CENTRAL SURGICAL ASSOCIATES, PLLC

Welcome to our practice!

We are happy that you have chosen to trust our physicians with your health care and look forward to meeting you.

Enclosed, you will find our New Patient Packet, which includes the forms that we need you to complete to tell us about yourself.

PLEASE REMEMBER TO COMPLETE ALL FORMS AND BRING WITH YOU FOR YOUR APPOINTMENT.

- ***Make sure you sign or initial all the highlighted areas on the forms.***
- ***We will collect your insurance co-payment or 20% the day of your visit***
- ***PLEASE VERIFY THE LOCATION OF YOUR APPOINTMENT.***
- ***If Your Appointment is in our Jackson Main Office***

Jackson- 1190 North State St. Suite 502 Jackson, MS. 39202

- ***If Your Appointment is in one of our Satellite Clinics***

Monday- Dr. Rooks Lackey- Memorial Hospital 330 North Broad St. Forest, Ms. 1st floor

Tuesday- Dr. Fiser Kosciusko- Attala- Baptist Medical Center 1st Floor Outpatient Clinic

Thursday- Dr. Jones Magee-Medical Tower at Tuscan Court-360 Simpson Hwy 149-Suite 170

Thursday- Dr. Nicols- Hazlehurst- Copiah County Medical Center 27190 Hwy 28

Friday- Dr. Logan- Madison Clinic 401 Baptist Dr. Suite 204 Madison, Ms. 39110

We look forward to a long and healthy relationship with you.

Visit our website: www.csurgical.com
Main Office: 601.944.1781
Fax: 601.353.0439

Patient Information **PLEASE USE INK ONLY** **NO PENCILS PLEASE**

Patient Name_____
LAST First Middle

Date of Birth _____Age _____ Sex ( ) Male ( ) Female

Social Security _____ ( ) Married ( ) Single ( ) Divorce ( ) Separated ( ) Widowed

Please use your physical mailing address

Patient Mailing Address: _____Apt:_____

City_____ State_____ Zip_____

Home Phone ( ) _____ Cell Phone ( ) _____

Patient Employment_____ Business Phone_____

Patient Email Address _____

Spouse Name_____ Spouse Date of Birth_____
Last First Middle

Spouse Social Security #_____

Spouse Employment _____ Spouse Employment Phone _____

Primary Health Insurance Company_____
Policy Number_____ Group Number_____
Primary Policy Holder_____ Date of Birth_____
Last First Middle

Secondary Health Insurance_____
Policy Number_____ Group Number_____
Primary Policy Holder_____ Date of Birth_____
Last First Middle

Name of person responsible for this account: _____

Relationship to patient _____

Contact # _____ DOB _____SS#_____

Address _____

Emergency Contact_____ Relationship _____

Home Phone _____ Work _____Cell _____

Please Check Ethnicity Information

Black or African American		Hispanic/ Latino		English	
White		Non-Hispanic/Latino		French	
American Indian Alaska Native		Refuse to Report		German	
Native Hawaiian/Pacific Island				Japanese	
Other				Spanish	

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Billing and Insurance Claims:

- IT IS THE PATIENT'S RESPONSIBILITY TO NOTIFY US OF ANY INSURANCE REQUIREMENTS: PRE-CERT, SECOND OPINION, REFERRAL NUMBERS, CO-PAYS, X-RAYS, LAB PREFERENCE OR HOSPITAL PREFERENCE PER YOUR INSURANCE CARRIER.

- DENIAL OF CLAIMS OR UNPAID BILLS DUE TO INCORRECT INFORMATION WILL BE THE PATIENTS RESPONSIBILITY.

CENTRAL SURGICAL ASSOCIATES, PLLC CANNOT AND WILL NOT CHANGE PHYSICIAN DIAGNOSIS TO COVER NON-COVERED SERVICES. IF YOU FEEL THERE IS AN ERROR IN YOU MEDICAL RECORD YOU MAY PUT IN A REQUEST AND OUR MEDICAL RECORDS DEPARTMENT WILL LOOK AT IT AND DETERMINE IF YOUR REQUEST IS VALID.

PATIENT/GUARDIAN BY SIGNING BELOW YOU ARE RESPONSIBLE FOR ANY CO-PAYMENTS UN-MET DEDUCTIBLES AND ANY UN-PAID PORTION OF THE BILL.

Disability/FMLA Forms:

- I UNDERSTAND THAT ANY ADDITIONAL CLAIM FORMS SUCH AS ATTENDING PHYSICIAN STATEMENTS OR DISABILITY FORMS THAT CENTRAL SURGICAL ASSOCIATES, PLLC FILLS OUT FOR ME, WILL ONLY BE FILLED OUT ON FRIDAYS AND I WILL BE CHARGED $ 10.00 PER FORM DUE WHEN FORMS ARE PICKED UP, MAILED OR FAXED.
- FAMILY MEDICAL LEAVE (FMLA) FORMS ARE FILLED OUT AT A NO CHARGE TO THE PATIENT AND WILL BE FILLED OUT ON FRIDAY'S ONLY.

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS:

BY SIGNING THIS FORM, I AUTHORIZE:

- CENTRAL SURGICAL ASSOCIATES, PLLC, NURSE, PHYSICIAN OR PHYSICIAN ASSISTANT TO TREAT ME.
- I FURTHER AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY FOR THE COMPLETION OF-- (TPO) TREATMENT, PAYMENT OR OPERATIONS.
- I AUTHORIZE PAYMENT DIRECTLY TO CENTRAL SURGICAL ASSOCIATES, PLLC AND THE TREATING PHYSICIAN FOR ALL MEDICAL BENEFITS OTHERWISE PAYABLE TO ME UNDER THE TERMS OF MY INSURANCE.
- I UNDERSTAND THAT WHILE I AM UNDER CENTRAL SURGICAL ASSOCIATES, PLLC/PHYSICIAN TREATMENT IT IS ALSO MY RESPONSIBILITY TO NOTIFY CENTRAL SURGICAL ASSOCIATES, PLLC OF ANY CHANGES. SUCH AS ADDRESS CHANGE, PHONE NUMBER, INSURANCE, JOB, OR MARITAL STATUS. IT IS ALSO MY RESPONSIBILITY TO MAKE SURE CENTRAL SURGICAL ASSOCIATES; PLLC HAS A CORRECT COPY OF MY INSURANCE CARD(S).

CENTRAL SURGICAL ASSOCIATES, PLLC WILL FILE YOUR INSURANCE CLAIM FOR YOU. HOWEVER, YOU ARE RESPONSIBLE FOR MAKING SURE CLAIMS ARE PAID.
A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I HAVE READ THE ABOVE AND UNDERSTAND MY RESPONSIBILITIES.

Patient/Guardian Signature:_____**Relationship:**_____

Date:_____

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Dear Patient,

The following form for you to sign is called an arbitration agreement. This form states that if you are unhappy with our services and want to file a lawsuit, you will agree to go in front of an arbitrator instead of a twelve-person jury trial. You are not waiving your rights to file a lawsuit. An arbitrator is a retired lawyer or judge. A law firm in another state chooses this person, so the person is not partial to either party. Our Clinic does require you to sign this before you meet with the Physician for an office visit or procedure. If you want to make any changes to this form, the Physician will review it and will decide on treatment. If you refuse to sign this form, our Clinic will be happy to refer you to another physician or back to the Physician that referred you to our Clinic. Please carefully read the arbitration agreement, and if you still have any questions, call our office at 601.944.1781. Please sign the highlighted areas and initial the highlighted boxes on the back of the arbitration.

Thank you,

Central Surgical Associates, PLLC

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CLINIC – PHYSICIAN – PATIENT ARBITRATION AGREEMENT

_____, ("Patient") engages Central Surgical Associates, PLLC, or employee(s) thereof ("Clinic"), J. Russell Rooks, M.D., PLLC, H. Gregory Fiser, M.D. PLLC, Lee M. Nicols, M.D., PLLC, T. Matthew Jones, M.D., PLLC, Kara S. Logan, M.D., PLLC, Courtney C. Wright, PA-C, Tammy Sims Davis, PA-C, Heather G. Morris, PA-C, E.Mackenzie Carmody, PA-C And associated Physicians/PA's, member(s) or employee(s) thereof ("Members"), and each Physician that renders medical care and services to perform services in conjunction with Patient's medical care. For and in partial consideration of the rendition of any and all present and future medical care and services, Patient agrees that in the event of any dispute, claim or controversy arising out of or relating to the performance of medical services, including but not limited to, patient fees, informed consent, negligence or medical malpractice, between Patient (whether a minor or an adult) or the heirs-at-law or personal representative(s) of Patient, as the case may be, and the Clinic, the Members, and each Physician individually, where the claim or the amount in controversy exceeds $5,000, such dispute or controversy shall be submitted to JAMS, or its successor, on an arbitration form for final and binding arbitration. All claims for unliquidated damages shall be deemed claims for in excess of $5,000.

Either party may initiate arbitration of any matter subject to arbitration by filing a written demand for arbitration at any time. Patient shall be entitled to an in-person hearing in his or her county in accordance with the Federal Arbitration Act. The arbitration shall be administered by JAMS pursuant to its Comprehensive Arbitration Rules and Procedures and Minimum Standards of Procedural Fairness, and all parties agree to be bound by the arbitrator's decision. Any decision by the arbitrator(s) shall be accompanied by a reasoned opinion. Judgment may be entered on the arbitrator's award, if any, by the court having jurisdiction of the subject matter.

All parties agree that their relationship affects interstate commerce and that this Agreement shall be governed by the Federal Arbitration Act and, if not, by Mississippi law. The party requesting arbitration shall bear all costs of the arbitration, except the Patient is not required to pay any more than $125.00, with Clinic or Members bearing the other arbitration costs.

If you are not willing to submit to binding arbitration, the Clinic may perform the services or refer you to another health care provider capable of rendering the medical care or services which you require (although Physician assumes no responsibility for the quality of care or service rendered by any other health care provider). Please inform a Clinic representative immediately if you do not agree to binding arbitration and desire such referral.

This Agreement may be rescinded by written notice by either party within fifteen (15) days of signature. However, any claim or dispute related to medical services rendered after execution of this Agreement and prior to the date of such written notice of rescission shall be subject to the terms of this Agreement. Written notice of such rescission may be given by a guardian or conservator of Patient if Patient is a minor or incapacitated. If any portion of this Agreement is found unenforceable, that portion shall be stricken and the remainder of this Agreement fully enforced. If a court rules that the dispute must be litigated and not arbitrated, Patient agrees the suit will be heard in the county where services are rendered.

NOTICE: BY SIGNING THIS AGREEMENT YOU ARE AGREEING TO HAVE ANY CLAIM OF NEGLIGENCE OR MEDICAL MALPRACTICE DECIDED BY NEUTRAL BINDING ARBITRATION AND YOU ARE GIVING UP YOUR STATUTORY AND CONSTITUTIONAL RIGHT TO A JURY OR COURT TRIAL.

Witness our signatures this the _____ day of _____, 20_____.

CENTRAL SURGICAL ASSOCIATES, PLLC
H. GREGORY FISER, M.D., PLLC
T. MATTHEW JONES, M.D., PLLC
KARA S. LOGAN, M.D., PLLC
LEE M. NICOLS, M.D., PLLC
J. RUSSELL ROOKS, M.D., PLLC
Tammy Sims Davis, PA-C
Heather G. Morris, PA-C
Courtney C. Wright, PA-C
E.Mackenzie Carmody, PA-C
and associated Physicians/PA's

By: _____
Authorized Representative (Clinic)

By: _____
Patient

If a parent or guardian has signed on behalf of their minor child or ward, such parent or guardian hereby attests that he or she has full legal authority to execute this agreement on behalf of said child or ward. Furthermore, said parent or guardian hereby agrees to indemnify and hold harmless the Clinic, the Members, and their employees and Physicians from any claim, demand or loss which may occur in the event said parent or guardian does not, in fact, have such legal authority.

By: _____
Parent or Guardian

A photo static or electronic copy of this authorization shall be considered as effective and as valid as the original.

_____
Physician Initials

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SUMMARY OF ARBITRATION AGREEMENT PATIENT: _____

		Patient's Initials In Each Box
1.	Before signing the Agreement the Patient may make written changes in the Agreement if they so desire and present these to the Clinic for approval.	
2.	The Patient is agreeing to arbitrate any disputes above $5,000. You are agreeing not to sue the Clinic, its Members, or any of their Physicians or employees in a court of law.	
3.	The Patient is waiving his or her constitutional or statutory right to a jury trial.	
4.	Arbitration will be performed by JAMS. This is a national association of neutral arbitrators. They don't work for the Clinic, Physician(s), or for the Patient. The Clinic or the Members will pay the costs, except for the first $125.00, and each side will pay for their own attorneys and other costs.	
5.	This Agreement is effective to the date of this Agreement.	
6.	The Patient can rescind this Agreement within 15 days, but must still arbitrate any claim arising before the Agreement is rescinded.	
7.	If the Patient does not agree to arbitrate, or if you rescind this Agreement, the Clinic will either treat the Patient or immediately refer them to another doctor or group who can provide the medical care they need. The Patient is not in need of emergency care or under immediate stress.	
8.	If a court rules that a dispute must be litigated and not arbitrated, any lawsuit must be filed in the county where services are rendered.	
9.	In arbitration, each side will have a fair opportunity to present their evidence, but court rules do not necessarily apply. There is no appeal except in limited circumstances.	
10.	Patient, Physician(s), Members and the Clinic all have the right to terminate their relationship at any time.	
11.	A claim by you or the Physician(s), Members, or Clinic will be waived and forever barred if, on the date of the demand for arbitration, the claim would be barred by the applicable statute of limitations.	
12.	If you still have any questions, you should consult an attorney before signing.	

I hereby confirm that I have explained the Agreement to the Patient, and the Patient has affirmed his or her understanding of the Agreement by initialing or signing beside each of the foregoing provisions.

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Heather G. Morris, PA-C
Courtney C. Wright, PA-C
E.Mackenzie Carmody, PA-C
and associated Physicians/PA's

By: _____
Authorized Representative (Clinic)

_____

Physician Initials

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PATIENT PORTAL AUTHORIZATION FORM

Our patient portal lets established patients communicate more easily with us. The portal is not intended for 'Web Visits' or new problems. Instead, it will make regular communication more flexible. The portal is a voluntary option and is free of charge to all patients. The patient portal provides you with a much more seamless way to access your health information and contact our office.

Through the portal, you can:

- Request refills and appointments.
- Update your contact and insurance information.
- Check your medication list, medical history and your visits.
- Get your lab results quickly.
- Email us securely back and forth.
- Email billing questions.

We want your records to be complete and correct. Let us know if there's any problem with your records.

Privacy matters. We will never sell/trade/abuse your e-mail address. The patient portal is protected just like all other interactions with our office. We also think it's important for you to protect privacy on your end, and we recommend that you protect your username and password to avoid misuse.

We take security seriously, too. Computer networks do have real risks. We use appropriate technologies to protect your health information. We follow all security laws, including HIPAA and HITECH.

Bedside manner is complicated via email. It's easy to misread information or emotion. We'll keep things brief and clear in the Portal. We appreciate your help on that, too. If a message takes a long time to write, it's probably something better done in person at an office visit.

If we have troubles, abuse or "Spam," we may need to change policies, suspend accounts, or even terminate the use of the portal.

You can access the portal day or night, but we don't have a 24 hour presence on our end. As a safeguard, the portal should not be used for pressing issues, or <u>if you are experiencing an emergency, you should call dial 911 or go to the nearest Emergency Room.</u>

By signing below and providing my **<u>Email address,</u>** I acknowledge that I would like a Patient Portal account and agree to the terms and conditions set forth above.

_____YES, I wish to sign up for portal **_____No I DO NOT wish to sign up for Portal**

If yes, Email Address: _____

Signature: _____

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HIPAA Information and Consent Form

2015 Patient Paperwork

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy as a patient. Implementation of HIPAA requirements officially began on April 14, 2003. While we have followed these policies for years, there have been a few updates that we wanted you to be aware of. This is a shortened version of the HIPP*A* policy. The full policy is available upon your request.

There are rules and restrictions on who may see or be notified of your Protected Health information (PHI). These restrictions do not include the normal exchange of information within our office. HIP*AA* provides certain rights and protections to you as the Patient. We follow these guidelines and provide you with the quality care you deserve. Additional information is available from the U.S. Department of Health and Human Services. You can find them online at www.hhs.gov

Patient information will be kept confidential except when it is necessary to provide services or to ensure that all administrative matters related to your care are handled properly. This may include, but not limited to, the sharing of information with other healthcare providers, laboratories, and health insurance companies. Patient information (treatment plans, insurance forms, eob's, etc.) may be stored in file cabinets not accessible to patients. Preparing for and during your office visit, such records may be left, at least temporarily, in administrative areas such as the front office, doctor's desk, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

We send out reminders to our patients. We do this by one or more of the following: e-mail, texting, and calling. We try to make every effort to remind you of your appointment and any treatment that you may need.

You agree to us sending electronic e-referrals to specialists, which include your PHI and x-rays if needed. We also send electronic claims to your health insurance, which includes submitting PHI to receive payment for services provided.

You permit us to remind you to take pre-medication before appointments, if applicable.

You give us permission to call in prescriptions you may need and share your PHI with the pharmacist.

The practice utilizes some vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in the normal performance of their duties.

You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor, and understand that you have the right to file a complaint. We can help you do this, and you will not be penalized for filing a complaint

Your confidential information will not be used for marketing or advertising of products, goods or services without your permission

We agree to provide patients with access to their records by state and federal laws. We may update this policy as needed to serve the needs of our patients and our practice.

By signing below, I agree that I have been offered and will receive a full version of the HIPAA policy upon my request. I understand and acknowledge my agreement to the terms outlined in the HIPP*A* information and consent form and any future updates to this policy.

Signature: _____

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❖ **Patient Name:** _____

Please Circle:
Which Physician are you seeing today: Fiser Jones Logan Nicols Rooks

Reason for visit: _____
Symptoms/Complaints: _____
How long have you had this complaint? _____
Referring Physician: _____Family Physician: _____

PAST MEDICAL HISTORY (please check all that apply)

Aids/HIV		Hepatitis	
Asthma		High Blood Pressure	
Blood Clots		High Cholesterol	
COPD		Kidney Disease	
Diabetes		Jaundice	
Heart Attack		Seizures	
Heart Disease		Stroke	
Cancer (type): Year Diagnosed:			
Other:			

Tobacco	Never	Current	Former	Packs Per Day	# Years
Cigarettes					
Smokeless					

Alcohol	Never	Occasional	Daily	Drinks per day

Controlled Substances(Drugs)	Never	Occasional	Daily	Type Used

Family History

Heart attack	Stroke	High Blood Pressure	Diabetes	Cancer	Type
☐Mother	☐Mother	☐Mother	☐Mother	☐Mother	_____
☐Father	☐Father	☐Father	☐Father	☐Father	_____
☐Brother	☐Brother	☐Brother	☐Brother	☐Brother	_____
☐Sister	☐Sister	☐Sister	☐Sister	☐Sister	_____

Other:

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❖ Patient Name: _____

SURGICAL HISTORY ***Please check all that apply and circle right or left as it applies.***

Appendectomy		Mastectomy Right or Left or Both	
Colon Surgery		Lumpectomy Right or Left or Both	
Thyroid Removal		Hemorrhoidectomy	
Heart Surgery		Kidney Transplant	
Hysterectomy		Hiatal Hernia Repair	
EGD (throat scope)		Incisional Hernia Repair	
Colonoscopy		Umbilical Hernia Repair	
Gastric Bypass		Inguinal Hernia Repair R or L or Both	
Gallbladder Surgery		Other:	
Prostate Surgery		Other:	

Pharmacy Information

Preferred Pharmacy	Location	Phone

List Medications "Currently Using" over the counter or prescribed

Medication	Dose	Times per day	Medication	Dose	Times per day

Use back page if you need more space

Medication Allergies:

Penicillin		Lidocaine	
Cipro		General Anesthesia	
Bactrim		IVP DYE (X-ray dye)	
Doxycycline		Silver Products	
Clindamycin		Sulfa	

Please list any other allergies:_____

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❖ **Patient Name:** _____

Have you had a mammogram within the last year?
☐ No
☐ Yes, Date: _____ Location: _____

Do you see a Cardiologist (heart doctor)? If so, Dr_____
Do you see a Pulmonologist (lung doctor)? If so, Dr_____

Dialysis Patients Only
Days you dialyze: ☐Monday/Wednesday/Friday ☐Tuesday/Thursday/Saturday
Dialysis Unit Name/Location: _____
Dialysis Time: _____ Unit Phone #: _____

Workman's Compensation Only

Are you being seen for a work-related accident? ☐YES ☐NO
Have you reported the accident/injury to Workman's Compensation? ☐YES ☐NO
Date of accident/injury: _____
Describe accident/injury: _____
_____
_____

I authorize Central Surgical Associates, PLLC to discuss my medical conditions and care with the following person(s):

1. _____Relationship_____
2. _____Relationship_____
3. _____Relationship_____

Do you have a person who can make medical decisions on your behalf if you are unable to?

YES ☐ **NO** ☐

If so, Name: _____Relationship: _____

Please rate your pain using the chart below

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