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

DO YOU HAVE A LIVING WILL OR ADVANCED CARE PLAN? YES NO

WHO IS YOUR SURROGATE DECISION MAKER? ______________________________

WHICH PHARMACY DO YOU USE?

NAME:______________________________ LOCATION:______________________________

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

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:_________________

You have the right to receive a “Good Faith Estimate” explaining how much your health care will cost

Under the law, health care providers need to give **patients who don’t have certain types of health care coverage or who are “self-pay”** an estimate of their bill for health care items and services before those items or services are provided.

•You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

•If you schedule a health care item or service at least 3 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate inwriting within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the healthcare provider or facility gives you a Good Faith Estimate in writing within 3business days after you ask.

•If you receive a bill that is at least $400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.

•Make sure to save a copy or picture of your Good Faith Estimate and the bill.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov

If you believe you've been wrongly billed, visit the CMS website for instructions on disputing charges as well as additional information about surprise billing protections.

CAPITAL SURGICAL
ASSOCIATES

INJURY QUESTIONNAIRE

Name:____

What date did the injury happen:____

Please share the details of your injury, please be specific about where (location), when, and how the injury happened: ____

____

____

____

____

____

Was this related to an Auto Accident: Yes No

If yes, were you the: Driver Passenger Were you at fault of the accident? Yes No

Have you filed a claim with your auto insurance: Yes No

Was this related to an on the job injury: Yes No

If yes, name and number of your employer:____

____

Did you fill out an injury report with your employer? Yes No

Signature____________________________________Date:__________________

MEDICAL HISTORY FORM

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 used recreational drugs within 30 90 days or over a year
What type of drug?

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

Have you had the COVID-19 Vaccine? Yes No If yes, when?_________________

Have you had a colonoscopy? Yes No If yes when and where?_____________

____

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

Name: ____

PAST SURGICAL HISTORY:

Surgery	Year	Surgery	Year

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: ________________________

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 of 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 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 in full is required at least 72 hours prior to the scheduled procedure unless a payment contract stipulating monthly payments is in place.

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.

NO SHOW POLICY: Please be aware that late arrival may result in re-scheduling and potential associated fees. We kindly request 24 hours' notice should you need to change your appointment time. If you do not make it for your scheduled appointment time it will result in a $50 fee without appropriate notice.

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

_________________________________ ______________________

Signature Date