SURGICAL INNOVATIONS OF TEXOMA

Today's Date: _____

Last name: _____ First name: _____ Middle initial: _____

Street Address: _____ City: _____State: _____Zip: _____

Home Phone: _____ Cell Phone: _____

Date of birth: _____ Age: _____ Sex: _____ Marital status: _____

Social security number: _____-_____-_____Email Address: _____

Preferred method of contact (please circle one): Home phone Cell Email

Occupation: _____ Employer: _____

Spouse / Parent name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Primary care physician: _____ Referring physician: _____

Primary insurance: _____ Insured name: _____

Relationship to patient: _____ Insured DOB: _____ Insured SSN: _____

Secondary insurance: _____ Insured name: _____

Relationship to patient: _____ Insured DOB: _____ Insured SSN: _____

Pharmacy (include city): _____ Phone: _____

All co-payments, co-insurance, and deductibles must be paid at the time of service. In case of surgery, prepayment of your co-insurance must be paid before surgery is scheduled. I understand that I am responsible for any fees associated with the collection of my account balance.

I authorize Surgical Innovations of Texoma to release any medical or other information about me to the Social Security Administration and Health Care Financing Administration or its intermediaries of carrier, commercial insurance companies, insurance companies, insurance adjusters, attorneys, my referring physician or consults which may be necessary to process claims on my behalf.

I hereby consent to receiving emails, calls or texts on my mobile device.

I hereby consent to treatment by Dr. Chad Friedle, which could include in office procedures and injections.

Signature of patient: _____ Date: _____

Signature of guardian/personal representative: _____ Date: _____

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Patient Agreement & HIPAA Acknowledgement

1. I understand that under the Health Insurance Portability and Accountability Act (HIPAA), that I have certain rights to privacy regarding health information. If requested, I have the right to receive a copy of the authorization.

2. I authorize Surgical Innovations of Texoma to use any electronic means to communicate with me regarding appointments, reminders, general medical information, test results, billing, and/or referral information.

3. I authorize Surgical Innovations of Texoma to communicate with the following family member(s) or friend.

   Name of family/friend: _____

4. I authorize my insurance carrier to make direct payments on my behalf to Surgical Innovations of Texoma for medical services rendered.

5. I understand that I am responsible for all specialist co-payments, deductible, or co-insurance at the time of service (**no checks**). Surgery fees will be collected at the time of scheduling. I accept ultimate financial responsibility for all charges incurred with Surgical Innovations of Texoma whether paid by insurance or not. *There is a $50 surgery reschedule fee, $100 cancellation fee, and $500 no show fee for scheduled surgeries.* Anesthesia, hospital, and lab fees are **not** handled by this office.

6. When your insurance company requires a referral, it is **your** responsibility to see it is in our office 24 hours prior to your appointment.

7. I understand that all prescription refill requests require 48 hours notice.

8. There is a $35 charge for FMLA and other forms the office must complete.

9. I hereby consent and authorize all diagnostic and therapeutic treatment performed at Surgical Innovations of Texoma considered necessary or advisable in the judgment of the physician.

The attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Patient/guardian signature: _____ Date: _____

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Patient name: _____ DOB: _____ Age: _____Sex: _____

Reason for today's visit: _____ Date first noticed: _____

Is it due to a work-related injury? Yes ☐ No ☐ If yes, please specify date of injury: _____

Are you disabled: Yes ☐ No ☐ Reason: _____

Recent diagnostic testing (please circle): X-ray / Ultrasound / CT / Labs

If so, please indicate date and where tests were done: _____

Personal Medical Symptoms / History

- ☐ Abdominal pain
- ☐ AIDS
- ☐ Anal Fissure
- ☐ Anemia
- ☐ Anesthesia Complications
- ☐ Anxiety
- ☐ Asthma
- ☐ Cancer
- ☐ Changes in bowel habits
- ☐ Chest pains
- ☐ Crohn's Disease
- ☐ Cirrhosis
- ☐ Colon Polyps
- ☐ COPD
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Diverticulosis
- ☐ DVT
- ☐ GERD
- ☐ GI Bleeding
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Thyroid Disorders
- ☐ IBS
- ☐ Liver Disease/Hepatitis
- ☐ Melanoma
- ☐ Pilonidal Cyst
- ☐ Rectal Bleeding
- ☐ Rectal Pain
- ☐ Sleep Apnea/Snoring
- ☐ TB
- ☐ Weigh Loss / Gain
- ☐ Other _____

(Office use only)

Vitals

Height: _____ Weight: _____ BP: _____

Plan:

Patient Name: _____

Medications

Please list ALL current medications, dose, and how often you take them.

1. _____ Dose: _____ How often? _____
2. _____ Dose: _____ How often? _____
3. _____ Dose: _____ How often? _____
4. _____ Dose: _____ How often? _____
5. _____ Dose: _____ How often? _____
6. _____ Dose: _____ How often? _____
7. _____ Dose: _____ How often? _____
8. _____ Dose: _____ How often? _____

ALLERGIES: _____

Flu Vaccine: _____ Pneumococcal Vaccine: _____ Covid Vaccine: _____

Pharmacy: _____ Phone: _____

Personal Past Surgeries (Please indicate date)

- ☐ Abdominal_____
- ☐ Appendectomy_____
- ☐ Breast_____
- ☐ Cardiovascular _____
- ☐ C-Section_____
- ☐ Eye_____
- ☐ Gallbladder_____
- ☐ Hernia repair with or without mesh_____
- ☐ Hysterectomy / Vasectomy_____
- ☐ Orthopedic_____
- ☐ Rectal_____
- ☐ Thyroid/Parathyroid_____ _____
- ☐ Tonsillectomy_____
- ☐ Other_____

Family History (Please indicate relationship)

Father Alive / Deceased Age: _____ Present health or cause of death: _____

Mother Alive / Deceased Age: _____ Present health or cause of death: _____

Siblings Alive / Deceased Age: _____ Present health or cause of death: _____

Sister Alive / Deceased Age: _____ Present health or cause of death: _____

Children Alive / Deceased Age: _____ Present health or cause of death: _____

Check illnesses that have occurred in any of your BLOOD RELATIVES

- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Stroke

Personal Habits

Tobacco: ☐Yes ☐ No How many packs per day: _____ for _____years Drugs: Y / N

Alcohol: Never Daily Weekly Monthly

Caffeine: ☐Yes ☐ No How much daily: _____