PORTAGE SURGICAL
ASSOCIATES, INC.

John Gusz, MD
Lynn Wotjasik, MD

3973 Loomis Parkway, Suite A
Ravenna, Ohio 44266

Phone: (330) 296-8239
Fax: (330) 296-6528

Thank you for choosing Portage Surgical Associates to participate in your health care. The physicians and staff look forward to caring for you.

****Please take a few minutes to complete the enclosed paperwork and bring it to your scheduled appointment along with your insurance card(s), photo ID, and copay if applicable.**

When filling out your paperwork, please pay special attention to the section regarding medications. We need complete and accurate information, including the name, dosage, and instructions for each medication you take on a regular basis. We can accept medications lists but only if it contains all the above information.

Please remember that insurance is considered a method of reimbursing the physician for services rendered and is not a substitute for payments. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amounts, co-insurance, or any other balance not paid by your insurance company. It is also your responsibility to make sure a referral is in place if your insurance company requires one. If you are unsure if any of the above applies to you, please contact your insurance company to check your benefits.

If you have any questions prior to your appointment, please contact our office at 330-296-8239. Thank you for your cooperation.

TELL US ABOUT YOURSELF

Name_____ _____ _____ Date of Birth _____
First Middle Last

Primary Care Physician_____ Last Office Visit_____

Allergy	Reaction	Allergy	Reaction

Medical History - Do you have a history of the following, please check all that apply:

Anesthesia Problems
- ☐ No past anesthesia issues
- ☐ Family history of Malignant Hyperthermia
- ☐ Difficult Intubation
- ☐ Nausea and vomiting after surgery
- ☐ Difficult to wake up

Hearing Problems
- ☐ No hearing problems
- ☐ Hearing difficulty
- ☐ Wear hearing aids

Blood Problems
- ☐ Are you taking a blood thinner? Coumadin, Aspirin, Plavix, Motrin, Ibuprofen, Naprosyn, Fish oil, Flax seed oil, Vitamin E
- ☐ Will accept blood transfusion if needed
- ☐ Will **not** accept blood transfusion
- ☐ History of blood clots
- ☐ Blood disorder
- ☐ History of a blood transfusion
- ☐ History of blood transfusion reaction
- ☐ Anemia

Cardiovascular
- ☐ No Cardiac History
- ☐ High Blood Pressure
- ☐ Heart Murmur / Mitral Valve Prolapse
- ☐ Heart Attack
- ☐ Bypass surgery / Angioplasty
- ☐ High Cholesterol
- ☐ Abnormal Stress Test
- ☐ Pacemaker / Defibrillator
- ☐ Irregular heart beat
- ☐ Heart Catherization
- ☐ Chest Pain
- ☐ Stroke

GI Problems
- ☐ No GI problems
- ☐ Ulcers
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hepatitis
- ☐ Difficulty swallowing
- ☐ GERD/reflux
- ☐ Irritable bowel syndrome / Crohns
- ☐ Blood in Stool / Rectal bleeding

GYN/Urology
- ☐ No urology problems
- ☐ No GYN problems
- ☐ Kidney Stones
- ☐ Kidney Infections
- ☐ Uncontrolled Urination
- ☐ Urinary frequency
- ☐ Kidney failure

Health Habits
- ☐ Do not drink, smoke, use illegal drugs
- ☐ Drug use
- ☐ Smoke
- ☐ Past history of smoking
- ☐ Drink alcohol

Infections and skin
- ☐ No rashes/scratches/wounds
- ☐ No infections
- ☐ Rashes
- ☐ Open areas on skin
- ☐ MRSA
- ☐ VRE

Nervous System/Psychological
- ☐ No history
- ☐ Chronic headaches
- ☐ Dizziness
- ☐ Seizures
- ☐ Depression
- ☐ Mental Health Treatment
- ☐ Anxiety

Muscular/Skeletal
- ☐ No problems
- ☐ Gout
- ☐ Arthritis
- ☐ Back injury or pain
- ☐ Broken bones
- ☐ Total knee or hip replacement
- ☐ Fibromyalgia

Respiratory
- ☐ No breathing problems
- ☐ Sleep apnea
- ☐ Asthma
- ☐ Chronic bronchitis
- ☐ Short of breath
- ☐ Pneumonia
- ☐ CPAP use
- ☐ Emphysema

Vision
- ☐ No vision problems
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Glasses/contacts

Other
- ☐ Cancer
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Implants/foreign material in or on body
- ☐ HIV
- ☐ Other

TELL US ABOUT YOURSELF

Surgical History

List all previous surgeries:

Date	Surgeries

List Medication - DO NOT FORGET OVER THE COUNTER AND HERBAL MEDICATIONS

Medication	Dosage	Frequency

Family History

☐ Cancer --- Where:_____	☐ Mother	☐ Father	☐ Brother/Sister
☐ Heart Disease	☐ Mother	☐ Father	☐ Brother/Sister
☐ Stroke	☐ Mother	☐ Father	☐ Brother/Sister
☐ Diabetes	☐ Mother	☐ Father	☐ Brother/Sister

Comments or Concerns

_____

_____

_____

_____

_____

PORTAGE SURGICAL ASSOCIATES, INC.

John R. Gusz, M.D., F.A.C.S.

Lynn A. Wojtasik, M.D., F.A.C.S.

PATIENT INFORMATION

Last Name: | Phone: | Alternate phone:

First Name & MI: | Social Security #: | Sex: ☐ Female ☐ Male | Date of Birth:

Address: | Marital Status: ☐ Single ☐ Married ☐ Divorced or ☐ Widowed

City: | State: | Zip: | Primary Physician: | Referring Physician:

Email Address:

RESPONSIBLE PARTY INFORMATION

Last, First Name & MI | Social Security Number: | Date of Birth:

Address: | Phone Number: | Alternate phone:

City: | State: | Zip: | Relationship to patient:

Primary insurance

Insured Party: ☐ Same as Patient or ☐ Same as Guarantor | Relationship to patient:

Insured ID Number: | Insured Phone #:

Insurance Company: | Social Security Number: | Date of Birth:

secondary insurance

Insured Party: ☐ Same as Patient or ☐ Same as Guarantor

Insured ID Number:

Insurance Company:

Social Security Number: | Date of Birth:

Emergency contact

Name:

Phone number:

Relationship:

Patient's Employer:

Insurance Authorization & Assignment/Consent to Treatment

I, with my signature, authorize Portage Surgical Associates, Inc. and any employee working under the direction of the physician, to provide medical care to me or to this patient for which I am the parent/legal guardian. I authorized Portage Surgical Associates, Inc. to furnish information to the identified insurance carrier for prior authorization, pre-certification or payment of healthcare services. This information may include claims, copies of medical information, faxes and phone calls concerning care provided or proposed. I assign all payments for these services to this practice. I understand that I am responsible for all co-payments, deductibles and other amounts that may be deemed my responsibility by the insurance plan as required by my contract with my insurance plan and state regulations.

I authorize and give consent to the identified physician/practice and other healthcare professionals associates with this physician to discuss my care or other relevant information with attorneys, accountants, malpractice carrier, outside consultants, transcription, billing agents, coding specialists as deemed necessary by my physician. This includes all services relating to my medical care including hospital services, nursing home services, lab services, radiology services, and care directly ordered by my physician.

I understand that my contract with my health care insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

DATE: _____ SIGNATURE: _____

PORTAGE SURGICAL

ASSOCIATES, INC.

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

Portage Surgical Associates is very concerned about the protection of your health information. **Federal law** is requiring all physician offices to have a signed privacy statement on file for every patient. In order to serve you we must have an existing Privacy Acknowledgement form on file. This law is intended to protect the privacy of your medical records.

Thank you

We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We and other healthcare providers may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by completing a form and giving it to the front desk staff.

SIGNATURE: _____ **DATE:** _____

Any and all situations can be discussed with (representative & relationship) _____

_____

☐ I do, ☐ I do not give permission to leave detailed message on answering machine regarding appointments, instructions for surgery, test results, billing and/or insurance issues or other pertinent information from Portage Surgical Associates.

_____ This may be used as a secondary contact.
(Email Address)

FOR OFFICE USE ONLY

I have made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above patient, but was unable to for the following reason:

- ☐ Language Barrier
- ☐ Patient Cannot Read
- ☐ Patient Objects
- ☐ Read Later and Return
- ☐ Unable to sign
- ☐ Other: _____

Employee Name: _____ Date: _____

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FINANCIAL AGREEMENT

Thank you for choosing Portage Surgical Associates, Inc as your healthcare provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is part of that relationship. Please ask if you have any questions about our fees, our policies or your responsibilities. It is your responsibility to notify our office of any patient information changes (address, name, insurance, ect.)

Co-pays:
The patient is expected to present an insurance card(s) at each visit. All Co-payments and past due balances are due at your visit unless previous arrangements have been made. We accept cash, check and credit cards. If you have no insurance coverage you will be considered a Self-pay account. You will be required to pay $50.00 at the time of your appointment and any remaining balance will be billed to you.

Insurance Claims:
Insurance is a contract between you and your insurance company. In most cases, we are not a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurances, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. If your insurance plan is one with which we are not a participating provider, you will be responsible for payment in full.

Worker's Compensation:
It is the patient's responsibility to provide our office staff with employer authorization/contact information regarding a worker's compensation claim. If the claim is denied by the worker's compensation carrier, then it becomes the patient's responsibility. At your request, we will submit the claim to your primary insurance carrier with a copy of the worker's compensation denial. If your primary medical insurance claim is denied, you will be responsible for payment in full.

Outstanding Balance Policy:
It is our policy that all past due accounts, over 90 days, will receive a letter to make payment arrangements. If no resolution can be made, the account will be placed to our collection agency, attorney and possibly result in discharge from the practice.

By my signature below I acknowledge receipt of the Financial Agreement:

Printed name: _____

Signature: _____ **Date:** _____

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Dr. John Gusz, MD
Dr. Lynn Wojtasik, MD

MEDICAL APPOINTMENT/PROCEDURE CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Portage Surgical Associates, INC. When you schedule an appointment with our office, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment/procedure please contact our office as soon as possible, and no later than 48 hours prior to your scheduled appointment. This will give us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

Effective May 1, 2023 any patient who fails to show or cancel/reschedule an appointment and has not contacted our office within **at least 24 hour notice** will be considered a No Show and charged a $50.00 fee (Insurance companies will not cover this fee).

Any patient that is scheduled for a Procedure or Surgery who fails to show or cancel/reschedule an appointment and has not contacted our office within **at least 48 hour notice** will be considered a No Show and charged a $100.00 fee (Insurance companies will not cover this fee).

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, we may be able to accommodate the situation. If you should call to cancel after hours, you may leave a message with our answering service and that would be counted as an attempt to contact our office.

I have read and understand the Medical Appointment/Procedure Cancellation/No Show Policy and agree to its terms.

Signature (Parent/Legal Guardian) _____ Relationship to Patient _____

Printed Name _____ Date _____

Demographic Questionnaire

These questions are asked to help us comply with governmental demographic reporting requirements. This practice does not discriminate on the basis of race, ethnicity, color, national origin, sex, disability, veteran status or age.

Patient Name_____Date of birth_____

Race

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ I decline to provide this information

Ethnicity

Are you Hispanic or Latino? Yes ☐ No ☐

- ☐ I decline to provide this information

Preferred Language_____