insurance company should settle your bill in full within 60 days from the date of service. We require that co-payment, deductible, and non-covered services be paid at the time of service. If you are not able to make your co-payment, you may be asked to reschedule your appointment. Accounts not paid in full within 120 days are subject to a 1% monthly finance charge.

INSURANCE: The insurance claim will be filed for you based on the information you provide. Please keep the billing office informed of any changes. You are responsible for payment regardless of insurance coverage.

MEDICARE: We are participating providers with Medicare. Please provide us with your secondary insurance information so that we may bill it for you. You will be responsible for any balance up to the Medicare allowable that is not paid by Medicare or the secondary insurance.

PATIENTS WITHOUT INSURANCE: For our patients without health insurance coverage, we require a payment in full for the initial consultation. Patient can be billed 20% of each visit thereafter with payment arrangements set up on the balance. Unpaid balances require payment arrangements through the billing office. Surgical care will require a deposit of no less than 50% of the estimated surgical fee, before the surgery is scheduled. Payment is required at least 72 hours prior to the scheduled procedure. A payment contract stipulating monthly payments is required.

STATEMENTS: You will receive an itemized bill. The statement will indicate if your insurance has been billed. Please do not ignore the bill. We are willing to allow you to make monthly payments.

All payment plans need to be arranged through the billing office. The billing staff is available from 8:30 am to 4:30 pm Monday through Friday. Billing staff can be reached at (208) 375-2782.

We accept cash, debit cards, checks, money orders, VISA, MasterCard, and American Express. There will be a $30 returned check fee assessed to your account on all returned checks.

I acknowledge that I have read, understand, and will comply with this financial policy.

_____ _____

Signature Date

CAPITAL SURGICAL
ASSOCIATES

PATIENT ACT

Should you choose to have surgery with Capital Surgical Associates, you will receive a separate bill from one of the agreed upon facilities based on your needs;

St Lukes,
St Alphonsus,
Treasure Valley Hospital,
Millenium surgery center,

You will also receive a separate bill from one of the following anesthesia groups;

Anesthesia Consultants of TreasureValley,
Boise Anesthesia,
Anesthesia Consultants of Idaho,
Anesthesia Associates of Boise,
Treasure Valley Anesthesia,
Independent Anesthesia.

I understand that there will be a billing from 3 separate facilities for any surgery being done.

Patient signature: _____ Date: _____

CAPITAL SURGICAL ASSOCIATES

DESIGNATION FOR RELEASE OF MEDICAL INFORMATION TO A FAMILY MEMBER, FRIEND OR LEGAL REPRESENTATIVE

Introduction

It is the physician's responsibility to ensure that the physician-patient relationship is confidential. The Health Portability and Accountability Act (HIPAA) will allow physicians to use their professional judgment on disclosing certain personal health information to family, friends, etc. without an authorization. This form is an aid to the physicians in making a determination on disclosing such information. Capital Surgical Associates realizes that there are times when you, the patient, may want another person to be knowledgeable about your medical condition or medical needs. Your doctor wants you to be able, if you so desire, to name a person to whom you want the office staff to speak with about your medical condition. To enable that, we would ask that you complete the form listed below. Please note the following points:

- If you designate no one, Capital Surgical Associates will not release information to any family member, friend or legal representative.
- This Release of Information expires 1 year from the date it is signed.
- This designation is valid until you cancel it in writing.

Designation Statement

I, _____, designate the following person(s) to be able to speak to a physician at Capital Surgical Associates, or other staff member, should it be necessary, on my behalf. I hereby give permission to Capital Surgical Associates through its physicians and staff to release to my designee(s) any information about my medical condition or medical needs or the status of my account and I release Capital Surgical Associates its physicians, and staff, from any claim of confidentiality in connections with the release of this information.

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

Patient's Name:_____ Patient's Signature_____

Date: _____

I decline to designate another person to speak with my physician or clinical staff.

Patient's signature:_____ Date:_____

CAPITAL SURGICAL ASSOCIATES

Jeffrey G. Hessing, M.D.
Timothy E. Doerr, M.D.
Steven W. Williams, M.D.

Lisa Jack
Practice Administrator

West Boise Professional Center
8854 W. Emerald, Ste. 140
Boise, Idaho 83704
(208) 378-2868
(208) 321-4790
Fax (208) 321-4836
Toll Free Numbers
1-888-321-4741
1-877-378-2868

HOSPITAL OWNERSHIP DISCLOSURE

As a patient of ours, your physician may order tests or schedule procedures that are performed at local hospitals. These include (but are not limited to) laboratory tests, X-rays, CAT scans, MRI's, injections and surgical procedures. The physicians in Capital Surgical Associates are investors at Treasure Valley Hospital, which is one of the local hospitals, that provides these services. Our physicians also practice at St. Alphonsus and St Luke's where they do not have an ownership interest. This form is to confirm that you understand, as a patient of ours, you have the right to choose the hospital where you would like to receive your services.

Patient Signature_____Date_____

CAPITAL SURGICAL ASSOCIATES

HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

CAPITAL SURGICAL ASSOCIATES

LISA JACK, PRIVACY OFFICER, 208-321-4790

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Would you like to receive a copy of any amended Notice of Privacy Practices: ☐YES☐ NO (mark one)

If yes, write your email or mailing address to send the amended notice to:_____

Signed: _____Date:_____Birthdate:_____

Print Name:_____ Telephone:_____

If not signed by patient, please indicate relationship:

- Parent or Guardian of minor patient.
- Guardian or Conservator of an incompetent patient
- Beneficiary or Person representative of deceased patient.

Name of Patient: _____

****

FOR OFFICE USE ONLY

- Signed form received by:_____
- Acknowledgement refused:

Efforts to obtain:_____

Reasons for refusal:_____

CAPITAL SURGICAL ASSOCIATES

HIPAA EMAIL CONSENT

VERY IMPORTANT! PLEASE READ!

HIPAA stands for the Health Insurance Portability and Accountability Act

HIPAA was passed by the U.S. Government in 1996 in order to establish privacy and security protections for health information.

Information stored on our computers is encrypted

Most popular email services (ex. Hotmail, Gmail, Yahoo) do not utilize encrypted email.

When we send you an email, our systems are secured but not encrypted. When you send us an email, the information that is sent may or may not be secured or encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.

Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA

The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website.

http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf

The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via encrypted email.

OPTION 1 – **ALLOW** ENCRYPTED EMAIL

I understand the risks on unencrypted email and do hereby give permission to the Capital Surgical Associates to send me personal health information via unencrypted email.

_____ _____ _____ _____

Signature Date Printed Name Print email address

(parent or guardian if patient is a minor)

OPTION 2 – **DO NOT ALLOW** UNENCRYPTED EMAIL

I do not wish to receive personal health information via email.

_____ _____ _____

Signature **Date** **Printed name**

(parent or guardian if patient is a minor)

Please bring completed form to your visit

CAPITAL SURGICAL ASSOCIATES

Name: _____ **DOB:** _____ **Date:** _____

PATIENT PROFILE:

Age:	Marital Status:	Occupation:
Height:	Weight:	BMI:
Do you drink alcohol: Yes ☐ No ☐	If so how much?	
Do you use tobacco? Yes ☐ No ☐ Never ☐	If so how much?	
Have you ever used tobacco?		
Have you ever used recreational drugs? Please Specify.		

What other physicians do you see? (Full names, please) _____

_____

Date of last exam: _____ Date of EKG: _____ Date of blood tests: _____

Do you have a living will or advanced care plan? ☐Yes ☐No

Who is your surrogate decision maker? _____

Have you had an influenza (flu) shot? ☐Yes ☐No

If yes, when? _____

If no, why? ☐Declined ☐Allergic ☐Not Available

PAST MEDICAL HISTORY: (Check all that apply and explain)

	High Blood Pressure		Reflux
	Heart Attack		Strokes
	Congestive Heart Failure		Seizures
	Blood Transfusion		Glaucoma
	Angina		Psychiatric problems
	Heart murmur		Depression
	Irregular heartbeat		Anxiety Reactions
	Lung disease (specify)		Anemia
	Shortness of breath		Blood Clots
	Asthma		Muscle Disease
	Sleep Apnea		Arthritis
	Diabetes		Urinary Incontinence
	Liver Disease (specify)		HIV/ AIDS
	Kidney Disease (specify)		Ulcers
	Thyroid Disease		Hepatitis
	Cancer (specify)		Other

PAST SURGICAL HISTORY:

Surgery	Year	Surgery	Year

Name: _____

ALLERGIES: List allergies and the reaction you have. If no allergies, write **NONE.**

Allergy	Reaction

Which pharmacy do you use?
Name: _____ Location: _____

MEDICATIONS: List ALL prescriptions, over the counter medications, and herbal supplements you are currently taking.

Medication	Dosage	Times per day	Reason for use

OFFICE USE:

History updated: _____
History updated: _____

Vital Signs:
Date: _____ BP: _____ Pulse: _____
Date: _____ BP: _____ Pulse: _____
Date: _____ BP: _____ Pulse: _____

Reviewed by:
Date: _____ Clinical Staff: _____ MD: _____
Date: _____ Clinical Staff: _____ MD: _____
Date: _____ Clinical Staff: _____ MD: _____

CAPITAL SURGICAL ASSOCIATES NOTICE OF PRIVACY PRACTICE
(SHORT VERSION)

EFFECTIVE DATE: APRIL 14, 2003

THIS NOTICE DECRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY:

We understand that medical information about you and your health is personal. Capital Surgical Associates is required by law to maintain the privacy of your health information, to follow the terms of this Notice, and to provide you with this notice of our legal duties and privacy practices with respect to your health information. We are required to follow the terms of the Notice that is currently in effect. A paper copy of this notice may be obtained upon request.

How Capital Surgical Associates May Use or Disclose Your Health Information:

Capital Surgical Associates protects the privacy of your health information. We must have your written authorization to use or disclose your health information. However, the law permits Capital Surgical Associates to use or disclose your health information for the following purposes without your authorization:

- **For Treatment**- Information obtained by Capital Surgical Associates will be used for medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.
- **For Payment**- We may use and disclose your health information about you so that treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or third party.
- **For Health Care Operations**- We may use and disclose health information about you, in order to run the office and make sure that you and our other patients received quality care.
- **As Required by Law**- We will disclose health information about you when required to do so by federal, state or local law.
- **To avert a Serious Threat to Health or Safety**- We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- **Public Health Risks**- We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
- **For Health Oversight Activities**- We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities, which are necessary for the government to monitor the health care system, include audits, investigations, inspections and licensure.
- **Lawsuits and Disputes**- If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court order or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.
- **For specific Government Functions**- Capital Surgical Associates may disclose health information for the following specific government functions (1) health information of military personnel, as required by military command authorities; (2) health information of inmates, to a correctional institution of law enforcement official; (3) in response to a request from law enforcement, if certain conditions are satisfied; and (4) for national security reasons.

When Capital Surgical Associates May Not Use or Disclose Your Health Information:

Except as described in this Notice, Capital Surgical Associates will not use or disclose your health information without your written authorization. If you do authorize Capital Surgical Associates to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

You Have the Following Rights with Respect to Your Health Information:

- You have the right to request restrictions on certain uses and disclosures of your health information. Capital Surgical Associates is not required to agree to a restriction that you request. If we do agree to any restriction, we will put the agreement in writing and follow it, except in emergency situations. We cannot agree to limit the uses or disclosures of information that are required by law.
- You have the right to inspect and copy your health information as long as Capital Surgical Associates maintains the health information. Your health information usually will include your medical records and billing records. To inspect or to receive a copy of your health information, you must submit a written request to 8854 W Emerald, Ste 140, Boise, Idaho 83704. We may charge a fee for the costs of copying, and mailing, that are necessary to grant your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed. You have a right to choose to obtain a summary instead of a copy of your health information.
- You have the right to request that Capital Surgical Associates amend your health information that is incorrect or incomplete. To request an amendment, you must submit a written request to the privacy officer, Lisa Jack, 8854 W Emerald Ste 140, Boise, Idaho 83704, along with the reason for the request. Capital Surgical Associates is not required to amend health information that is accurate and complete.
- You have the right to receive an accounting of disclosures of your health information we have made April 14, 2003 for purposes other than disclosures.
- (1) for Capital Surgical Associates treatment, payment or health care operations, (2) to you or based upon your authorization and (3) for certain government functions. To request an accounting, you must submit a written request to 8854 W Emerald, Ste 140, Boise, Idaho 83704. You must specify the time period, which may not be longer than six years.
- You may request communications of your health information by alternative means or at alternative locations. For example, you may request that we contact you about your health matters only in writing or at different residence or post office box. To request confidential communication of your health information, you must submit a written request to Orthopaedic Associates. Your request must state how or when you would like to be contacted. We will accommodate all reasonable requests.

Changes to this Notice of Privacy Practices:

Capital Surgical Associates reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we have about you as well as any information we receive in the future. Any revised Notice will be posted in the front office of Orthopaedic Associates. Upon request, we will provide a revised Notice to you.

For More Information or to Report a Problem:

If you have questions or would like additional information about Capital Surgical Associates privacy practices, you may contact the Privacy Officer, Lisa Jack, 8854 W Emerald , Ste 140, Boise, Idaho 83704 or phone 208-321-4790 or FAX 208-321-4836. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer above or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.