MAT-SU SURGICAL ASSOCIATES

Patient Interview Form

First Name_____ Last Name_____ Date of Birth _____ Age _____

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

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

Diagnostic Studies/Tests				
☐ None				
☐ Colonoscopy	☐ CT Abd/Pelvis	☐ MRI Abd/Pelvis	☐ Ultrasound Abd/Pelvis	☐ Blood Tests
☐ EGD	☐ CT Chest	☐ PET Scan	☐ ERCP	
Other:	Other:	Other:	Other:	Other:

Social History			
Alcohol	☐ None		
☐ Daily	☐ Weekly	☐ Socially	
Drug Use	☐ None		
☐ Marijuana	☐ Recreational/ Street Drugs		
Tobacco	☐ Never Smoker	☐ Former Smoker	
☐ Current everyday smoker	☐ Current some days smoker	☐ Light tobacco smoker	☐ Heavy Tobacco smoker

	Date Started	**Date Quit**	**Quantity**
☐ Cigarettes			
☐ Cigars			
☐ Chewing Tobacco			
☐ Smokeless/Vaping			

Family Medical History: Check all that apply

☐ No Family History of Colon Cancer ☐ No knowledge of Family History ☐ 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)

☐ Recurrent Infections	☐ Throat Tenderness	☐ Black Tarry Stools	☐ MRSA Infection
☐ Strong Allergic Reactions or Hives	☐ Thyroid Issues or Mass	☐ Blood in Stools	☐ Joint Pain
☐ Chest Pain	☐ Increased Thirst	☐ Hernias	☐ Muscle Weakness
☐ Irregular Heartbeat	☐ Increased Hunger	☐ Swallowing Problems	☐ Muscle Pain
☐ Palpitations	☐ Weight Gain	☐ Frequent Urination	☐ Dizziness
☐ Difficulty Climbing Stairs	☐ Weight Loss	☐ Incontinence	☐ Headaches
☐ Chest Pain with Activity	☐ Blurry Vision	☐ Trouble Urinating	☐ Numbness
☐ Short of Breath - Exertion	☐ Vision Changes	☐ Breast Discharge	☐ Seizures
☐ Fatigue	☐ Abdominal Pain	☐ Breast Lumps	☐ Memory Loss
☐ Fever	☐ Change in Bowel Habits	☐ Breast Pain	☐ Balance Difficulty
☐ Chills	☐ Constipation	☐ Breast Tenderness	☐ Anxiety
☐ Night Sweats	☐ Diarrhea	☐ Anemia	☐ Depression
☐ Sore Throat	☐ Heartburn	☐ Bleeding Easily	☐ Difficulty Sleeping
☐ Runny Nose	☐ Nausea	☐ Blood Clots	☐ Suicidal Thoughts
☐ Hoarseness	☐ Rectal Bleeding	☐ Itching	☐ Cough
☐ Voice Changes	☐ Vomiting	☐ Rashes	☐ Breathing Problems

Allergies

☐ No Known Allergies		☐ No known drug allergies		
☐ Adhesive Tape	☐ Shellfish	☐ Aspirin	☐ Erythromycin	☐ Sulfa's
☐ Latex	☐ Iodine	☐ Cephalosporins	☐ Penicillin's	
Other:	Other:	Other:	Other:	

Current Medications and Supplements ☐ 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	☐ Yes	☐ No

X _____ _____

Signature of Patient/Responsible Party **Date**

MAT-SU SURGICAL ASSOCIATES

INTERNAL USE ONLY – Reviewed with

☐ **Patient**	☐ **Parent**	☐ **Guardian**	☐ **Not Present**

MAT-SU SURGICAL ASSOCIATES

Patient Registration Information		
First Name:	Middle Name:	Last Name:
Preferred Name:	Date of Birth:	Sex: ☐ Male ☐ Female
Marital Status: ☐ M ☐ S ☐ W ☐ D	SS#	E-mail:

Race:	Ethnicity:	Preferred Language:
☐ American Indian or Alaska Native ☐ Black or African American ☐ Decline to provide ☐ White ☐ Asian ☐ Other	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to provide	(If not specified, English will be chosen)

Mailing Address	Physical Address (if different)
Street: City: State: Zip:	Street: City: State: Zip:
Cell Phone:	Home Phone:
May we leave a confidential voice mail? ☐ Yes ☐ No	Pharmacy:
Referring Physician:	Primary Care Physician:

Guarantor / Responsible Party		
Name:	Date of Birth:	Sex: ☐ Male ☐ Female
Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ 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 _____
☐ Emergency Contact ☐ Medical Health Information ☐ Billing Information

Name _____ Relationship _____ Contact Number _____
☐ Emergency Contact ☐ Medical Health Information ☐ 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

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FINANCIAL POLICY

Thank you for choosing Mat-Su Surgical Associates, APC for your healthcare needs. We are committed to providing you with the best surgical healthcare available. The following information outlines your financial responsibilities related to payment for professional services. Please Initial each section and sign to acknowledge and agree to our financial policy.
A copy of this policy will be provided to you upon request.

☐ ALL PATIENTS

Patients are responsible for any charges incurred on the account resulting from treatment provided. Any balance due must be paid 30 days from the date of service, unless you contact our billing department to make payment arrangements.

- **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. **There is a fee of $30 for any checks returned as NSF.**
- **NO SHOW POLICY** – Our office reserves the right to charge patients that do not provide us with at least a 24-hour notice to cancel/reschedule an appointment. Our policy is to charge $75.00 for missed office visits and $150 for missed procedures.
- **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.
- **PROCEDURES/SURGERY** – If the procedure is performed at Mat-Su Regional Medical Center or Surgery Center of Wasilla, there will be a separate bill with a charge for the facility and a separate bill for the physician's treatment. You may also receive separate bills for anesthesia and any laboratory or pathology services.

☐ INSURED PATIENTS

As a courtesy to our patients, we bill and participate with most insurance types. Your medical insurance is a contract between you and your insurance company. Patients are responsible for knowing their coverage limitations and benefits. If you are unsure of your benefits, please contact your insurance carrier. Our billing office cannot quote benefits from your health plan or guarantee payment.

- **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. You will be considered a self-pay patient until the insurance information is provided to our office. If your insurance coverage changes, please notify us as soon as possible.
- **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.
- **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.
- **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.

☐ UNINSURED PATIENTS

SELF-PAY ACCOUNTS – You are required to bring $200 toward the 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**