Surgical Care of North Texas

Patient name: _____

Date of birth: _____

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, Surgical Care of North Texas may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge Surgery Associates of North Texas may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to Surgery Associates of North Texas any insurance or other third-party benefits available for health care services provided to me. I understand Surgery Associates of North Texas has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Surgery Associates of North Texas, I agree to forward all health insurance or third party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Surgery Associates of North Texas by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for Surgery Associates of North Texas, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Surgery Associates of North Texas or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Surgery Associates of North Texas or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: _____ **Date:** _____

If you are not the patient, please identify your relationship to the patient.

Circle or mark relationship(s) from list below:

☐ Spouse Guarantor ☐
☐ Parent Healthcare Power of Attorney ☐
☐ Legal Guardian Other (please specify) _____
☐

SURGICAL CARE OF NORTH TEXAS

Fall Risk Assessment age 65 and older

Please note: This screening is required by federal mandate to be completed annually

Patient Name _____

Date of Birth _____

Date: _____

Increased Fall Risk Factors (Check all that apply)

- ☐ Diagnoses (Do you have 3 or more existing medical conditions?)
- ☐ Do you have a prior history of falls within 3 month?
- ☐ Incontinence (Do you have an uncontrolled bladder?)
- ☐ Visual Impairment (Do you have trouble seeing?)
- ☐ Impaired functional mobility (Do you use a cane or walker?)
- ☐ Polypharmacy (Do you take more than 3 medications?)
- ☐ Pain affecting level of function (Does pain keep you from performing your daily activities?)
- ☐ None of the above

History of falls in the past year? ☐ YES ☐ NO

If yes, how many? _____

Surgical Care of North Texas

NEW PATIENT ASSESSMENT

NAME: _____ Age: _____ Height _____ Weight _____

Physician Information

Primary Care Physician Name: _____ Phone Number: _____

Referring Physician Name: _____ Phone Number: _____

Pharmacy

Pharmacy Name: _____ Pharmacy Address: _____

Pharmacy Phone #: _____ Pharmacy Fax #: _____

Immunizations

Have you had the Flu shot this Flu Season? ___ Yes ___ No If Yes, when? _____

Have you had the Pneumococcal vaccine? ___ Yes ___ No If Yes, when? _____

Medications:

Medication	Dose

Allergies:

Drugs/Foods	Reaction

Past Medical History

Have you ever had any of the following (circle all that apply)

Problem	Yes	No	Comments
High Blood Pressure			
Diabetes (sugar)			Pill or Insulin?
Chest Pain (angina)			
Shortness of Breath			
Stroke			
Chronic Bronchitis			
Asthma			
Hepatitis			What Type?
Stomach Ulcer			
Frequent Bladder Infections			
Cancer or Tumor			
Arthritis			Where?
Thyroid Problems			
Anema (low blood count)			
Depression			
Blood Clots			
Kidney Problems			
Other Problems:			Explain:

Surgical History

Type of Surgery	Date of Surgery

Family History:

What illnesses have there been in your family?

	Major Illnesses, or had the same problem as you do now	Living?	Age of Death
Father			
Mother			
Sibling			
Grandparent			
Child			

Social History:

Tobacco: Do you smoke now? ___Yes ___No If Yes, how many packs per day? _____ How many years? ____

Have you quit? ___Yes ___No If yes, when? _____

Do you use alcohol? ____ Yes ____ No If Yes, how many drinks per week? _____

Have you ever used Illegal drugs? ___Yes ___No If yes, what kind? _____

Who lives at home with you? Mother ☐ Father ☐ Husband ☐ Wife ☐ Children ☐ Other ☐

SURGICAL CARE OF NORTH TEXAS

REVIEW OF SYSTEMS

NAME: _____ DATE: _____

What is the reason for your visit today? _____

Please check any symptoms or any other problems you are having today:

GENERAL:
- ____ None
- ____ Fever
- ____ Chills
- ____ Body aches
- ____ Tired
- ____ Weight loss/gain
- ____ Loss of appetite
- ____ Night sweats

HEAD/EYES:
- ____ None
- ____ Headaches
- ____ Vision changes
- ____ Yellow eyes

EARS/NOSE/THROAT:
- ____ Hearing loss
- ____ Ringing in ears
- ____ Nosebleed
- ____ Difficulty swallowing
- ____ Sore throat
- ____ Lumps or swollen glands
- ____ Neck pain
- ____ Neck stiffness
- ____ Neck tenderness

HEART:
- ____ None
- ____ Chest pain
- ____ Palpitations
- ____ Skipping beat, pounding, or racing heart
- ____ Heart murmur
- ____ Shortness of breath with activity
- ____ Fainting/near-fainting
- ____ Light-headed
- ____ Swelling legs/feet

LUNGS:
- ____ None
- ____ Shortness of breath
- ____ Nonproductive cough
- ____ Productive cough
- ____ Blood in sputum
- ____ Hoarseness
- ____ Sleep apnea
- ____ Abnormal sputum production

GASTROINTESTINAL:
- ____ None
- ____ Heartburn
- ____ Reflux
- ____ Change in appetite
- ____ Nausea
- ____ Vomiting
- ____ Abdominal pain
- ____ Excessive belching
- ____ Excessive flatulence
- ____ Bloating
- ____ Change in bowel habits
- ____ Diarrhea
- ____ Constipation
- ____ Rectal bleeding
- ____ Blood in stool
- ____ Black tarry stool
- ____ Mucous in stool
- ____ Narrow stool

MUSCULOSKELETAL:
- ____ None
- ____ Back pain
- ____ Joint pain
- ____ Muscle aches
- ____ Muscle cramps
- ____ Difficulty walking

SKIN:
- ____ None
- ____ Rashes
- ____ Lumps
- ____ Color change
- ____ Easy bruising
- ____ Changes hair/nails
- ____ Changes to skin/moles
- ____ Itching
- ____ Hives

NEUROLOGIC:
- ____ None
- ____ Confusion
- ____ Dizziness
- ____ Fainting
- ____ Memory changes
- ____ Tingling/Numbness
- ____ Muscular weakness
- ____ Incoordination
- ____ Seizures
- ____ Loss of balance

PSYCHIATRIC:
- ____ None
- ____ Anxiety
- ____ Depression
- ____ Hallucinations
- ____ Suicidal
- ____ Trouble sleeping

ENDOCRINE:
- ____ None
- ____ Cold intolerance
- ____ Heat intolerance
- ____ Weight gain
- ____ Weight loss
- ____ Hot flashes

HEMATOLOGIC/LYMPHATIC:
- ____ None
- ____ Easy bleeding
- ____ Easy bruising
- ____ Tender/enlarged lymph node
- ____ Taking blood thinner

I have provided the above medical history and verify that it is accurate and complete.

Patient Signature:_____ Date_____

Patient Health History has been reviewed by _____ on _____

(Physician Signature) Date

SURGICAL CARE OF NORTH TEXAS

Policy on Narcotic Medications

In 2010, there was 8.76 million prescription abusers in the United States. On October 56, 2014, the Drug Enforcement Agency determined that all the Hydrocodone products are now schedule II restricted prescriptions. Prescriptions of these medications now require a special prescription form from the government. These prescriptions cannot be renewed over the phone and include:

Hydrocodone

Norco

Vicodin

Percocet

Oxycodone

Oxycontin

Therefore, it is the policy of this office that the above medications will be provided for patients only immediately after surgery and for the use after discharge from the hospital.

At the time of your first follow up visit and thereafter ,if you require ongoing pain medications you will be switched to one or more of the following schedule III medications:

Tylenol #3

Tylenol #4

Tramadol

If you required schedule II medication beyond 2-3 weeks after surgery you will be asked to schedule an appointment with a Pain Management doctor.

_____ _____ _____

Signature Printed Name Date

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Suite 400
Flower Mound, TX 75028

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6750 N MacArthur Blvd.
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