

MAT-SU SURGICAL ASSOCIATES

Patient Interview Form

First Name _____ Last Name _____ Date of Birth _____ Age _____

Past or Present Medical Conditions				
<input type="checkbox"/> None				
<input type="checkbox"/> Anemia	<input type="checkbox"/> Barrett's Esophagus	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Reflux Disease (GERD)	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Lung Cancer	<input type="checkbox"/> Gout
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Peptic Ulcer Disease	<input type="checkbox"/> Thyroid Cancer	<input type="checkbox"/> Pre-Diabetes	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Bowel Obstruction	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Diabetes- Type 1	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes- Type 2	<input type="checkbox"/> Alzheimer's Disease
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> COPD	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Anxiety Disorder
<input type="checkbox"/> Transient Ischemic Attack	<input type="checkbox"/> Colon Polyps	<input type="checkbox"/> Oxygen Dependence	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Bipolar Disorder
<input type="checkbox"/> Stroke	<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> End Stage Renal Disease	<input type="checkbox"/> Dementia
<input type="checkbox"/> Vascular Disease	<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Depression
<input type="checkbox"/> Blood Clots (Leg)	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Frailty
<input type="checkbox"/> Blood Clots (Lung)	<input type="checkbox"/> Celiac Disease	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Wheelchair Bound
<input type="checkbox"/> High Cholesterol	Other:	Other:	<input type="checkbox"/> HIV	Other:

Previous Procedures/Surgeries				
<input type="checkbox"/> None				
<input type="checkbox"/> Abdominal Aortic Aneurysm (AAA) Repair	<input type="checkbox"/> Colon Resection	<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Lung Lobectomy	<input type="checkbox"/> Bilateral Tubal Ligation
<input type="checkbox"/> Cardiac Cath – with stent placement	<input type="checkbox"/> Small Bowel Resection	<input type="checkbox"/> Exploratory Laparoscopy	<input type="checkbox"/> Thyroid Removed	<input type="checkbox"/> Hysterectomy- Abdominal
<input type="checkbox"/> Coronary Artery Bypass Graft	<input type="checkbox"/> Hemorrhoidectomy	<input type="checkbox"/> Hernia- Abdominal Wall	<input type="checkbox"/> Lumpectomy, Breast	<input type="checkbox"/> C-Section
<input type="checkbox"/> Defibrillator Placement	<input type="checkbox"/> Fundoplication-Nissen (Hiatal Hernia Repair)	<input type="checkbox"/> Hernia -Right Inguinal <input type="checkbox"/> Hernia - Left Inguinal	<input type="checkbox"/> Mastectomy, Left <input type="checkbox"/> Mastectomy, Right	<input type="checkbox"/> Gastric Bypass
<input type="checkbox"/> Pacemaker Placement	<input type="checkbox"/> Gallbladder Removed	<input type="checkbox"/> Hernia Repair- Umbilical	<input type="checkbox"/> Joint Replacement (Specify site)	<input type="checkbox"/> Gastric Lap Band
<input type="checkbox"/> Heart Valve Replacement	Other:	Other:	Other:	Other:

Diagnostic Studies/Tests				
<input type="checkbox"/> None				
<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> CT Abd/Pelvis	<input type="checkbox"/> MRI Abd/Pelvis	<input type="checkbox"/> Ultrasound Abd/Pelvis	<input type="checkbox"/> Blood Tests
<input type="checkbox"/> EGD	<input type="checkbox"/> CT Chest	<input type="checkbox"/> PET Scan	<input type="checkbox"/> ERCP	
Other:	Other:	Other:	Other:	Other:

Social History				
Alcohol		<input type="checkbox"/> None		
<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Socially		
Drug Use		<input type="checkbox"/> None		
<input type="checkbox"/> Marijuana	<input type="checkbox"/> Recreational/ Street Drugs			
Tobacco		<input type="checkbox"/> Never Smoker		
		<input type="checkbox"/> Former Smoker		
<input type="checkbox"/> Current everyday smoker	<input type="checkbox"/> Current some days smoker	<input type="checkbox"/> Light tobacco smoker	<input type="checkbox"/> Heavy Tobacco smoker	
	Date Started	Date Quit	Quantity	
<input type="checkbox"/> Cigarettes				
<input type="checkbox"/> Cigars				
<input type="checkbox"/> Chewing Tobacco				
<input type="checkbox"/> Smokeless/Vaping				

Family Medical History: Check all that apply																		
<input type="checkbox"/> No Family History of Colon Cancer						<input type="checkbox"/> No knowledge of Family History						<input type="checkbox"/> Patient is adopted						
Relation	Alive	Age at Death	Colon Cancer	Rectal Cancer	Colon Polyps	Ulcerative Colitis	Barrett's Esophagus	Crohn's Disease	Esophageal Cancer	Breast Cancer	Thyroid Cancer	Lung Cancer	Malignant Hyperthermia	Heart Disease	Hypertension	Diabetes	Other:	Other:
Father																		
Mother																		
Brother																		
Sister																		
Son																		
Daughter																		

Review Of Symptoms: Check all that apply (Current or recent symptoms)			
<input type="checkbox"/> Strong Allergic Reactions or Hives	<input type="checkbox"/> Increased Thirst	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Itching
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Increased Hunger	<input type="checkbox"/> Change in Bowel Habits	<input type="checkbox"/> Rashes
<input type="checkbox"/> Difficulty Climbing Stairs	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Constipation	<input type="checkbox"/> Joint Pain
<input type="checkbox"/> Chest Pain with Activity	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Muscle Pain
<input type="checkbox"/> Short of Breath - Exertion	<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Headaches
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Vision Changes	<input type="checkbox"/> Nausea	<input type="checkbox"/> Seizures
<input type="checkbox"/> Fever	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Chills	<input type="checkbox"/> Urethral Discharge or Incontinence	<input type="checkbox"/> Black Tarry Stools	<input type="checkbox"/> Depression
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Trouble Urinating	<input type="checkbox"/> Blood in Stools	<input type="checkbox"/> Suicidal Thoughts
<input type="checkbox"/> Runny Nose	<input type="checkbox"/> Anemia	<input type="checkbox"/> Hernias	<input type="checkbox"/> Cough
<input type="checkbox"/> Throat Tenderness	<input type="checkbox"/> Bleeding Easily	<input type="checkbox"/> Swallowing Problems	<input type="checkbox"/> Breathing Problems
<input type="checkbox"/> Thyroid Issues or Mass	<input type="checkbox"/> Transfusion Reaction		

Allergies				
<input type="checkbox"/> No Known Allergies		<input type="checkbox"/> No known drug allergies		
<input type="checkbox"/> Adhesive Tape	<input type="checkbox"/> Shellfish	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Sulfa's
<input type="checkbox"/> Latex	<input type="checkbox"/> Iodine	<input type="checkbox"/> Cephalosporins	<input type="checkbox"/> Penicillin's	
Other:	Other:	Other:	Other:	

Current Medications and Supplements				<input type="checkbox"/> See List Provided By Patient			
Name	Dose	Times/How taken		Name	Dose	Times/How taken	

Consent to Import Medication History		
I consent to obtaining a history of my medications purchased at pharmacies	<input type="checkbox"/> Yes	<input type="checkbox"/> No

X

 Signature of Patient/Responsible Party

 Date



MAT-SU SURGICAL ASSOCIATES

Patient Registration Information		
First Name:	Middle Name:	Last Name:
Preferred Name:	Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> D	SS#	E-mail:
Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Decline to provide <input type="checkbox"/> Other		Ethnicity: Hispanic or Latino Not Hispanic or Latino Decline to provide
Preferred Language: (If not specified, English will be chosen)		
Mailing Address		Physical Address (if different)
Street:		Street:
City:	State: Zip:	City: State: Zip:
Cell Phone:		Home Phone:
May we leave a confidential voice mail? <input type="checkbox"/> Yes <input type="checkbox"/> No		Pharmacy:
Referring Physician:		Primary Care Physician:
Guarantor / Responsible Party		
Name:	Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian		Other:
Mailing Address:		Cell Phone:
Insurance		
PRIMARY INSURANCE:		SECONDARY INSURANCE:
Subscriber/Member ID#:		Subscriber/Member ID#:
Group #:		Group #:
Subscriber Name:		Subscriber Name:
Relationship to Patient:		Relationship to Patient:
Date of Birth:		Date of Birth:
Emergency Contact and Consent to Disclose Health Information		
We respect your right to privacy regarding medical information. Please list the names of individuals with whom we may share information without additional written consent and check the boxes for the type of consent.		
Name _____ Relationship _____ Contact Number _____ <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Medical Health Information <input type="checkbox"/> Billing Information		
Name _____ Relationship _____ Contact Number _____ <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Medical Health Information <input type="checkbox"/> Billing Information		

BENEFIT ASSIGNMENT / ACKNOWLEDGEMENT OF PRIVACY PRACTICES

(Initial) I certify that the above insurance and demographic information is true and correct to the best of my knowledge. I authorize Mat-Su Surgical Associates, APC to administer medical treatment. The office has my permission to obtain or release medical records from outside sources that may be important for the continuation of my care (or in the best interest of my dependent if I am signing as a parent or guardian).

(Initial) I understand that I have the right to receive and review a written description of how this practice will handle health information about me. This is known as a Notice of Privacy Practices and describes the use and disclosure of health information made and the information practices followed by the employees, staff, and other office personnel of the Providers, and my rights regarding my health information. The current version of the Notice of Privacy Practices is posted in the waiting/reception area and on our website @ matsusurgical.com.

(Initial) I authorize payment of medical benefits to Mat-Su Surgical Associates. I understand that I am financially responsible for all charges, even if not paid by insurance. I authorize the release of any information necessary to secure the payment of benefits. I agree that all charges for medical services rendered that are not directly paid by my insurance will be my responsibility.

X

Signature of Patient / Responsible Party

Date



MAT-SU SURGICAL ASSOCIATES

FINANCIAL POLICY

Thank you for choosing Mat-Su Surgical Associates for your healthcare needs. We are committed to providing you the best surgical healthcare available. You are required to read and sign our financial policy prior to any treatment. Please feel free to ask any questions. A copy of this policy will be provided to you upon request.

(Initial) INSURANCE - As a courtesy to our patients, we bill and participate with most insurance types. It is your responsibility to know your insurance benefits. If you are unsure of your benefits, please contact your insurance carrier with questions. If you do not provide proof of insurance, you will be expected to pay in full at the time of service or make payment arrangements with our billing staff. You will be considered a self-pay patient until the insurance information is provided to our office.

- **PROOF OF INSURANCE** –We must obtain a copy of your insurance card(s) and a copy of a photo ID for billing. Failure to provide us with the correct information will result in the inability to assist you in filing insurance claims.
- **CLAIM SUBMISSION** –As a courtesy to our patients, we will submit claims. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their requests.
- **CO-PAYMENT/CO-INSURANCE/DEDUCTIBLE** – Co-pays are due at time of service. Co-pays, co-insurance, and deductibles are part of your contractual obligation with your insurance company and are patient responsibility.
- **SCREENING COLONOSCOPY**- Prior to scheduling a screening colonoscopy, you will have a pre-op exam in the office. The office exam is NOT part of the procedure and will be billed to your insurance carrier. This office visit may be subject to your deductible or co-insurance depending on your insurance plan.
- **NON-COVERED SERVICES** – Please be aware that some or all of the services provided may not be covered or not considered reasonable or necessary by some insurers. It will be your responsibility to pay for these services.
- **CHANGE IN COVERAGE** - If your insurance coverage changes, please notify us as soon as possible, so we can make the appropriate changes to help you receive your maximum benefits.
- **USUAL AND CUSTOMARY** – Our prices are representative of the usual and customary charges for our geographic area. You are expected to pay in full for any balance after insurance.

(Initial) NON-PAYMENT – If your account is thirty days past due, you may be contacted by our billing department asking for payment in full or to make payment arrangements. If your balance is unpaid after three months, we may refer your account to Cornerstone Credit Services, a collection agency.

(Initial) CREDIT BALANCE – A refund will be generated to the responsible party if an account has a credit balance over \$10.00. Balances less than \$10.00 will be retained and applied to future balances unless a refund is specifically requested.

(Initial) NO SHOW POLICY – any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least a 24-hour notice will be considered a 'No Show' and charged a \$75.00 fee.

(Initial) SELF-PAY ACCOUNTS – You are required to bring a minimum of \$200 toward the initial office visit. If the total balance due is more than you are able to pay at time of service, reasonable payment arrangements may be made by signing a self-pay financial agreement.

I acknowledge that I have read and agree to the above Financial Policy.

X

Signature of Patient / Responsible Party

Date