Surgical Associates of the Mid-Cities

2050 Hall Johnson Road, Suite 200
Grapevine, TX 76051
Ph: 817-267-2678
Fax: 817-251-0039

(We are located inside the Simmons Bank Building on the 2nd floor.)

Dear Patient:

We would like to take this opportunity to welcome you to our office. Please bring the following to your appointment.

- PICTURE ID
- INSURANCE CARD
- CO PAYMENT
- MEDICATION LIST
- MEDICAL HISTORY LIST

Please note that your insurance will be verified prior to your appointment. Any copay, deductible, and co-insurance will be due at the time of service.

Attached you will find your **NEW PATIENT PACKET**.

If you do not have the ability to print, please arrive 30 minutes prior to your appointment time to fill out paperwork. This will help expedite your check-in process. You may email or fax your new patient paperwork prior to your appointment.

If you have any questions regarding your appointment, please do not hesitate to contact our office. We look forward to meeting you and helping you with your healthcare needs.

Thank You,
Surgical Associates of the Mid-Cities

PATIENT INFORMATION FORM

SURGICAL ASSOCIATES
OF THE MID-CITIES, PA

Patient Last Name _____ First Name _____ MI_____

Address: _____

City: _____ State: _____ Zip: _____ Gender: _____

Phone: H) _____ M) _____ Race: _____ Ethnicity: _____

Email Address: _____

DOB: _____ Age: _____ SS#: _____ Marital Status: M S D W

Referring Doctor: _____ Referring Dr. Phone # _____

Primary Doctor: _____ Primary Dr. Phone # _____

Cardiologist: _____ Cardiologist Phone # _____

Pharmacy Name: _____ Pharmacy Phone # _____

Pharmacy Address: _____

City: _____ State: _____ Zip: _____

PRIMARY INSURANCE

Name of Insurance: _____

Name of Policy Holder: _____ DOB: _____ Relationship: _____

ID#: _____ Group#: _____ Insured SS#: _____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip: _____

SECONDARY INSURANCE INFORMATION

Name of Insurance: _____

Name of Policy Holder: _____ DOB: _____ Relationship: _____

ID#: _____ Group#: _____ Insured SS#: _____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip: _____

CONTINUED

SURGICAL ASSOCIATES OF THE MID-CITIES, PA

Special Communication Needs:	
Language Preference:	
If "yes" to any of the questions below, how can we assist?	
Visual Impairment	
Hearing Impairment	
Speech Impairment	
Cognitive Impairment	

Are you currently living at any of these facilities? If yes, please check one

Skilled Nursing ____ Hospice ____ Rehab Facility ____ Other _____

EMERGENCY CONTACT NAME: _____

Phone # _____ Relationship _____

*** Is this a job-related injury? Y N** *** Is this an automobile related injury? Y N**

I give Surgical Associates of the Mid Cities, and/or any of the staff, permission to release any information regarding my medical records to the following persons (Grandparents, Spouse, Adult Children, Caregivers**)**

Name: _____

Phone # _____ Relationship: _____

Name: _____

Phone # _____ Relationship: _____

I give Surgical Associates permission to leave test results via:

Home Phone # _____ _____ OK to leave message with detailed information

Mobile Phone # _____ _____ Leave message with call back number ONLY

_____ DO NOT leave a message

Patient Signature: _____

Patient Printed Name: _____

Legal Representative: _____ Relationship: _____

We promise to provide you with the highest quality surgical care combined with empathy and compassion!

Surgical Associates of the Mid-Cities, PA

SURGICAL ASSOCIATES OF THE MID-CITIES, PA

Health History

(Please complete this form entirely so we are able to provide you with the best of care)

Name: _____ DOB: _____

Age: _____ Sex: _____ Height: _____ Weight: _____

Reason for Visit: Hernia Gallbladder Colon/Rectal Vascular Thyroid Other

Describe your symptoms?
When did your symptoms begin?
How long do they last?
What makes them worse?
Pain on a scale of 1(no pain) to 10 (unbearable)? #
Have you been treated for this before?
When?
By whom?

Personal Health History

Please circle ONLY what applies to you: - past (P) or current (C) problems or conditions		
P/C -Anemia	P/C -HIV	P/C -Stroke
P/C -Anesthesia Problems	P/C -Headaches/Migraines	P/C -Tuberculosis
P/C -Arthritis	P/C -High Blood Pressure	P/C -Thyroid Problems
P/C -Arrhythmias	P/C -Kidney Disease	P/C -Ulcers
P/C -Asthma	P/C -Liver Disease	P/C -Sleep Apnea
P/C -Bleeding Disorder	P/C -Hepatitis -Type A B C	P/C -SARS-COVID-19
P/C- Breast Problem	P/C -Bowel/Digestive	P/C -Addiction Issues
P/C -Cancer/Type:	P/C -Hernia – Type-	
P/C -Circulation Problems	P/C -Hiatal Hernia	P/C -Mental Illness
P/C -Diabetes	P/C -High Cholesterol	P/C -Seizures
P/C -Depression/Anxiety	P/C -Lung Problems	P/C -Ehlers-Danlos Syndrome
P/C -Dialysis	P/C -Multiple Sclerosis	P/C -Osteoporosis
P/C -COPD/Emphysema	P/C -Pacemaker	P/C -Dizziness
P/C – Acid Reflux-GERD	P/C -Vascular Issues- PVD	P/C -Chronic Cough
P/C -Gout	P/C -Pneumonia	P/C -Food Allergies
P/C -Heart Disease-CHF/CAD	P/C -Polio	P/C -Environmental Allergies
P/C -Heart Surgery-Stents	P/C -Prostate Problems	*** -No Pertinent History

SURGICAL ASSOCIATES OF THE MID-CITIES, PA

Previous Surgical Procedures: (Check what applies to you)

	Procedure	Year
	No Prior Surgery	
	Heart Surgery	
	Carotid Artery Surgery (Endarterectomy)	
	Vascular Surgery/Stents	
	Abdominal Aneurysm Repair (EVAR)	
	Hysterectomy (Total-Partial)	
	Gallbladder Removed	
	Appendix removed	
	Tonsillectomy/Adenoids	
	Spine Surgery- (Neck-Back)	
	Breast Biopsy/Surgery	
	Abdominoplasty	
	Breast Augmentation	
	Mastectomy (Left-Right- Bilateral)	
	Prostate Surgery	
	Hernia Surgery -Ventral -Umbilical -Femoral -Incisional -Inguinal (Left-Right-Bilateral) -Paraesophageal	
	Cataracts	
	Cesarean Section	
	Prostatectomy	
	Hemorrhoidectomy	
	Arthroplasty- Shoulder- (Left- Right- Bilateral) -Knee- (Left- Right- Bilateral)	
	Arthroscopy- Shoulder- (Left- Right- Bilateral) -Knee- (Left- Right- Bilateral)	
	Oral Surgery/Wisdom Teeth	
	Vasectomy	
	Splenectomy	
	Colon Surgery	
	Colostomy/Ileostomy	
	Oophorectomy (ovaries removed)	
	Lap Band/ Gastric Sleeve	

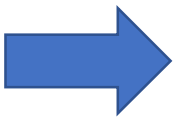
Any other Surgical procedures not listed: _____

_____

Have you had a Colonoscopy? Yes / No Date of last Colonoscopy: _____

Women Only:

Are you pregnant? Yes/No Pregnant- weeks of gestation?



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Habits:

- Tobacco**:** Have you ever smoked? Y / N Current smoker? Y / N
- Smoking Hx: # packs / day_____ # of years used_____
- When did you start? _____ When did you stop? _____
- Alcohol: Drinks/per day_____ Per week _____ #of years used_____
- Exercise: _____
- Occupation: _____

Family History: (check all that apply, indicate Maternal/Paternal)

	Heart Disease	**Diabetes**	**High Blood Pressure**	**Stroke**	**Gallbladder Problems**	**Colon Cancer**	**Other Cancers**
Father							
Mother							
Sister							
Brother							
Grandmother							
Grandfather							
Other							

Please list any other: _____

Allergies/Intolerance:

Medication	**Reaction**	**Severity**

- **No Drug Allergies**

Current Medications:

SURGICAL ASSOCIATES
OF THE MID-CITIES, PA

No Show/Cancellation Policy

At Surgical Associates of the Mid-Cities, our goal is to provide quality surgical care in a timely manner. We have implemented a no show and cancellation policy which enables us to better utilize available appointments for our patients in need of surgical care. The following policy is with regards to patients who fail to keep their scheduled office visit appointment. Please be courteous and call our office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to timely surgical care.

- Patients who fail to show for their scheduled appointment or did not notify the office within 24 hours of their scheduled appointment time, shall be subject to a "No Show/Cancellation" fee of $35.00. In the event of an actual emergency and prior notice could not be given, consideration will be given, and a one-time exception may be granted.

- As a courtesy, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

- These fees are not covered by insurance and is therefore the sole responsibility of the patient.

How to Cancel Your Appointment
To cancel or reschedule an appointment call Surgical Associates of the Mid-Cities at 817-267-2678.

_____ _____
Patient Signature Date

SURGICAL ASSOCIATES OF THE MID-CITIES, PA

FINANCIAL POLICY

SURGICAL ASSOCIATES OF THE MID-CITIES recognizes the need for a clear understanding between patient and surgeon regarding payment for surgical care. The following information is provided to avoid any misunderstanding concerning payment for professional services:

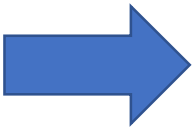
- Payment: If your deductible or out of pocket expense that is your responsibility has not been met, we expect payment when services are rendered. You are exempt from this policy if your primary insurance carrier is Medicare or a managed care insurance that requires only a co-payment at the time of service. EVEN THOUGH INSURANCE WILL BE FILED, YOU ARE RESPONSIBLE FOR ANY BALANCE AFTER INSURANCE PAYMENTS HAVE BEEN MADE. All charges for treatment become due and payable WITHIN ninety (90) days after date of service. This period allows you time to make payment in full of any remaining balance.
- Nurse/Surgical Assistant Fees: Your surgeon may have this nurse, or one of his partners in the operating room, acting as a first assistant. The first assistant's presence helps your operation proceed in a safe and responsible manner. Your insurance will be billed for the assistant's service and you may be financially responsible for a portion of the assistant's charges after the insurance company has paid your allowable.
- Self-payment (private, cash payments): If you have no insurance coverage, we ask that you coordinate your care with our business office prior to your surgery. We require an advance payment for professional services.
- Managed Care: All Managed Care co-payment amounts are due to at the time of service
- Medicare: We are participating providers with the Medicare program and accept as payment. If you have secondary insurance to cover the 20% portion of charges, please provide us with a copy of both insurance cards.
- Children of divorced parents: Responsibility of payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgement must be determined between the individual involved, without the inclusion of Surgical Associates of the Mid-Cities.
- IT IS YOUR RESPONSIBILITY TO ENSURE THAT THE PHYSICIAN YOU ARE SEEING IS PART YOUR INSURANCE NETWORK. It is also required that you OBTAIN AND HAVE AT THE TIME OF YOUR VISIT ANY REFERRAL REQUIRED BY YOUR PLAN. Failure to obtain this referral may deem your medical treatment as "Out of Network" by your insurance company and you will be responsible for a larger amount of the charges. We will obtain pre-certifications required for your office procedure and surgeries.
- Collections: I understand that I am financially and legally responsible for all charges. I further agree that should I not pay the balance within ninety (90) days after date of service my account will be turned over for collections and will be responsible for all costs, collection agency fees and interest, which shall accrue at the maximum rate allowed by law.
- General Consent for Treatment: I consent to and authorize Surgical Associates of the Mid-Cities to treat any condition that I might have and seek to have treated.

Signature: _____ Date: _____

Parent Signature: _____ Date: _____

(If patient is a minor under 18 years of age)

Patient Name (please print): _____



SURGICAL ASSOCIATES OF THE MID-CITIES, PA

Notice of Privacy Practices Acknowledgement

This Notice of Privacy Practices below details how your information can/may be used. We at Surgical Associates of the Mid-Cities honor the privacy of your health information and yield these terms.

You understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have certain rights to privacy regarding your protected health information. You understand that this information can and will be used to:

- Conduct, plan, and direct your treatment and follow-up among the multiple healthcare providers who may be involved in that treatment
- Obtain payment from third-party payers such as insurance, verify eligibility and benefits, billing and/or collections
- Conduct normal healthcare operations such as quality assessments and physician certifications to help SAMC provide you with the utmost quality care

Surgical Associates of the Mid-Cities will not disclose any health information without your permission.

You as a patient at Surgical Associates of the Mid-Cities have the right to:

- Request restrictions on uses and disclosures
- Receive confidential communication regarding your protected health information
- Inspect and copy your protected health information
- Change or modify your protected health information as you see fit

You acknowledge that you have received your Notice of Privacy Practices of the uses and disclosures of your health information. You understand that Surgical Associates of the Mid-Cities has the right to change its notice of Privacy Practices at any time, and that you may contact this organization to obtain a current copy of the Notice of Privacy Practices.

You understand that you may request in writing that you restrict how your private information is used or disclosed to carry out treatment, payment, or health care operations.

Patient Name: _____

Signature (patient or legally authorized representative): _____

If authorized representative, please specify relationship to patient: ☐ parent ☐ minor ☐ guardian ☐ other

Date: _____

For office use only

I attempted to obtain the patient's signature on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Consent to receive text messages from Surgical Associates of the Mid Cities, PA
Adult Patient or Parent/Guardian Consent

_____ _____
(Print name of Patient or Parent's/Guardian) (Date of birth)

By providing your mobile phone number to Surgical Associates of the Mid Cities, PA ("Clinic"), you are agreeing to be contacted by text (SMS) messages to your mobile phone and other wireless devices and the use of an automatic telephone dialing system, artificial voice, and prerecorded messages.

You may opt-out of receiving text (SMS) messages from the Clinic with the word STOP from the mobile device receiving the messages. You do not need to provide this consent for text (SMS) messages to receive any services from the Clinic. However, you acknowledge that opting out of receiving text (SMS) messages may impact your experience with the service(s) that rely on communications via text (SMS) messaging. I can withdraw my consent for receiving text (SMS) messages from the Clinic at any time by speaking or writing to my physician.

_____ **YES**, mobile phone text messages

_____
(Patient Signature)

_____
(Date)

_____ _____
(Staff Signature) (Date)