



**Patient Registration**

Patient Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
DOB: \_\_\_\_\_ Sex M  F  Marital Status: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Primary Phone#: \_\_\_\_\_ Home Phone#: \_\_\_\_\_  
Alternate Phone#: \_\_\_\_\_ Email: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
Preferred Pharmacy: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_  
Pharmacy Address: \_\_\_\_\_

**Insurance Information**

**Primary** Insurance Name: \_\_\_\_\_ ID#: \_\_\_\_\_  
Name of Insured/Subscriber: \_\_\_\_\_ Group #: \_\_\_\_\_  
Date of Birth of Insured/Subscriber: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Phone#: \_\_\_\_\_  
**Secondary** Insurance Name: \_\_\_\_\_ ID#: \_\_\_\_\_  
Name of Insured/Subscriber: \_\_\_\_\_ Group #: \_\_\_\_\_  
Date of Birth of Insured/Subscriber: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

**Work Related Injury**

Worker's Comp. Claim#: \_\_\_\_\_ \*Date of Injury: \_\_\_\_\_  
Case Manager's Name: \_\_\_\_\_ \*Phone#: \_\_\_\_\_

**Emergency Contact Information**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_  
Relationship to patient (other than Self): \_\_\_\_\_



## **Patient Financial Responsibilities**

Proliance - Surgical Specialists at Overlake, a division of Proliance Surgeons is committed to providing you with the highest quality medical care. Because patients are ultimately responsible for the charges associated with their care, even when insurance is in place, you may find the following information helpful. We realize you have choices for your medical care and appreciate your choosing Proliance - Surgical Specialists at Overlake.

### **Patient Responsibilities**

You can help ensure an efficient experience by assisting with the following:

- Providing us with your picture identification, insurance card and Social Security number to enable us to submit your claims timely and accurately
  - Knowing your insurance benefits and limitations
  - Ensuring there is an authorization for our providers to treat you if it is required by your insurance, including obtaining a referral
  - Providing us with copies of any pertinent medical records, including tests (MRI/CT/Arthrogram) and x-rays
  - Paying your estimated portion of the charges at the time of service
  - Paying any additional amount owed when due
  - Completing required incident/accident forms within 30 days of date of service
  - Maintaining a current account with Proliance Surgeons at all times
  - Providing us with at least 24 hours advance notice should you need to cancel or reschedule an appointment
- Please note that co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

### **Insured Patients**

We will bill your primary and secondary insurance carrier in a timely manner. If you are disputing payment with your insurance carrier or have a balance over \$100.00 with us, you must notify our business office and make payment arrangements.

**Co-Pays/Deductibles/Co-Insurance** – Please be prepared to pay for your portion of the charges on the date of service.

**Surgery** – If surgery is indicated, a pre-payment of both physician and facility fees is required for all elective, non-emergent procedures prior to the surgery being performed. Your out-of-pocket cost is estimated based on your benefits and our fees. Anesthesia and other providers are separate fees.

**Non-Participating Insurance** – If we do not participate in the insurance you have, we will file a claim as a courtesy. All unpaid claims will become your responsibility 45 days following filing and be immediately due and payable.

### **Uninsured Patients**

**Office Visits** – A \$150.00 deposit is required prior to the appointment for appointments with a general surgeon. Patients coming in for a Bariatric consultation are required to pay a \$250.00 deposit prior to the appointment. If visits and services

are paid in full at the time of service, we offer a 20% discount (see exclusions below). Office visits may include x-rays, casting and materials at an additional charge. Charges are not finalized until chart notes are complete.

**Surgery** – For uninsured patients having surgery, we offer a 20% discount when charges are paid in full prior to the day of service (see exclusions below).

**Exclusions** – The discounts referenced above do not apply in cases of cosmetic procedures, motor vehicle accidents, third party insurance claims or in other cases when the patient may be reimbursed in full. Private pay patients who receive retroactive Medicaid coverage need to immediately notify our business office.

**Motor Vehicle Accidents (MVA) Insured and Third Party Patients -**

We do not extend discounts for MVA-insured accidents, third party insurance claims or in other cases when patients may be reimbursed in full. We will bill the MVA insurance carrier one time. The bill becomes your responsibility if not paid by the carrier in 30 days. We regret that we are not in a position to confer with attorneys or defer payment obligations while a case settles. If your personal injury protection benefit on your MVA policy is exhausted, we will bill your private insurance at your request provided we are furnished the necessary information at the date of service.

**Workers' Compensation**

If your visit is work-related, we will need the case number and carrier name prior to your visit in order to bill the workers' compensation insurance carrier. If your workers' compensation claim is not yet accepted and you have no other insurance, we require a \$250.00 deposit that will be refunded after the claim has been opened.

**Other Charges**

**No Show** – Please provide us with at least 24 hours advance notice if you need to cancel or reschedule an appointment. We may charge a fee for missed appointments. Please provide us with at least 48 hours advance notice if you need to cancel or reschedule an appointment and an interpreter has been scheduled. Otherwise, you may be charged for the interpreter.

**Forms** – There may be a charge associated with our completion of some forms. We require payment of the charge before returning the completed form to you. A signed Release of Information may also be necessary. Please allow five business days for us to complete forms.

**Payment**

**Payment Options** – We accept cash, checks, major credit/debit cards and money orders for payment (no post-dated or third party checks). We charge a \$40.00 NSF fee for any returned checks.

**Delinquent Accounts** – We charge a \$10.25 monthly account management fee on balances over 45 days old. We may assign an account to collections if balances are unpaid after 90 days. Patients assigned to collections may be denied additional service.

**Alternative Payment Arrangements** – If you are unable to pay your balance when due, please contact our business office to make alternative arrangements. Any patient with a past due amount may be denied additional service until the amount is paid or the patient is complying with an alternative payment arrangement.

**Bankruptcy/Prior Bad Debt** – Patients who have previously filed for bankruptcy or never satisfied their payment obligations for prior episodes of care with Surgical Specialist at Overlake or other Proliance Surgeons care centers may be required to pay for their portion of new charges at the time of service.

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Signature of Patient/Parent/Power of Attorney

Printed Name of Patient

Date

I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release information required for my medical claim. I consent to the release of medical information from or to other doctors and healthcare insitutions as is necessary to my care and treatment. This authorization is valid for 12 months from the date it is signed.



**Adel El-Ghazzawy, MD, FACS**  
**Brad Watkins, MD, FACS**

**Authorization to Leave Personal Health Information, Alternate Means**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

**Please fill in all that apply.**

1. May leave detailed message on voicemail at Primary Number: \_\_\_\_\_
2. May leave detailed message on voicemail at Alternate Number: \_\_\_\_\_
3. May leave information with spouse (name): \_\_\_\_\_
4. May leave information with other family member (name): \_\_\_\_\_
5. May leave information at different location (specify): \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient/Parent/Power of Attorney

\_\_\_\_\_  
Date

Note: With my signature, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my health care provider(s) should I change one or more of the contacts listed above.



**Adel El-Ghazzawy, MD, FACS**  
**Brad Watkins, MD, FACS**

## **NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT**

We keep a record to the health care services we provide you. You may ask to see and copy that record. You may also ask to correct said record. We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the administrator of the location at which you have been treated. Please call the main office number and ask for the administrator.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you can access your information. You may obtain a copy of our Notice of Privacy Practices at any point by requesting one from the staff.

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Signature of Patient/Parent/Power of Attorney

Date

**PATIENT HEALTH HISTORY FORM**

HT \_\_\_\_\_ WT \_\_\_\_\_

**PLEASE LIST CURRENT MEDICATIONS**

Mgs/Strength/Dosage

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**ARE YOU CURRENTLY TAKING ASPIRIN?** Y  N

DOSAGE \_\_\_\_\_

**PLEASE LIST CURRENT ALLERGIES**

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**PAST SURGICAL HISTORY**

**YEAR/OPERATION**

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## PATIENT HEALTH HISTORY

Have you ever been seen by a Cardiologist : Y  N  Name/Location of Cardiologist \_\_\_\_\_

Have you or any relatives had any problems with Anesthesia? : Y  N  Please Describe: \_\_\_\_\_

When and where was your most recent EKG? \_\_\_\_\_

Can you climb 2 flights of stairs without shortness of breath? Y  N  Do you require assistance? Y  N

## PERSONAL HEALTH HISTORY

HIGH BLOOD PRESSURE : Y  N

GLASSES/DENTURE : Y  N

ARTHRITIS/GOUT : Y  N

DIABETIC : Y  N  TYPE I  or II

MRSA : Y  N  ACTIVE: Y  N

PULMONARY EMBOLISM : Y  N

CORONARY ARTERY DISEASE : Y  N

HIGH CHOLESTEROL : Y  N

CPAP MACHINE : Y  N

PACEMAKER : Y  N  (IF YOU ANSWERED YES PLEASE LIST BRAND/MODEL # \_\_\_\_\_)

## SOCIAL HISTORY AND HEALTH HABITS

Relationship Status	Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>
Smoking	Y <input type="checkbox"/> N <input type="checkbox"/> Type: Packs per day : Quit (Year) :
Alcohol	Y <input type="checkbox"/> N <input type="checkbox"/> Drinks per week : Quit (Year) :
Drugs	Type :

**Please list any major health issues for the following family members, if deceased; please give cause of death**

Mother		Father	
Grandfather		Grandfather	
Grandmother		Grandmother	
Aunt/Uncle		Aunt/Uncle	

<b>Siblings and or other Relatives (Please list)</b>

**Constitutional Symptoms**

- Weight Loss/Gain : \_\_\_\_\_lbs
- Fevers
- Night Sweats

**Eyes**

- Glaucoma
- Macular Degeneration

**Head and Neck**

- Sinus Infection
- Swollen Glands
- Dentures/Partial Plate
- Radiation to Face or Neck

**Heart**

- Chest Pain
- Heart Attack
- Irregular Heartbeat
- Shortness of Breath Standing/Laying Down
- Swelling in Feet or Legs
- Heart Stents
- Pacemaker

**Lungs**

- Asthma/Wheezing
- COPD/Emphysema
- Respiratory Infections
- Sleep Apnea

**Gastrointestinal**

- Heartburn/GERD
- Ulcers
- Frequent Diarrhea
- Constipation
- Blood in Stool
- Hemorrhoids
- Hepatitis

**Genitourinary**

- Difficulty Voiding
- Frequent Urination
- Kidney Stones
- Painful Urination

**Fertility/Reproduction:**

- Pregnancies : \_\_\_\_\_
- Miscarriages : \_\_\_\_\_
- Menopause/Post-Menopausal
- Tubal Ligation
- Vasectomy

**Muscles/Joints :**

- Arthritis
- Joint Replacement
- Back Pain

**Skin:**

- Rashes
- Skin Cancer
- MRSA (ACTIVE)
- History of MRSA

**Breasts:**

- Breast Pain R L Bilateral
- Breast Mass R L Bilateral
- Nipple Discharge R L Bilateral

**Neurologic:**

- Loss of Memory
- Seizures
- Migraines
- Depression
- Bipolar Disorder
- Anxiety
- Stroke

**Endocrine:**

- Thyroid Problems
- Diabetes

**Blood Problems:**

- Anemia
- Bleeding
- Clotting
- Transfusions

**Allergies:**

- Rashes
- Latex
- Iodine/Contrast