EVANSVILLE
SURGICAL
ASSOCIATES

Patient Information Form

Patient Information

First Name	M I	Last Name	SSN	Date

Street	City	State	Zip Code	
				☐M ☐F

Home Phone	Cell Phone	Preferred Language	Birthdate

☐ Married ☐ Single ☐ Widowed ☐ Divorced	Email Address (If patient is minor, do not answer here)
☐ Retired ☐ Employed ☐ Student ☐ Disabled	Optional: ☐ African American ☐ Caucasian ☐ Other

Employer/ School Name	Phone

Insurance Information: Name of individual who carries the insurance, if other than patient

First Name	M I	Last Name	SSN

Street	City	State	Zip Code	
				☐M ☐F

Home Phone/Cell Phone	Name of Insurance Carrier	Birthdate

Relationship to Patient	Employer

Responsible Party Information: If minor, parent's information

First Name	M I	Last Name	SSN	Phone Number

Street	City	State	Zip Code	Date of Birth

Relationship	Email address

Pharmacy Information

Name	Preferred Location	State	Phone

Work Comp	Auto Accident
Is your visit today a result of a work injury? ☐Y ☐N Date of Injury:	Is your visit today a result of an auto accident? ☐Y ☐N Date of Accident:

Ownership Disclosure

If you have a procedure, it may be scheduled at the Evansville Surgery Center or Surgicare. Your physician may be a part-owner of the Evansville Surgery Center or Surgicare. The physician believes that the Evansville Surgery Center or Surgicare is an appropriate setting for services for which you are being referred. Nevertheless, the selection of a specific facility always rests with the patient, and you may choose to be referred to an alternate location if you so desire.

Policy for Prescription of Narcotics

As surgeons, we treat pain caused by an operation or severe injury. Thus, we cannot prescribe medications prior to surgery related to pain relief, muscle relaxants, sleeping aids, or "nerve pills". If you feel these medications are necessary, please refer that request to your regular doctor. We accept requests for refills of narcotic medications ONLY during our normal business hours of 8:00 a.m. to 4:30 p.m., Monday thru Friday. The on-call

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surgeon will not authorize refills on narcotics after hours or on weekends. Please understand that there can be no exceptions to this rule. If at any time during your recovery your surgeon feels that your pain is more severe or has lasted longer than expected, he/she may require that you be evaluated face to face in order to determine if a larger problem is present. We require that our patients receive narcotic prescriptions from one source only. If we suspect any overuse or abuse of narcotics, Indiana law gives us the right to obtain a report that details each prescription for narcotics filled within the last several months.

Authorization for Disclosure of Protected Health Information

I authorize Evansville Surgical Associates, Inc. to verbally disclose all protected health information about me to the family member or personal health representative listed below. Should you wish for our office to disclose information to your spouse or significant other, he/she must be listed below. You are also allowing them to have access to your Greenway Patient Portal, if they so choose. This authorization will expire one calendar year from your signature listed below, unless you specify an alternate expiration date. If the authorization has expired, you must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if other than one year:

_____

You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization. The practice places no condition to sign this authorization on the delivery of healthcare or treatment. We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice. You have the right to receive a copy of signed authorizations upon request.

Individual's Name: _____ Relationship: _____ Phone: _____

Individual's Name: _____ Relationship: _____ Phone: _____

Individual's Name: _____ Relationship: _____ Phone: _____

Financial Policy

I hereby authorize Evansville Surgical Associates, Inc. to furnish information to the Insurance Carrier/Employer/FMLA/Disability Co. concerning my illness and treatment. This authorization is valid as long as I am a patient at Evansville Surgical Associates, Inc. I agree that I am responsible for all financial obligations of health services for the patient on this record and for reimbursement and payment of claims from my insurance company, including but not limited to account obligations insured to Evansville Surgical Associates, Inc. prior to this date for a retroactive period not to exceed 45 days and for prospective account obligations to be incurred one-year subsequent to this date. I agree to pay all costs of collection, including, but not limited to collection agency fees, reasonable attorney fees, or the assigned collection agency's reasonable attorney fees and/or court costs. I agree to allow Evansville Surgical Associates, Inc. to service my account or to collect any amounts I may owe. I agree that I may be contacted by telephone at any number associated with my account, including but are not limited to, cell phone numbers that could result in a charge to me. Methods of contact may include, but are not limited to, using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable. I have read this disclosure and agree that I may be contacted by the facility, its' employees, agents, attorneys, and collection agencies as described above.

Consent to Release Information

I hereby authorize the physician(s) of Evansville Surgical Associates, Inc. to release any information regarding services rendered and allow a photocopy of my signature to be used to file insurance. I request that payment under the medical insurance program be made to the physician(s) of Evansville Surgical Associates, Inc. I certify that the information given to me in applying for payment under title XVIII of the Social Security Acts (if applicable) is correct and I assign the benefits payable for physician services to the physician or organization furnishing the service or authorize such physician or organization to submit a claim to Medicare.

Referral Notice

When we refer you to another provider, please be advised:

1. An out-of-network provider may be called to render healthcare items or services to a patient during course of treatment
2. An out-of-network provider is not bound by the payment provisions applicable to healthcare items or services rendered by a network producer under the covered individual's health plan.
3. A patient may contact their health plan before receiving healthcare items or services rendered by an outside provider to obtain a list of network providers that may render healthcare items or services for additional assistance.

This does not apply in the following situations:

1. Treatment of an emergency medical condition.
2. Referral made immediately following treatment of an emergency medical condition and by provider that rendered the treatment of emergency medical condition.
3. Referral for medically or psychologically necessary therapeutic services rendered to an admitted patient in a hospital or another facility to which a patient may be admitted for more that twenty-four (24) hours.
4. Referral made by a provider that has confirmed the provider is in network with respect to the patient's health plan.

My signature herby certifies all the information provided is correct and that I have reviewed Evansville Surgical Associates, Inc. ownership disclosure notice; I consent to release information as stated above and have received/reviewed a copy of the facilities Notice of Privacy Practice and Financial Policy.

Completed by: _____ _____ _____

Signature of Patient/Parent or Legal Guardian/ Responsible Party | Printed Name | Date