Wiregrass
SURGICAL

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

Welcome to our practice! Wiregrass Surgical is devoted to delivering the best possible care to you or your family member. We are happy to serve the Wiregrass community, and we are thankful you have trusted us with your care.

Please take a moment to complete the attached paperwork prior to your appointment. Bringing this completed paperwork along with your ***drivers' license, insurance card and a list of your current medications*** to your appointment will ensure you are seen promptly.

Again, thank you for choosing Wiregrass Surgical.

Best regards,

Your Wiregrass Surgical Team

WIREGRASS SURGICAL PATIENT INFORMATION FORM

PATIENT'S FULL NAME: _____PREFERRED NAME: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____DOB: _____

HOME PHONE: _____CELL PHONE: _____

EMPLOYER: _____WORK 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: _____ _____ _____

Flowers Hospital Doctor's Center
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Chart number:_____ Date: _____

Medical Questionnaire

Patient Name :_____ Date of Birth:_____

Who is your Primary Care Physician? _____

Are you under a pain management agreement? ❒ Y ❒ N If Yes, who is your physician? _____

Do you have a cardiologist (heart doctor)? ❒ Y ❒ N If Yes, who is your physician? _____

Is this visit related to a Worker's Compensation claim? ❒ Y ❒ N If yes, date of injury: _____

Reason for Visit

What is the reason for your visit today? _____

How long have you had this problem? _____ Have you had this problem before? ❒ Y ❒ N

On a scale of 0 – 10 (10 is the worst), how severe is your pain? ❒0 ❒1 ❒2 ❒3 ❒4 ❒5 ❒6 ❒7 ❒8 ❒9 ❒10

What is the quality of your pain? ❒ Sharp ❒ Dull ❒ Stabbing ❒ Throbbing ❒ Aching ❒ Burning

The pain is ❒ Constant ❒ Comes and goes

Tests/Scans – Have you had any tests or scans for this problem?

❒ X-rays ❒ MRI ❒ CAT scan ❒ HIDA scan ❒ Ultrasound ❒ Mammogram/breast imaging

❒ Other: _____

Facility where tests/scans were performed: _____

Medication Allergies

Are you **allergic** to any medications? ❒ Yes ❒ No If yes, please list and describe reaction:

Medication	Reaction

Chart number:_____ Date: _____

What medications do you take on a daily basis? Include over-the-counter, prescriptions and vitamins.

Name	Dose	Frequency (How often)

Chart number:_____ Date: _____

Family History – Indicate **M** for Mother; **F** for Father; **S** for Sister, **B** for Brother

❒ No current problems/disabilities _____
❒ Aneurysm _____
❒ Blood clotting disorder _____
❒ Breast cancer _____
❒ Colon cancer _____
❒ Diabetes mellitus _____
❒ Heart disease _____
❒ Hypertension _____
❒ Hyperthyroidism _____
❒ Hypothyroidism _____
❒ Stroke _____

Social History

Marital Status: ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Live alone ❒ Live with others
Occupation: _____ ❒ Student ❒ Retired
Do you drink alcohol? ❒ Yes ❒ No ❒ Occasionally/Socially
Smoking status: ❒ Never smoked ❒ Former smoker ❒ Current smoker
Chewing Tobacco: How much? _____
Vape/Vapor: ❒ Yes ❒ No

Surgical History – Please check **ALL** that apply:

❒ Adenoidectomy
❒ Aneurysm Repair
❒ Appendectomy
❒ Breast Augmentation
❒ Breast lump (right or left)
❒ Breast lumpectomy for cancer (right or left)
❒ Bowel resection
❒ Bladder surgery
❒ Back surgery
❒ Colonoscopy
❒ Colectomy
❒ Cesarean Section
❒ Coronary Artery Bypass Graft (CABG)
❒ Diagnostic Laparoscopy
❒ Defibrillator
❒ EGD
❒ Exploratory Laparotomy
❒ Gastric Sleeve
❒ Gastric Bypass
❒ Gallbladder (laparoscopic or open)
❒ Hernia repair with mesh (specify: _____)
❒ Hernia repair without mesh (specify: _____)
❒ Hiatal Hernia Repair
❒ Hysterectomy (partial or complete)
❒ Heart catheterization
❒ Heart stent
❒ Heart valve
❒ Hemorrhoidectomy
❒ Incision and Drainage of Abscess
❒ Joint Replacement (specify: _____)
❒ Joint Surgery (specify: _____)
❒ Lap Band
❒ Lung Surgery
❒ Mastectomy (left or right)
❒ Nephrectomy
❒ Nissen Fundoplication
❒ Pacemaker
❒ Prostate Surgery
❒ Powerport/Infusaport
❒ Tubal ligation
❒ Thyroidectomy (circle one: left right total)
❒ Tonsillectomy
❒ Wide Local Excision for Skin Cancer

Other:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Chart number:_____ Date: _____

Past Medical History – Please check **ALL** that apply:

- ❒ AIDS/HIV
- ❒ Acid Reflux (GERD)
- ❒ Adrenal Disease
- ❒ Anemia
- ❒ Anesthesia Complications
- ❒ Aneurysm
- ❒ Anxiety/Depression
- ❒ Arthritis
- ❒ Artificial Joints
- ❒ Asthma
- ❒ Atrial Fibrillation
- ❒ Bleeding Disorder
- ❒ Blood Clot
- ❒ Brain Injury
- ❒ COPD
- ❒ Cancer (Type: _____)
- ❒ Cerebral Palsy
- ❒ Chemotherapy
- ❒ Cirrhosis
- ❒ Congestive Heart Failure (CHF)
- ❒ Dementia
- ❒ Diabetes
- ❒ Dialysis
- ❒ Depression
- ❒ Enlarged heart
- ❒ Epilepsy/Seizures
- ❒ Enlarged Heart
- ❒ Gastric ulcers
- ❒ Gout
- ❒ Heart attack (MI)
- ❒ Heart Disease
- ❒ Heart Attack (MI)
- ❒ Heart Failure
- ❒ Heart Valve Disease
- ❒ Heart Rhythm Changes
- ❒ Hepatitis
- ❒ Hernia
- ❒ Home Oxygen
- ❒ Hypertension
- ❒ Kidney Disease
- ❒ Kidney Stones
- ❒ Leg or Foot Ulcers
- ❒ Lupus
- ❒ Lyme Disease
- ❒ MRSA infection
- ❒ Neuropathy
- ❒ Obstructive Sleep Apnea
- ❒ Peripheral Vascular Disease
- ❒ Pulmonary Embolism
- ❒ Pregnant
- ❒ Radiation Treatment
- ❒ Sickle Cell Disease
- ❒ Multiple Sclerosis
- ❒ Tuberculosis
- ❒ Hypothyroidism
- ❒ Hyperthyroidism
- ❒ Other:

_____
_____
_____
_____
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_____
_____
_____
_____

The information provided on this Medical Questionnaire is accurate to the best of my knowledge.

_____ _____

Signature Date

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 _____

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The surgeons at Wiregrass Surgical often times utilize the assistance of a physician assistant or nurse practitioner during surgery and for office clinics, as well as sometimes require the use of another physician to assist in surgery cases. The assistance of these individuals, who have been specialty trained, ensures that your surgery goes smoothly and safely, and is best for quality patient care.

Please be advised that while many insurance companies cover the costs associated with this, if our group is considered out of network with your provider, or if you are receiving care that is not considered a covered service with your insurance provider, then you may be responsible for these charges. Please also be aware that allowable charges will be processed with your insurance provider for those who assisted in your care in addition to your primary surgeon, so you may see those providers listed on any claims, benefit or insurance statements. For your reference, all of our providers are listed below.

If you have questions regarding this information, please ask to speak with someone in our insurance department.

Thank you,

The Physicians of Wiregrass Surgical

Patient Signature:_____ Date:_____

Wiregrass Surgical Providers
Steven M. Fendley, MD
R. Burton Pfeiffer, MD
Bradley T. Marker, MD
Emily E. Cannon, MD
Leigh Phillips, CRNP
Sarah Beth Sloop, PA
Sara Krystyn, CRNP

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SURGERY RESCHEDULING & CANCELLATION POLICY – GENERAL SURGERY

Please carefully consider your surgical date before scheduling. Our staff accommodates the needs of patients to schedule surgery in a timely manner. This requires careful planning and coordination among our office and the surgical facilities. Short notice cancellation or rescheduling of a scheduled procedure results in significant expense to our providers due to the unused operating time.

Surgeries may be cancelled up to one week prior to surgery. **Any surgery cancelled less than 7 days before surgery will be assessed a $100 cancellation fee**. This fee is not billable to insurance, and it is non-refundable. If you paid out of pocket expenses for the surgery and you cancel the procedure outside of the required time frame, you will receive a refund less the $100 surgery deposit.

Surgeries may be rescheduled up to 72 hours prior to surgery. **Any surgery rescheduled less than 72 hours before surgery will be assessed a $100 rescheduling fee**. This fee is not billable to insurance, and it is non-refundable.

Any outstanding cancellation or rescheduling fees must be paid in full prior to any future appointments.

By signing below, you are acknowledging that you have read and understand the surgery rescheduling and cancellation policy outlined above.

Signature: _____ Date:_____

****

Office Use

Patient Name: _____ Patient DOB: _____

Patient Chart Number: _____

Witness: _____