Office use only: ☐Wheelchair ☐Stretcher

Patient Questionnaire

Date: _____

Patient's Name: _____ DOB: _____

Best Contact Number: _____ Emergency Contact: _____ Cell: _____

YOU MUST fill out this page- OMITING INFO COULD CAUSE SERIOUS PROBLEMS DURING YOUR SURGERY*

***Do you currently have: ☐Rashes ☐Fever ☐ Other: _____

If you have any paperwork (tests, labs, prescription list, etc please give to front desk)

Reason for Visit: _____

Allergies: _____ Allergic Reaction to Anesthesia: YES NO

Family Doctor: _____

Opthamologist (Eye): _____ Last seen Month/ Year Neurologist: _____ Last seen Month/ Year

Pulmonologist (Lung): _____ Last seen Month/ Year Oncologist/Hematologist: _____ Last seen Month/ Year

Cardiologist (Heart): _____ Last Seen: ____/____ Month/ Year

Choice of home health if needed after surgery: _____ ☐No preference, Angelina Surgical can choose home health

Height: ____' ____" Weight: _____ Lbs Pharmacy: _____ Pharmacy Street: _____

Do you take any of the following below in PILL form, Please check:

Pills or Tablets: ☐Aspirin ☐BC Powder ☐Alka-Seltzer ☐Advil ☐Aleve ☐Ibuprofen ☐Motrin ☐Cayenne ☐Cinnamon ☐CoQ10 ☐Garlic ☐Fish Oil ☐Naproxen ☐Omega-3 ☐Saw Palmetto ☐Turmeric ☐Vitamin E ☐Multivitamins ☐Ginger

Prescription Medications

Prescription Medications:	Dosage:# of times taken daily:	Prescription Medications:	Dosage:# of times taken daily:
Mg/Mcg/Units:	Mg/Mcg/Units:	Mg/Mcg/Units:	Mg/Mcg/Units:

☐ Eliquis(Apixaban: _____ ☐ Coumadin(Warfarin): _____ ☐ Diclofenac: _____ ☐ Pletal (Cilostazol): _____

☐ Pradaxa(Dabigatran): _____ ☐ Plavix (Clopidogrel): _____ ☐ Mobic (Meloxicam): _____ ☐ Blood thinners not mentioned here: _____

☐ Xarelto(Rivaroxaban): _____ ☐ Brilinta(Ticagrelor): _____ ☐ Diet Pills: _____

SCREENINGS:

If you are aged **21 - 64 years**, have you had a Mammogram? ☐ _____ Approximate Year Pap Smear ☐ _____ Approximate Year

If you are aged **40 - 75 years**, Have you had a Colon Cancer Screening? If YES, When? _____ Approximate Year

Are you using tobacco products? ☐Yes ☐No If yes, check : ☐ Smoke ☐ Chew ☐ Vape, How Long: _____ If No, Have you in the past? YES NO

Must check

Have you had a Blood Transfusion?: YES or NO If YES, did you have a reaction? YES or NO

Parent: (Please mark at least one)

Dad Alive: ☐ Age : _____ Dad Passed: ☐ Age: _____ **Does Parent have:** ☐Diabetes ☐Heart Disease ☐Cancer

Mom Alive: ☐ Age : _____ Mom Passed : ☐ Age : _____ **Does Parent have:** ☐Diabetes ☐Heart Disease ☐Cancer

Are you? ☐ Married ☐ Divorced ☐ Single ☐ Widowed **Do you live Alone?** ☐Yes ☐ No

Are you Working? ☐Yes ☐ No If Yes, Where? _____

***WOMEN ONLY:**

Are you Pregnant? YES or NO Date of Last Menstrual Cycle: _____

Number of Pregnancies: _____ Number of Children: _____

FILL IN ALL PATIENT INFORMATION

First Name _____ Middle _____

Last Name _____

Social Security # _____

Sex _____ Date of Birth _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

(Check One) ☐ Employed ☐ Retired ☐ Full Time Student ☐ Other _____

Employer _____

Mailing Address _____

City, State Zip _____

Email _____

Contact Phone _____

Cell/Work Phone _____

Primary Care Doctor: _____

Referring Physician _____

PLEASE PROVIDE FRONT DESK WITH ALL INSURANCE INFORMATION

EMERGENCY CONTACT AND/OR INSURANCE GUARANTOR/RESPONSIBLE PARTY IF NOT PATIENT

Relationship _____

First Name _____

Last Name _____

Contact Phone _____

Address _____

City, State Zip _____

Guarantor SS # _____ Guarantor Sex: _____

Guarantor Employer _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims

I HEREBY AUTHORIZE ANY MEDICAL RECORDS NEEDED TO THE CONTNUATION OF MY CARE BE RELEASED TO ANGELINA SURGICAL ASSOCIATES.

_____

Signature (Patient or Parent if Minor) Date

FOR OFFICE USE ONLY

OFFICE NOTES____OPERATIVE REPORTS____RADIOLOGY____LAB/PATHOLOGY____
DEMOGRAPHIC/INSURANCE INFORMATION____OTHER_____

____DR. DARRY MEYER
____DR. ALAN BASSIN
____DR. JEFFREY HAMAKER
____DR. ASHLEY MCELROY

PHONE 936-634-8216
FAX 936-888-2201

Angelina Surgical Associates

Darry G. Meyer, DO
Alan S. Bassin, MD FACS

Angelina Surgical Associates

Jeffrey S. Hamaker, MD
Ashley N. McElroy, MD

OFFICE POLICY

Our office is pleased to accept your insurance assignment on your surgery as soon as your exact coverage is verified. We will file your claim and assist you in every way we can. However**, you are responsible for full payment according to your insurance policy guidelines for copays, deductibles and coinsurance at the time of your initial visit and 3 days prior to any scheduled procedures being done.**

Office policy regarding insurance assignment:

1. You must understand that the contract you have is between you and your insurance company and you are fully responsible for any allowed amount not paid by your insurance company.

2. Once your insurance remits payment, if there is any balance owed, payment is due in full at that time.

3. Our office does not guarantee that your insurance will pay. We will make every attempt at the beginning of your health care to verify your policy coverage. However, if for some reason your insurance claim is denied, you will be responsible for the full allowed amount of your bill.

4. You are required to sign a statement authorizing the payment to be directly paid to our office.

5. Our office will not enter into a dispute with your insurance company over the claim. This is your responsibility and obligation.

6. Delinquent accounts will be turned over to a collection agency when deemed necessary. Delinquent accounts in collections will need to be paid in full before appointments will be allowed to be scheduled at any point in the future if you have other surgical needs.

By signing this statement, you are stating that you understand and agree to follow this policy.

Signature **Date**

109 Westside Medical Blvd., Lufkin, Texas 75904 (936)634-8216 Fax (936)888-2201

Darry G. Meyer, DO
Alan S. Bassin, MD FACS

Angelina Surgical Associates

Jeffrey S. Hamaker, MD
Ashley N. McElroy, MD

Notice of Privacy Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read (or have had the opportunity to read if I chose) and understand the preceding Notice of Privacy Practices of Angelina Surgical Associates containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

_____

Patient Signature (or Authorized Representative)

_____

Printed Name

_____

Relationship to Patient Date

Listed below are the person(s)that have my permission to receive medical information regarding my health.

_____

Print Contact Name Relationship

_____

Print Contact Name Relationship

_____

Print Contact Name Relationship

Office Use Only

I attempted to obtain the patients signature in acknowledgement of this Notice of Privacy Practices, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____

Cancellation/No Show Policy

ASA Cancellation Policy/No Show Policy for Appointments and Surgery

Cancellation/No Show Policy for Office Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

- If an appointment is not cancelled at least 24 hours in advance you will be charged a Thirty-five dollar ($35) fee; this will not be covered by your insurance company.

Scheduled Office Appointments

- We understand that delays can happen, however we must try to keep the other patients and doctors on time. Patients who fail to show up for an appointment without a call to cancel an office appointment will be considered a NO SHOW. Patients who NO SHOW three (3) times may be dismissed from the practice AND be denied future appointments.
- Patients who are 15 minutes late for an appointment will be requested to reschedule.

Cancellation/No Show Policy for Surgery

When booking we are securing this date for your surgery. You are not only paying for the surgeon's expertise but also for operating room personnel, anesthesia and other resources. Costs are incurred regardless of whether the surgery proceeds or not. Due to the block of time required for surgery, last-minute cancellations cause problems and added cost to the office.

- **SURGERY MUST BE SCHEDULED AND PERFORMED WITHIN 3 MONTHS OF INITIAL VISIT, IF THE PATIENT DOESN'T WANT TO SCHEDULE WITHIN THIS TIME PERIOD, THEY'LL NEED A FOLLOWUP VISIT TO SCHEDULE THE SURGERY FORA LATER DATE.**
- If patient cancels surgery within **3 business days of scheduled procedure (including holidays)**, patient will be charged $100.00 — this will not be covered by your insurance company.
- FAILURE TO COMPLETE MEDICAL CLEARANCE TESTING, HOSPITAL PRE-REGISTRATION,FAILURE OF SMOKING CESSATION(if required by surgeon), UNFULFILLED FINANCIAL OBLIGATIONS TO YOUR SURGEON OR HOSPITAL ARE NOT MEDICAL REASONS FOR CANCELLATION.
- RESCHEDULING SURGERY TO ANOTHER DATE - No Fee the first time. The second time and thereafter $50 fee for each rescheduled date up to two times from first initial surgery date. — this will not be covered by your insurance company. After 2 rescheduled surgeries you will need to be reseen in the office by the surgeon to discuss rescheduling this surgery. Should the surgeon proceed, you will be allowed one more time to reschedule your surgery.

I have read and understand the above information

Name: Date:

_____ _____