Eastern Surgical Associates

Specializing in Minimally Invasive Laparoscopic & Robotic Surgery

PATIENT INFORMATION

Patient Name Last_____ First_____ MI_____

Address_____

City_____ State_____ Zip_____ Phone_____

Sex_____ Race_____ Marital Status_____ Date of Birth_____ Age_____

Retired_____ Employed_____ Full Time Student_____ Cell Phone_____

Employer_____ Phone_____

Social Security #_____ Drivers License_____

Person responsible for account_____ Relationship_____

Address_____

City_____ State_____ Zip_____ Phone_____

Employer_____ Phone_____

Social Security #_____ Drivers License_____

Spouse's Name_____ Employer_____ Phone_____

Person to notify in case of emergency_____ Phone_____

_____

INSURANCE POLICY INFORMATION

Insurance Company (Primary):_____

Policy holder's name_____ Date of Birth_____

Employer_____

Contract number_____ Group_____

Relationship of patient to policy holder_____

Insurance Company (Secondary)_____

Policy holder's name_____ Date of Birth_____

Employer_____

Contract number_____ Group_____

Relationship of patient to policy holder_____

Referred by_____

CONSENT FOR TREATMENT - I consent to necessary treatment, including drugs, medicine, performance of operations and conduct of X-ray, or other studies that may be used by the attending physician, his nurse or staff.

AUTHORIZATION FOR RELEASE OF INFORMATION - I authorize Eastern Surgical Associates, P.C. to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on the job injury.

ASSIGNMENT OF BENEFITS - I hereby authorize payment directly to Eastern Surgical Associates, P.C. of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed Eastern Surgical Associates, P.C. charges for these services. I understand that I am financially responsible to Eastern Surgical Associates, P.C. for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

GUARANTEE OF ACCOUNT - For services furnished by Eastern Surgical Associates, P.C. I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection, including attorney's fee.

SIGNATURE_____ **DATE**_____

Medication List

Allergies: _____

Pharmacy Name: _____ **Pharmacy Phone #:** _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize the physicians and/or staff of Eastern Surgical Associates, P.C. to release information to:

Check all those that apply:

____ only to myself

____ any member of my family

____ only to the following people:

_____

_____

EASTERN SURGICAL ASSOCIATES, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the attached Notice of Privacy Practices.

_____	_____	_____
Patient or Personal Representative Printed Name	Patient or Personal Representative Signature	Date

If personal Representative's signature appears above, please describe Personal Representative's relationship to patient: _____

Medical History:

Surgical History:

Social History:

Do You Smoke: ____ Yes ____ No

Do You Drink: ____ Yes ____ No

Referring Physician: _____

Primary Care Physician: _____

Patient Portal Authorization Form

Purpose of this Form:

The Patient Portal is designed to improve physician and patient communication. Once you are registered as a patient and have provided us with your secure email you will be assigned a username and password. After you registered with the Patient Portal you will be allowed the following:

- Update your contact information
- Request your own appointments
- Communication of laboratory results from staff to patient
- Request prescription refills
- View your medical summary, medication list, treatment history and visitation dates
- Receive reminders through your email
- View current and past statements

The following will **NOT** be accepted through Patient Portal:

- Receiving advice on the best course of treatment for your medical problem. All diagnosis will be made by your provider when your are seen for an office visit.
- Request for narcotics/controlled medications.
- Request for refill for medication not currently being prescribed by a Creekside Medical Provider

Online communications should never be used for life threatening, emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact 911 or your physician via telephone.

Reminders for Patient Portal:

- You will have 10 failed log in attempts before the account is locked
- You will be receiving reminders via email from reminders@eclinicalmail.com regarding your appointments, test results posting etc. Please make security adjustments to your email or computer to receive our emails.
- You will not be able to reply to our email reminders from reminders@eclinicalmail.com. If you have any questions regarding these emails please send us a message via Patient Portal.
- If you forget your password you may request another one through Patient Portal by clicking on the "Forgot Password" link.
- After you are finished accessing Patient Portal be sure to logout and close your browser. This reduces the risk of someone else accessing your private information.
- Avoid using a public computer to access Patient Portal.
- Patient Portal is provided as a courtesy service for our patients. There is no service fee. However if the patient abuses or misuses Patient Portal we reserve the right to terminate the patient's account.
- Our hours of operation are 8:00 am - 5:00 pm Monday-Friday. We encourage you to use the web site at any time; however messages are held for us until we return the next business day. Messages are typically handled within 2 business days. If your doctor is out of the office, your request may be held until your doctor returns to the office.
- We reserve the right to suspend or terminate the patient portal at any time and for any reason.

How the Secure Patient Portal Works:

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Patient Portal Authorization Form

Protecting Your Private Health Information and Risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect. We will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:

1) The secure message must reach the correct email address, and
2) Only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. **It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address.**

You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided.

Secure Email Address: _____

Print name: _____ DOB: _____

Patient Signature: _____ Date: _____

Complete the following if the email address does not belong to the patient: Please note, portal access is not available for patients aged 13-18 years.

Name of Parent/Guardian requesting access:

_____

Last Name Middle Initial First Name

_____

Relationship to the Patient Date

Our Patient Portal site may be accessed by two different URL's.

Our Website: www.easternsurgical.com

Patient Portal direct site: https://mycw20.eclinicalweb.com/portal1504/jsp/100mp/login.jsp

Eastern Surgical Associates

Specializing in Minimally Invasive Laparoscopic & Robotic Surgery

CONDITIONS AND CONSENT FOR TREATMENT

Welcome to our office! We are glad you have selected EASTERN SURGICAL ASSOCIATES, PC. So that we may assist you better, the following is an outline of our office policies. We will do our best to make your visit as pleasant as possible. By clearly communicating our policies we hope to avoid any problems or misunderstandings. Please let us know if you have any questions about your care, our policies, or the need for additional information.

INITIAL ALL AND SIGN AND DATE WHERE NOTED

_____ **MEDICAL / SURGICAL CONSENT:** I give my consent for myself/family member(s) to undergo diagnosis and treatment at or by the providers and staff of EASTERN SURGICAL ASSOCIATES, PC. I understand that during the course of medical, or surgical, diagnostic, laboratory, or treatment procedures, a variety of personnel working under the direction of the treating physician may be involved with or provide care to me or my family member(s).
Care may be rendered by, and may involve, personnel such as, but not limited to, nurse practitioners, physicians assistants, RN's, BSRN's, MSRN's, LPN's, medical assistants, medical technologists, operating room/scrub technicians, nurses in training, interns and physicians in training.

_____ **NO GUARANTEE OR WARRANTY:** I acknowledge and understand that the practice of medicine and surgery is not an exact science and that no guarantees nor warranty, expressed or implied, are given by anyone in this office to me or my family member(s) as to the effect of examinations, or the results of any treatment, diagnosis, recurrence, scarring or surgery. I understand the term "treatment" does not imply cure nor does it necessarily imply complete resolution of any particular condition. Smoking, certain medical conditions and medications, as well as nondisclosure of medical conditions including mental illness, disease, or treatment may adversely affect your diagnosis, treatment, scarring, recurrence of the condition, and eventual outcome.

_____ **ANCILLARY SERVICES:** I understand there are other healthcare professionals and facilities, including, but not limited to, physicians, rehab facilities, hospitals, laboratories and diagnostic facilities that are not part of, or employed by, EASTERN SURGICAL ASSOCIATES, PC and whose services may be requested, or who may become involved in the care of any particular patient, or whose consultative services are requested for the patient's benefit. These persons, facilities, or entities bill separately for their services rendered.

_____ **NON-COVERED CHARGES:** We want to provide you with the best healthcare that we can possibly deliver, however, we find that occasionally there are certain services that we consider **routine and necessary** for treatment that are **not covered** by some insurance carriers. Although we are happy to discuss changes in the manner that we deliver healthcare to any one individual, there may be charges that you or your family incur from our office that are **not covered** by your insurance plan. Unless you have specifically notified us **in writing** ahead of time or other financial arrangements have been made, you will be expected to pay for the charges incurred.

_____ **NON-COVERED PROCEDURES:** Certain insurance carriers such as Medicare, Blue Cross Blue Shield, and others limit procedures during your consultation to a small number of selected diagnostic and treatment procedures. In general, they do not provide for treatment or surgery which is considered elective and of a nonemergent nature **during your consultation**. These insurance carriers require that your procedure be scheduled separate form your consultation in order to provide coverage for you. Insurance carriers that allow procedures on the same day as consultation such as HMO's, PPO's, etc. will give permission for that treatment on their **written referral** and may require further determination before allowing further treatment.

_____ **RELEASE OF MEDICAL INFORMATION:** I authorize release of any and all medical records, related medical information, photographs, and billing information regarding my treatment for the purposes of substantiating insurance coverage and medical payment owed to this facility and its physicians or providers for all or part of the charges

involving my care or the care of my family member(s), for treatment or for medico legal issues and/or testimony. This authorization includes, but is not limited to, hospital or medical service companies, insurance companies, worker's compensation carriers, or welfare funds.

I certify that the information given by me in applying for payment under Title XVII and XIX of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration, or its intermediaries, or the Medicaid agency, or its intermediaries, any information needed for the processing of a Medicare or Medicaid claim.

I also authorize other healthcare providers and facilities that have provided examination, diagnosis and/or treatment to me, or my family member(s), to release any and all medical records, photographs, and related information regarding my diagnosis and treatment, to or by other healthcare providers for the purposes stated above.
I agree and consent to the release of any and all of said records and medical information by oral, written, or electronic means of communications, to or from this facility to the parties stated above.

EASTERN SURGICAL ASSOCIATES, PC will not be responsible for the loss of, miscommunication or retrieval of, or confirmation of any electronically transmitted or non-certified correspondence to or from this facility.

_____ **PHOTOGRAPHS:** I consent to the taking of photographs for documentation of the area(s) involved in diagnosis and treatment and for these photographs to be made part of my medical record. I hereby consent to the use of said photographs for teaching purposes, publications including websites, scientific articles, medico legal testimony, and for insurance purposes. I release and indemnify EASTERN SURGICAL ASSOCIATES, PC, its employees, and physicians from all damages connected with the release of and return of such photographs and waive all rights concerning publication including commissions and payments for the use of such photographs.

_____ **PERSONAL VALUABLES:** This facility shall not be liable for the loss of or damage to any money, jewelry, glasses, dentures, documents, or other personal articles brought into this facility. Parking is provided for your convenience. We will not be responsible for damage, loss, theft, to or from vehicles parked on the office property.

_____ **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby assign my right to payment of all benefits otherwise payable to me under any policies of insurance providing coverage for such charges to EASTERN SURGICAL ASSOCIATES, PC, its physicians and providers insofar as necessary to cover my expenses. This authorization is given for all insurance benefits to which I may be entitled whether designated as primary or secondary. I agree to permit a photocopy of this assignment to be used in place of the original. I agree to cooperate fully with this facility's efforts to obtain payment under any such policy (policies) and will execute any additional documents my insurance company may require in order to process this facility's claims. In the event of any over payment of insurance benefits, I authorize this facility to issue a refund to the company involved in making such overpayment and not to the owner or beneficiary of the policy directly.

_____ **DEDUCTIBLE AND CO-PAYS:** Payment of unpaid deductibles and copays will be expected at the front desk prior to your office visit when services are rendered, or when billed. It is not our policy to "write off" deductibles and copays. Non-payment will initiate the collection procedures.

_____ **FILING INSURANCE:** As a courtesy, we will file our charges for you with your health insurance carrier(s). We do not file separate cancer or other insurance policies that are not assigned to this facility or its providers. We will, however, provide you with information to file these policies yourself.

_____ **REFERRAL FORMS:** If your insurance requires a written referral from your primary physician, it is **your responsibility** to bring a **written referral** with you at the time of your consultation or treatment. By signing below, I am agreeing to pay charges for all services provided by this facility, its employees, and its physicians in good faith regardless of required referrals. I agree to waive any rights of exemption or protection provided to me by insurance carriers, state or federal laws, and cooperates fully with this facility's efforts to appeal any adverse decisions regarding referral forms or certifications. We will not be responsible for lost or forgotten referrals, unconfirmed faxes, or mailed referrals. You may incur additional administrative charges from this office for confirmation of referrals.

_____ **FINANCIAL RESPONSIBILITY:** By law, insurance carriers are required to pay their portion of the claim within 45 days after treatment has been rendered. Unless **specific prior arrangements** have been made, you will be expected to **pay the balance of your bill within 60 days after treatment has been rendered**. Unpaid balances after that date will initiate the collection process. Even small, unpaid balances such as copays and unpaid deductibles may be entered on your permanent credit record and may affect your ability to obtain future credit. We may be required to report to the IRS account balances that could be considered forgiven debts as taxable income. If you find that you are unable to make payment on you bill, please contact our office to make arrangements for payment. Failure to make payment is basis for legal action, and by signing below you are agreeing to pay all costs of collection including reasonable attorney fees and you are hereby waiving rights of exemption under the Constitution and Laws of the State of Alabama and any other state.

The undersigned certifies that he/she has read the foregoing, including the front and back, has received a copy thereof, and is the patient, the patient's guardian, or is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms.

Patient/Guardian Signature	Date	Witness	Date