



# CAPITAL SURGICAL ASSOCIATES

PLEASE FILL OUT EACH SECTION COMPLETELY- THANK YOU

PATIENT'S LEGAL NAME			DATE OF BIRTH		SEX <input type="checkbox"/> M <input type="checkbox"/> F		AGE		MARITAL STATUS						
MAILING ADDRESS				CITY		STATE/ZIP CODE									
PRIMARY PHONE#			CELL PHONE#		PREFERRED CONTACT METHOD			SOCIAL SECURITY #(GUARANTOR)							
RACE		ETHNICITY <input type="checkbox"/> HISPANIC <input type="checkbox"/> NON-HISPANIC				LANGUAGE			PATIENT'S EMPLOYER						
WHO IS YOUR REFERRING PHYSICIAN?			WHO IS YOUR PRIMARY CARE PROVIDER?			EMAIL									
SPOUSE'S NAME (if married)				SPOUSE'S SSN # (GUARANTOR)											
DATE OF BIRTH				SPOUSE'S PHONE#											
FATHER'S NAME (if minor)				FATHER'S SSN # (GUARANTOR)											
DATE OF BIRTH				FATHER'S CONTACT PHONE#											
MOTHER'S NAME (if minor)				MOTHER'S SSN # (GUARANTOR)											
DATE OF BIRTH				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 <input type="checkbox"/>		NO <input type="checkbox"/>		
WHO IS YOUR SURROGATE DECISION MAKER? _____															
PREFERRED PHARMACY:															
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					
<b>EMERGENCY CONTACT INFORMATION</b>															
NEAREST FRIEND/RELATIVE:															
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

## 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: \_\_\_\_\_



**UROLOGY MEDICAL HISTORY FORM**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

- Reason for your visit today/ What are your symptoms? \_\_\_\_\_
- Who referred you? \_\_\_\_\_
- Primary care provider: \_\_\_\_\_
- Preferred Pharmacy: \_\_\_\_\_
- Insurance company name: \_\_\_\_\_

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

Medication	Dosage	Frequency	Medication	Dosage	Frequency

**ALLERGIES:** Do you have medication/medical supply allergies?  YES  NO

If yes, please explain:

**MEDICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)**

**Respiratory conditions:**

Type: \_\_\_\_\_

Who manages care for this issue?  
\_\_\_\_\_

**Kidney disease:**

Type: \_\_\_\_\_

Who manages care for this issue?  
\_\_\_\_\_

**Heart disease and/or previous heart attacks and/or strokes:**

Type: \_\_\_\_\_

Who manages care for this issue?  
\_\_\_\_\_

**Cancer:**

Type: \_\_\_\_\_

Who manages care for this issue?  
\_\_\_\_\_

- Diabetes
- HIV/AIDS
- Hepatitis
- Liver disease
- Emphysema
- GERD
- Hypertension
- Hernia
- Anemia
- Arthritis
- Asthma
- Clotting disorder
- Crohn's disease
- Depression
- Varicose Veins
- High Cholesterol

**Other:**



CAPITAL SURGICAL ASSOCIATES

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

PAST SURGICAL HISTORY:

SURGERY YEAR/LOCATION OF SURGERY

Table with 2 columns: SURGERY, YEAR/LOCATION OF SURGERY. Contains 5 empty rows for data entry.

AGES 45 AND UP - DATE OF LAST COLONOSCOPY: \_\_\_\_\_

FAMILY HISTORY: (Check and provide which relative, indicating if on maternal or paternal side of family.)

Table for family history with 2 columns and 5 rows. Rows include: Diabetes, Aneurysms (where), Breast Cancer, Colon Cancer, Colon Polyps, Other Cancer (type), Issues with Anesthetic, Bleeding Problems.

Any other major family history of disease? \_\_\_\_\_

SOCIAL HISTORY:

Form for social history with fields for Age, Marital Status, Occupation, Height, Weight, Alcohol use, Tobacco use, and Recreational drugs.

Have you had an influenza (flu) shot? YES NO If yes, when?
Have you had the COVID-19 vaccine? YES NO If yes, when?
Do you have a living will or advanced care plan? YES NO
Who is your surrogate decision maker? \_\_\_\_\_

## International Prostate Symptom Score (I-PSS)

Patient Name:	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	YOUR SCORE
<b>1. Incomplete Emptying</b> Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	
<b>2. Frequency</b> Over the past month, how often have you had to urinate again less than two hours after you have finished urinating?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	
<b>3. Intermittency</b> Over the past month, how often have you found you stopped and started again several times when you urinated?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	
<b>4. Urgency</b> Over the past month, how often have you found it difficult to postpone urination?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	
<b>5. Weak Stream</b> Over the last month, how often have you had a weak urinary stream?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	
<b>6. Straining</b> Over the past month, how often have you had to push or strain to begin urination?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	
	NONE	ONCE	TWICE	3 TIMES	4 TIMES	5 OR MORE	YOUR SCORE

<b>7. Nocturia</b> Over the past month how many times did you most typically get up each night to urinate from the time you went to bed until the time you got up in the morning?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	
<b>Total I-PSS Score</b>							

**Quality of Life due to Urinary Symptoms**

Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Unhappy	Unhappy	Terrible
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If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
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The I-PSS is based on the answers to seven questions concerning urinary symptoms. Each question is assigned points from 0 to 5 indicating increasing severity of the particular symptom. The total score can therefore range from 0 to 35 (asymptomatic to very symptomatic).

Although there are presently no standard recommendations into grading patients with mild, moderate or severe symptoms, patients can be tentatively classified as follows: **0-7 = mildly symptomatic; 8-19 = moderately symptomatic; 20-35 = severely symptomatic.**

The international Consensus Committee (ICC) recommends the use of only a single question to assess the patient's quality of life. The answers to this question range from "delighted" to "terrible" or 0 to 6. Although this single question may or may not capture the global impact of BPH symptoms on quality of life, it may serve as a valuable starting point for doctor-patient conversation.



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## 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.

- A. **New Patients:** You have been asked to fill out our patient information sheet. The accuracy of this information is very important. Please print clearly. Please give us your given name as appeared on your insurance card. If you go by a different name, please add it in parentheses by your name. Please bring a form of photographic identification, and insurance card with you to your appointment.
- B. **Payment of Services:** You and your insurance company should settle your bill 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 cannot make your co-payment, you may be asked to re-schedule your appointment. Failure to pay the full account balance within 120 days may result in collections proceedings.
- C. **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.
- D. **Medicare:** We are participating providers with Medicare. Please provide us with your secondary insurance so we may bill it for you. You will be responsible for any balances not paid by Medicare.
- E. **Patients without insurance or high deductible:** We require payment in full for initial consultation for patients without health insurance coverage. Unpaid balances require payment arrangements through the billing office. Surgical care will require a deposit of no less than 75% of the estimated surgical fee before the surgery is scheduled. Payment is required at least 72 hours prior to the scheduled procedure unless a payment contract is in place.
- F. **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 or [Billing1@capsurgical.com](mailto:Billing1@capsurgical.com).

We accept cash, debit cards, checks, money orders, ACH, Visa, MasterCard, and American Express. There will be a \$30.00 returned check fee assessed to your account on all returned checks. All credit card transactions over \$100 will incur a convenience fee of up to 3%.

**No-show policy:** Please be aware that late arrival, late cancelling, or no-showing an appointment may result in re-scheduling and/ or late fees. We kindly request 24 hours' notice should you need to change your appointment time. There is a \$50.00 fee for a no-showed appointment

Should you no show surgery, or if it is cancelled due to non-compliance within 48 hours of the scheduled date, this may result in a fee of up to \$500.00. *Please review any questions with your provider regarding compliance.*

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

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Signature/Date



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## **Privacy Policy/ HIPPA Acknowledgement of Receipt of Notice/ HIPPA Email Consent**

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

- A. **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.
- B. **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.
- C. **For health care operations:** We may use and disclose health information about you, to run the office and make sure that you and our other patients receive quality care.
- D. **As required by law:** We will disclose health information about you when required to do so by federal, state or local law.
- E. **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.
- F. **Public health risks:** We may disclose health information about you for public health reasons to prevent or control disease, injury or disability; suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
- G. **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.
- H. **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.
- I. **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:**

- A. 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 restrictions 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.
- B. 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.
- C. 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.
- D. 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 account, you must submit a written request to 8854 W Emerald, Ste 140, Boise, Idaho 83704. You must specify the period, which may not be longer than six years.
- E. 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 residences or post office box. To request confidential communication of your health information, you must submit a written request to Capital Surgical 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 Capital Surgical 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.



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I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I understand that I may request a copy of any amended notice.

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Signature/Date

### **HIPPA Email Consent**

HIPAA stands for the Health Insurance Portability and Accountability Act. HIPAA was passed by the U.S. Government in 1996 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 for a lot of people to communicate, 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.

Common information we send via email is surgery pre-op instructions, appointment confirmations.

Please inform our team if you would prefer not to consent to emails from our practice.

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Signature/Date



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### **Idaho Patient Act**

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

St Luke's

Saint Alphonsus

Treasure Valley Hospital

Millenium Surgery Center

West Valley Medical Center

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

Anesthesia Consultants of Treasure Valley

Boise Anesthesia

Anesthesia Consultants of Idaho

Anesthesia Associates of Boise

Treasure Valley Anesthesia

Independent Anesthesia

I understand that there may be a billing statement from three separate facilities for any surgery being performed. Any additional testing, imaging, or laboratory procedures would come from said facilities above as well.

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Signature/Date



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## **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 Capital Surgical Associates physicians 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.

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Signature/Date



**CAPITAL SURGICAL  
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## **Surgical Deposit and Payment Policy**

To ensure operating room scheduling availability and minimize last-minute cancellations, Capital Surgical Associates requires a deposit at the time surgery is scheduled. The deposit is applied toward the patient's financial responsibility for the procedure.

### **Tiered Deposit Schedule**

<b>Estimated Patient Responsibility</b>	<b>Required Deposit</b>
1. \$0 – \$999	\$250
2. \$1,000 – \$1,999	\$750
3. \$2,000 – \$4,999	\$1,500
4. \$5,000 or greater	\$2,000

### **Payment Timeline**

1. Deposit is due at the time the surgery is scheduled.
2. Remaining patient responsibility will be billed after insurance processes your claim.
3. Payment arrangements for the remaining balance may be discussed with our billing department at 208-375-2782 or [billing1@capsurgical.com](mailto:billing1@capsurgical.com). All payment plans require a credit card on file.

### **Cancellation and Rescheduling Policies**

- Cancellations 7+ days prior: deposit is fully refundable or may be put towards a later date.
- Cancellations less than 7 days prior: \$250 of deposit will be forfeited.
- Cancellations less than 48 hours prior: \$500 fee or \$500 of deposit will be forfeited
- Deposits may be transferred to a rescheduled surgery date at the discretion of the practice.

*\*For insured patients only. Self-Pay patients will be provided with a detailed estimate, and payment will be required in full.*

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Signature/Date



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## **Patient informed consent for AI, Virtual Scribes, and Ambient Scribe Technology**

This document is designed to provide you with information about Ai used in this office, a HIPAA and PIPEDA compliant technology solution we intend to use during your medical consultation and care. It assists healthcare professionals in data collection and notetaking, generating clinical notes and letters, which in turn aids in patient care. The application can process information provided in various forms, such as text, audio, and live patient conversations and generate notes for your doctor. It may also involve a conversation with an autonomous virtual scribe assistant, which is strictly used for notetaking and the collection of health information by your healthcare provider.

**Purpose of Use:** To improve the efficiency and accuracy of medical documentation, thereby freeing more time for your healthcare provider to focus on your care. Any data transfer is secure and encrypted. The Ai application communicates with the Ai model over encryption grade security ensuring that all data requests and responses are encrypted.

**Consent:** By signing this form, you are providing consent to the use of Ai in the processing and documentation of your health information during your medical consultation and care. You have the right to withdraw your consent at any time, which will not affect the quality or provision of your healthcare.

Please ask if you have any questions about the technology we use in our office or about this form. We encourage you to discuss any concerns you may have with your healthcare provider before signing this consent form.

I understand the above explanation regarding Ai technology used in our office. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.

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Signature/Date