Welcome to University Surgeons Associates!

Thank you for choosing University Surgeons Associates. We welcome the opportunity to serve you. Our goal is to provide you with excellent medical care that is sensitive to your individual needs.

Office Hours:

Monday – Thursday: 8:00am to 4:30pm
Friday: 8:00am to 4:00pm
Saturday & Sunday – Closed
**Please note that when office is closed, urgent calls will be answered by our after-hours service.*
**In case of emergency – please call 911 or go to nearest emergency room*

Appointment Reminders:

- ***New patients – must arrive at least 30 mins prior to appointment time.***
- **To each appointment, please bring your photo ID, insurance cards, copay, or balance that you may owe, medication & allergy list and a referral from your insurance, if required**.
- Update address, phone number or other important information at each visit.
- **New Patient paperwork** is available to print from our website at UTSurgery.com.
  If you are unable to access the website and print, please ask us to email or mail you a copy to complete.

Late arrivals, Reschedules, Cancellations and No-Show Appointments:

- Please notify our office as soon as you realize you may be late. We will do our best to accommodate you when you arrive. ***Be advised, if you are more than 30 minutes late and if we are able to still see you, it may be in between or after other scheduled patients are seen, so there may be a wait.***
- If you need to reschedule or cancel your appointment, please call our office ***prior*** to your appointment. Otherwise, it will be marked as a "no-show". After three (3) no-show appointments, you may be dismissed from our practice, at our discretion.
- Multiple reschedules, and cancellations are also reviewed. At our discretion, you may be dismissed for non-compliance.

Prescriptions:

- If you have requested a refill, please check with your pharmacy before calling back. Most refills are sent electronically to your pharmacy.
- Please give us at least 24-hour notice for refills. Due to clinic schedules and provider availability, same day refills may not be possible.
- Narcotics – We are not able to call in certain medications due to laws governing these medications. If you are needing refills for these medications, you will be asked to pick up the written prescription and present a photo ID. If you are not able to pick up the prescription, an authorized person may pick it up for you and they will also need to provide a photo ID. You will need to inform the nurse that someone else may be picking up the prescription for you.

Test Results, FMLA, Short-Term Disability & Medical Records Requests:

- A front office employee will not be allowed to go over test results with you. Results are provided by your provider or nurse during follow up appointments, unless your provider says they will contact you by phone.
- Please allow 7-10 business days for medical records requests.
- FMLA/STD Paperwork – Please give explicit details of where to send paperwork and the deadline per your employer. We will do our best to accommodate that request.

Patient Name: _____ Date of Birth_____

Patient Signature:_____ Today's Date: _____

University Surgeons Associates Patient Registration Form

Date	For Internal Use Only	Patient Number

PATIENT INFORMATION

Social Security # Date of Birth

First Name Middle Last Name

Home Address City State Zip

Home Phone ( ) Cell Phone ( ) Work Phone ( )

Email Address Race Ethnicity

(Circle as many as are appropriate)

Birth Sex: Male Female

Current Gender : Male Female Transgender Other

Marital Status (Circle One) Married Single Divorced Widowed

Employment Status (Circle One) Employed Retired Disabled F/T Student Other

Employer

Primary Care Physician _____Phone ( ) _____

Referring Physician _____ Phone ( ) _____

How did you hear of us?

PRIMARY INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

Insurance ID # GR #

Name of Insured DOB SS#

SECONDARY INSURANCE INFORMATION

Insurance ID# GR #

Name of the Insured DOB SS#

EMERGENCY CONTACT

Relationship

First Name Middle Last

Home Phone Work Phone Cell

SPOUSE/GUARANTOR/RESPONSIBLE PARTY

Social Security # Sex Date of Birth

Relationship Daytime Phone ( )

First Name Middle Last Name

Address City State Zip

Employer Address

City State Zip

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims. I also 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.

SIGNATURE (Patient or Parent if Minor) DATE

PATIENT HEALTH HISTORY

Today's date: _____

Patient Name: _____ **Date of Birth:** _____

PHARMACY

Pharmacy Name: _____ **Phone:** ( ) _____

Address: _____

Street *City* *State* *Zip*

MEDICATION ALLERGIES: ☐ LIST ATTACHED ☐ NO KNOWN MEDICATION ALLERGIES

Do not write below if list attached. *If no list available, list medication allergies and your reaction:*

_____

_____

Are you allergic to any of the following: ☐ Latex ☐ Iodine ☐ CT Dye ☐ Shellfish

CURRENT MEDICATIONS: ☐ LIST ATTACHED ☐ NOT TAKING ANY MEDICATIONS

Do not write below if list attached. *If no list available, please list all medications including herbal and over the counter.*

Name of Medication	Dosage	How often do you take it?

Please list your current providers:

Cardiology: _____ **Phone:** _____

Gastroenterology: _____ **Phone:** _____

Pulmonary: _____ **Phone:** _____

Endocrinology: _____ **Phone:** _____

Nephrology: _____ **Phone:** _____

Other: _____ **Phone:** _____

Other: _____ **Phone:** _____

Patient Name: _____ **Date of Birth:** _____ **Today's date:** _____

PAST MEDICAL HISTORY: Mark all that apply

ENDROCRINE

_____ Diabetes Type I / Type II

_____ Thyroid Disease

CARDIOVASCULAR

_____ High Blood Pressure

_____ High Cholesterol

_____ Congestive Heart Failure

_____ Coronary Heart Disease

_____ Pacemaker / Defibrillator

_____ Heart Attack (Year:_____)

_____ Asthma

_____ Emphysema / COPD

_____ Bronchitis

_____ Pneumonia

_____ Pulmonary Embolism (Blood Clot)

_____ Sleep Apnea

_____ CPAP / BiPap use

GASTROINTESTINAL

_____ Colonic Diverticulitis

_____ GERD (Heartburn)

_____ Crohn's Disease

_____ Hiatal Hernia

_____ Irritable Bowel

_____ Gastroparesis

OTHER Medical or Surgical History

_____

_____

_____

_____

_____

HEPATIC

_____ Cirrhosis

_____ Hepatitis A /B /C

_____ Fatty Liver

UROLOGIC

_____ Dialysis

_____ Kidney Stones

_____ Prostate Disorders

_____ Renal Failure

MUSCULOSKELETAL

_____ Arthritis

_____ Lupus

_____ Fibromyalgia

CANCER

_____ Breast Cancer

_____ Skin Cancer

_____ Blood / Lymph Node Cancer

_____ Prostate Cancer

_____ Colorectal Cancer

_____ Ovarian / Uterine Cancer

Other: _____

NEUROLOGIC

_____ Stroke

_____ Seizure Disorder

_____ Brain Aneurysm

_____ Neuropathy

(weakness of hands/feet)

HEMATOLOGIC/LYMPHATIC

_____ Clotting Disorder

_____ Bleeding Disorder

_____ HIV

PAST SURGICAL: Mark all that apply

ARTERIAL/VASCULAR SURGERY

*** Please list Year ***

_____ Aneurysm Repair (AAA)

_____ Coronary Bypass (CABG)

_____ Peripheral Stent / Bypass (Leg/Trunk)

BREAST SURGERY

*** Please list Year ***

_____ Total Mastectomy R / L

_____ Lumpectomy R / L

ABDOMINAL / OTHER SURGERIES

*** Please list Year ***

_____ Appendectomy

_____ Gallbladder

_____ Splenectomy

_____ C-Section

_____ Hysterectomy

_____ Tubal Ligation

_____ Plastic Surgery

_____ Prostatectomy

_____ Colon / Bowel

_____ Bariatric Bypass / Sleeve / Band

HERNIA SURGERY

*** Please list Year ***

_____ Inguinal R / L

_____ Abdominal

_____ Umbilical

_____ Incisional

_____ Femoral

_____ Hiatal / Diaphragm

ENDOCRINE SURGERY

_____ Thyroid

_____ Parathyroid

_____ Adrenal

Patient Name: _____ **Date of Birth:** _____ **Today's date:** _____

SOCIAL HISTORY:

Current Smoker ☐ YES ☐ NO

Former Smoker ☐ YES ☐ NO

***** If former smoker:*** How long did you smoke? _____ When did you quit? _____

E-Cigarettes/Vape ☐ YES ☐ NO **Smokeless Tobacco** ☐ YES ☐ NO **Caffeine Use** ☐ YES ☐ NO

Drug use: *including marijuana* ☐ YES ☐ NO

Alcohol Use: ☐ YES ☐ NO

REVIEW OF SYMPTOMS: Have you experienced any symptoms listed below in the last 30 days? Please mark all that apply.

SYSTEMIC
- _____ Weight Change
- _____ Chills
- _____ Fever
- _____ Night Sweats
- _____ Feeling tired or poorly

HEAD
- _____ Headache
- _____ Facial Pain
- _____ Sinus Pain

NECK
- _____ Neck Pain
- _____ Neck Stiffness
- _____ Lump/Swelling in neck

EAR
- _____ Earache
- _____ Hearing Loss
- _____ Ringing in Ears

MOUTH
- _____ Mouth Sores
- _____ Bleeding gums
- _____ Hoarseness
- _____ Throat Pain

EYE
- _____ Eyesight Problems
- _____ Sensitivity to light
- _____ Eye Pain
- _____ Itching of eyes

CARDIOVASCULAR
- _____ Chest Pain / Discomfort
- _____ Fast Heart Rate
- _____ Palpitations

PULMONARY
- _____ Shortness of Breath
- _____ Cough
- _____ Wheezing

BREAST
- _____ Breast Pain R / L
- _____ Nipple Discharge R / L
- _____ Breast Lump R / L

GASTROINTESTINAL
- _____ Changes in appetite
- _____ Difficulty Swallowing
- _____ Heartburn / Acid Reflux
- _____ Nausea
- _____ Vomiting
- _____ Abdominal Pain
- _____ Constipation
- _____ Diarrhea
- _____ Black or Bloody stools

MUSCULOSKELETAL
- _____ Joint Pain
- _____ Joint Stiffness
- _____ Muscle Aches

SKIN
- _____ Chronic Itching Skin
- _____ Skin Lesions
- _____ Rashes

GENITOURINARY
- _____ Painful Urination
- _____ Increased Urinary Frequency
- _____ Blood in Urine

NEUROLOGICAL
- _____ Dizziness
- _____ Vertigo
- _____ Syncope (Fainting)

PSYCHOLOGICAL
- _____ Anxiety
- _____ Depression
- _____ Memory Loss

FAMILY HISTORY: Please check boxes of any family members that have had the following conditions.

	Father	Mother	Brother	Sister
Diabetes				
Heart Disease / Heart Attack				
High Blood Pressure				
Stroke				
Reaction to Anesthesia				
Bleeding Problems				
Cancer **Type?*				

Patient Privacy Questionnaire and Notification

Patient Name:_____ Date of Birth:_____

I give permission to the physicians and their staff at University Medical Group to leave messages regarding my healthcare in the following manner when I am not available:

Contact Information:

I would prefer to be contacted at*: _____Home #_____

_____Cell #_____

_____Work #_____

_____Other #_____

_____May ONLY leave information with me. (If you check here, no other choice should be marked).

_____May leave appointment reminders on my answering machine/voicemail.

_____May leave lab results on my answering machine/voicemail.

_____May leave general questions/information on my answering machine/voicemail.

_____May leave a message with a call back number only.

Please list the name of the individual and relationship of anyone we may give information to:

Name:_____Relationship:_____

Name:_____Relationship:_____

_____May leave appointment reminders with the above listed person

_____May leave lab results with the above listed person

_____May leave general questions/information with the above listed person

_____May discuss billing information with the above listed person

_____I prefer that all healthcare messages be given to the above listed person

*If we are unable to reach you by another means, we will send information through the U.S. Postal Service to your home address. We keep a record of each visit. This record may include your test results, diagnosis, medications, and your response to medications or other therapies. This allows your physicians and other clinical staff to provide appropriate care to meet your medical needs. The information in your record is called protected health information. We may disclose your protected health information to other healthcare providers or entities involved in your care.

I understand that my protected health information may be used to coordinate my treatment as described above. I have been *offered a copy of the University Health System, Inc. (UHS) Notice of Information Practices. I understand that this Notice describes how my health information may be used or disclosed by this practice, UHS, UHS Ventures Inc., Physicians, and other providers practicing at UHS or UHSV facilities and that I should read it carefully. I am aware that the Notice may be changed at any time.*

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to contact me or to employ a third-party automated outreach and messaging system to use my contact information, the name of my care provider, and other limited information, for the purpose of notifying me of balances due, when necessary. I authorize my health care provider or its agents to call my cell phone either manually or by auto dialer to collect any amount I owe. I understand that if any fees are incurred in the collection of my account, I will be responsible for any interest, court costs, and reasonable attorney's fee allowed by Tennessee Law.

Signature of Patient_____ Date_____

University Surgeons Associates - Insurance Payment Policy

Thank you for choosing University Surgeons Associates. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy of this can be provided to you upon request.

1. **Insurance Plans.** We are providers with Medicare, most Aetna plans, Beech Street, Blue Cross/Blue Shield, Blue Care, Champus-military only, Cigna, the Initial Group, Humana, Americhoice Tenncare, and United Health. We are **not** insured with UHC Secure Horizon. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but do not have an up to date insurance card, payment in full is required until we are provided with a current copy of your insurance information. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions that you may have regarding your coverage.
2. **Co-payments.** All co-payments must be paid in full at the time of service. This arrangement is part of your contract with your insurance company. Please help us in upholding your agreement by paying your co-payment at each visit.
3. **Non-Covered Services.** Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by your insurance, even though your physician feels that it is necessary. Our office will file each visit to your insurance company. If they deem that something is not reasonable or necessary, we ask that you submit payment for that item immediately.
4. **Proof of Insurance.** All patients must complete our patient information form before seeing a physician. We will also ask that you complete this form once a year. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct information in a timely manner, you may be responsible for the balance of the claim.
5. **Claim submission.** We will submit your claims and assist you in any way we can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. We will pre-collect any expected coinsurance or deductibles prior to scheduling surgeries and procedures. Your insurance benefit is a contract between you and your insurance company. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. If you have Medicare, we will bill you any money's owed after we have received payment from Medicare and/or a secondary policy that you might have.
6. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. We will also need to have a copy of your new insurance card.
7. **Non-Payment.** If your account is over 90 days past due, you will receive a letter from our billing department. Partial payments are accepted as long as you call them directly to set up the necessary payment plan. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

Patient Name: _____ **Date of Birth:** _____

I have read and understand the payment policy and agree to abide by all guidelines:

_____ _____

Signature of Patient or Responsible Party **Date**

Medical Records Release

Patient Name: _____ Date of Birth: _____ SS# _____

This form must be fully completed before signing

Name doctors you see who we have permission to obtain records from or send records to.

Provider: _____ Fax _____ Phone: _____

Provider: _____ Fax _____ Phone: _____

Provider: _____ Fax _____ Phone: _____

Provider: _____ Fax _____ Phone: _____

Provider: _____ Fax _____ Phone: _____

Provider: _____ Fax _____ Phone: _____

FOR DATES OF SERVICE: _____ or ☐ ALL DATES/Entire Record

Purpose of Disclosure: ☐ Treatment ☐ Payment ☐ Billing ☐ Operations ☐ Other: _____

I hereby authorize and request you to Release and/or Request my Medical Records. Information regarding alcohol abuse, substance abuse, HIV/AIDS or mental health may be disclosed. If you do not wish for us to disclose information regarding alcohol abuse, substance abuse, HIV/AIDS, or mental health, PLEASE INTITIAL HERE: _____

I understand that information disclosed has the potential for re-disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at University Surgeons Associates (USA). I understand that revoking this authorization stops any further disclosures but cannot undo any disclosures that have already occurred as requested in the original authorization. I understand authorization for the use or disclosure of the information is voluntary. Federal and state laws permit a fee to be charged for the copying of patient records. I understand that USA may charge a reasonable fee for the supplies, labor and postage involved in copying and mailing this information. USA with either notify or send an invoice if there is an associated fee. I agree that a copy of this authorization shall be considered as effective as the original.

I understand that this authorization will remain active for one year from date of signature.

Patient Signature: _____ Date: _____

If patient is represented by another person, please include description of legal authority to act for the individual and if applicable attach a copy of the proof of legal representation. A Durable Power of Attorney for Health Care is sufficient if the patient is unable to make their own health care decisions. POA for managing financing only authorizes the representative to obtain billing/payment records.

Legal Representative if patient unable to sign: _____ Date: _____

Identification Verified by: ☐ Driver's License ☐ Other Photo ID: _____ Staff Initials: _____