



**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 YOUR 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: \_\_\_\_\_**

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

Please Circle:

Which Physician are you seeing today: Fiser Hamilton 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: \_\_\_\_\_

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:	

**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:**

\_\_\_\_\_

\_\_\_\_\_

❖ 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

Wong-Baker FACES® Pain Rating Scale

