Wiregrass
SURGICAL

Flowers Hospital Doctor's Center
4300 West Main St., Ste. 24, Dothan, AL 36305
Office. 334.793.1534 | *Toll-Free.* 800.464.7951 | *Fax.* 334.793.6840
www.wiregrasssurgical.com

WIREGRASS SURGICAL PATIENT INFORMATION FORM

PATIENT'S FULL NAME: _____PREFERRED NAME: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____DOB: _____

HOME PHONE: _____WORK PHONE: _____

CELL PHONE:_____ E-MAIL:_____

SOCIAL SECURITY #: _____DRIVERS LICENSE #: _____

PREFERRED PHARMACY: _____PHARMACY ZIPCODE#: _____

SEX ( ) Male ( ) Female MARITAL STATUS ( ) Single ( ) Married ( ) Divorced ( ) Widow

RACE ( ) American Indian/Alaskan Native ( ) Asian ( ) Black/African American ( ) Pacific Islander ( ) White
Other: _____

REFERRING PHYSICIAN: _____FAMILY PHYSICIAN: _____

Primary Insurance: _____ Policy Holder: _____
Member ID/Policy #: _____Group #: _____
Date-of-Birth: _____

Secondary Insurance: _____ Policy Holder: _____
Member ID/Policy #: _____Group #: _____
Date-of-Birth: _____

Tertiary Insurance: _____ Policy Holder: _____
Member ID/Policy #: _____Group #: _____
Date-of-Birth: _____

EMERGENCY CONTACT AND PERSON(S) WE MAY RELEASE INFORMATION TO:

NAME: _____RELATION: _____ PHONE: _____

NAME: _____RELATION: _____ PHONE: _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize Wiregrass Surgical Associates, P.C. to release all medical records and pertinent medical information to any insurer, governmental agencies providing benefits, or to anyone liable for charges. I also authorize release of said information to my referring physician and to other medical providers who are or may become involved in my treatment.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I may obtain a copy of the Notice of Privacy Practices. Upon arrival, copies will be made available at my request. I also acknowledge that a copy is posted in the patient waiting area and available to access for my personal review.

SIGNATURE: _____ DATE: _____
PLEASE DO NOT SIGN BELOW: OFFICE USE ONLY

Verify: ____ ____ ____
Date: _____ _____ _____

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PATIENT MEDICAL HISTORY FORM

PRIOR TO YOUR APPOINTMENT, please carefully complete this MEDICAL HISTORY FORM, the PATIENT INFORMATION FORM, and the RISK ASSESSMENT FORM (if included, as applicable). Thank you.

***COMPLETION IN ADVANCE OF ARRIVAL WILL EXPIDITE THE PROCESS.**

Please list ALL MEDICATIONS that you are currently taking including DOSAGE and FREQUENCY:

MEDICATION	DOSAGE	FREQUENCY

Please list any ALLERGIES to medications or general allergies:

All information provided will be discussed at your appointment including the details pertaining to any personal or family history of cancer. Feel free to call our appointment scheduling department at (334) 793-1534 should you have any questions.

I, _____, (PRINT) acknowledge that the above information is accurate and a true reflection of my medical history.

_____
PATIENT'S SIGNATURE (or Personal Representative & relationship to the patient)

_____
Date

WS EMPLOYEE WITNESS _____

Wiregrass Surgical Risk Assessment Form for Hereditary Cancer Screening Program

Please complete this form **accurately and to the best of your ability. We will review it with you upon arrival.*

Patient Name: _____ Insurance: _____

Date of Birth: _____ Physician: _____ Today's Date: _____

This is a screening tool for cancer that runs in families. Please consider the following family members when completing the form:

1st Degree Relatives = Mother/Father/Sister/Brother/Children

2nd Degree Relatives = Aunt/Uncle/Grandparent/Grandchild/Niece/Nephew

3rd Degree Relatives = Cousin/Great-Grandparent/Great-Aunt/Great-Uncle

Have YOU or ANY OF YOUR RELATIVES been tested (BRCA/Colaris) for a Hereditary Cancer Syndrome? YES NO

Have YOU ever been diagnosed with ANY type cancer? YES NO If so, what Site: If so, what age:

		BREAST & OVARIAN CANCER (HBOC/BRCA*nalysis*)	Self	Siblings or Children	Your Relationship to Family Member		Age at Diagnosis
					Mother's Side	Father's Side	
Y	N	Breast Cancer at Age 45 or Younger (in Self, 1st or 2nd Degree Relative)					
Y	N	Ovarian Cancer at Any Age (in Self, 1st, 2nd or 3rd Degree Relative)					
Y	N	**2 Relatives** on Same Side of Family with Breast Cancer - **1 of them under the Age of 50**					
Y	N	3 Relatives on Same Side of Family with Breast Cancer at Any Age					
Y	N	**Multiple** Breast Cancers in the Same Person (in the same breast OR both breasts)					
Y	N	Triple Negative Breast Cancer (ER, PR and Her2 Negative Receptor Status) at Age 60 or Younger					
Y	N	Male Breast Cancer at Any Age (in Self, 1st, 2nd or 3rd Degree Relative)					
Y	N	Pancreatic Cancer with Breast, Ovarian or Prostate Cancer in the same person or on same side of the family					
Y	N	**Ashkenazi Jewish** ancestry with Breast, Ovarian or Pancreatic Cancer in same person or on same side of family					
Y	N	Family member with a known BRCA mutation					

		COLON & UTERINE CANCER (Lynch Syndrome/Colaris)	Self	Siblings or Children	Your Relationship to Family Member		Age at Diagnosis
					Mother's Side	Father's Side	
Y	N	Colon (Colorectal) or Uterine (Endometrial) Cancer before Age 50 (in Self, 1st or 2nd Degree Relative)					
Y	N	**2 or more** Relatives on Same Side of Family with any of the following - **(circle): *Colon, Uterine/Endometrial,*** *Ovarian, Stomach, Small Bowel, Brain, Kidney/Urinary Tract, Ureter, Renal Pelvis, Pancreas*					
Y	N	**3 or more** Relatives on Same Side of Family with any of the following (circle): ***Colon, Uterine/Endometrial,*** *Ovarian, Stomach, Small Bowel, Brain, Kidney/Urinary Tract, Ureter, Renal Pelvis, Pancreas*					
Y	N	Family member with a known Lynch Syndrome mutation					

Patient Signature: _____ HCP Signature: _____

For Office Use Only:

☐ Based on Personal & Family History, testing is NOT indicated for the Patient at this time. Chart #: _____

☐ Genetic Testing Recommended for Patient: BRACAnalysis (HBOC) or Colaris (Lynch)

☐ Patient Declined & Reason: _____

☐ Patient Accepted

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WIREGRASS SURGICAL FINANCIAL POLICY FORM

Thank you for selecting our office for your medical care. In order to prevent any misunderstandings concerning the responsibility for payment of medical and surgical services provided to our patients, the following is supplied: ***Please understand that our service agreement is with YOU and NOT your insurance company.*** *You are responsible for payment for the service(s) rendered not covered by your chosen insurance company.*

ASSIGNMENT OF BENEFITS

For services received, I hereby authorize and direct that payment(s) be made directly to **Wiregrass Surgical Associates, P.C.** for benefits payable under the terms of my policy. I recognize that if payment is made directly to me, the amount received, up to the amount due for services rendered, is the property of **WSA** and should be paid over to **WSA** immediately. I understand that I am financially responsible for charges not paid by this assignment.

MEDICARE

We are participating providers of Medicare Part B only. **Please remember that if you only have Medicare, the remaining 20% of the allowable fee plus the Medicare deductible (if not already met) is the patient's responsibility.**

MEDICAID

We are participating providers of Medicaid. If you are a Medicaid recipient, please provide us with your card to verify eligibility and your co-pay at the time of service, if applicable. If you have Medicaid coverage pending, we require payment for the services at the time of your visit. If it becomes retroactive and Medicaid pays for the services, we will refund your payments in coordination to what Medicaid has covered.

OTHER INSURANCES

Co-payments for office visits are required at the time of arrival. After filing with your insurance, if a balance is put to your responsibility, prompt payment is required. Deductibles and co-insurance are due prior to surgery. Our Financial Director is here to help explain your financial responsibility. For your convenience, we are pleased to accept various forms of payment as well as offer financial lending assistance.

REFERRALS

It is your responsibility to bring any required referrals for treatment at or prior to the visit. **If you do not have the referral, you may be asked to reschedule your appointment until one is acquired.**

RETURNED CHECKS AND DELIQUENT ACCOUNTS

There will be a **$25.00** charge for all returned checks. If your account becomes delinquent and must be placed with a collection agency, you agree to accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such is necessary.

PRIOR CONSENT TO CONTACT BY CELL PHONE

You agree, in order for us to service your account or collect monies you may owe, we may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages and/or emails. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

PERSONAL FORMS

There will be a fee of $25 **per form** that must be paid prior to our office completing (ex: disability, FMLA, personal policy claims, etc.). We also ask that you give us 5 business days following the date of the procedure to complete these form. Most forms cannot be completed until after surgery is performed and our physician has completed all associated notes.

***I have read and understand this policy and my financial responsibilities to Wiregrass Surgical Associates, P.C.**

Patient's Signature: _____ DOB: _____
Patient's Social Security Number: _____ Date: _____
If Minor - Adult's Acknowledgement: _____ Date: _____
If Minor - Adult's Social Security Number: _____ - _____ - _____

WS EMPLOYEE WITNESS _____