Madhu Prasad M.D., FACS | Sherry Johnson D.O.

Patient Information

Patient Name:_____ D.O.B.:____/____/____ SSN:_____/_____/_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Physical Address:_____

Hm Phone:_____ Cell Phone:_____ Wk Phone:_____

May we leave a message on your voicemail? (circle) **Yes or No** Email:_____

Employer:_____ Occupation:_____

Referring Physician:_____

Do you have a lab preference? _____ Pharmacy? _____

Parent/ Legal Guardian (if not patient): _____

Gender (circle one): Male Female **Marital Status (circle one):** Married Single Widowed Divorced

If married, spouse's name: _____Spouse's Phone: _____

Emergency Contact(s):

Name:_____ Phone:_____ Relationship: _____

Name:_____ Phone:_____ Relationship: _____

Insurance Information

Primary Insurance:

Insurance: _____ Ins. Phone#: _____

Policy #: _____ Group #:_____

Policy Holder: _____Policy Holder's SSN:_____/_____/_____ DOB:____/_____/ _____

Secondary Insurance:

Insurance: _____ Ins. Phone#: _____

Policy #: _____ Group #:_____

Policy Holder: _____Policy Holder's SSN:_____/_____/_____ DOB:____/_____/ _____

Signature: _____ **Date**:_____

2925 Debarr Rd. | Ste. D-350 | Anchorage, Ak | 907-276-3676 | 907-276-3679

Far North
GENERAL SURGERY & SURGICAL ONCOLOGY

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Today's Visit:

What is the reason for your visit today? _____

Where and when were you diagnosed? _____

Who is your primary care doctor? _____

Medical History

*Current Medications (list **all** prescribed medications, blood thinners and vitamin supplements):*

Medication	Dosage/ Frequency	Reason Used

Allergies (list any known drug allergies): ____ No known drug allergies

Medication	Reaction

Past Medical History:

- ☐ AIDS/ HIV
- ☐ Acid Reflux (GERD)
- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma/ COPD
- ☐ Blood Clots
- ☐ Cancer: _____
- ☐ Depression/ Anxiety
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ Gallbladder Disease
- ☐ Heart Disease
- ☐ Hepatitis A, B, C
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraines
- ☐ Obesity
- ☐ Seizures
- ☐ Stroke/ CVA/ TIA
- ☐ Thyroid Disease

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Female History (if you're being seen for breast issue):

Age when menstrual cycle began (usually 12-14): _____

Date of last menses:_____

Age at first live birth: _____

Number of pregnancies: _____

Number of children born: _____

Did you breast feed? YES NO

If yes, for how long? _____

Age at menopause: _____

Do you still have your uterus? YES NO

Do you still have your ovaries? YES NO

Past Surgical/ Hospitalization History (list any past surgeries or hospitalizations):

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

Family History-blood relatives only (If yes, please specify relationship):

- ☐ Alcoholism: _____
- ☐ Bleeding Disorder: _____
- ☐ Cancer *(specify type)*: _____
- ☐ Diabetes: _____
- ☐ Heart Disease/ Stroke: _____
- ☐ Hypertension: _____
- ☐ Liver Disease: _____
- ☐ Thyroid Disease: _____
- ☐ Other: _____

Social History

Do you exercise? *(circle one)* Sedentary Moderate Vigorous

Do you smoke? YES NO If yes, how many packs per day? _____ # of years? _____

Do you use other tobacco products? YES NO If yes, list type and frequency: _____

Do you use any recreational drugs? YES NO IF yes, list type and frequency: _____

Alcohol consumption: _____ drinks/ day **or** _____ drinks/week

Caffeine consumption: _____ drinks/ day **or** _____ drinks/ week

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Review of Symptoms

General/ Constitutional:

- ☐ Fever
- ☐ Fatigue
- ☐ Night sweats

HEENT:

- ☐ Difficulty swallowing
- ☐ Hearing loss
- ☐ Headaches
- ☐ Vision changes

Endocrine:

- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst/ hunger
- ☐ Weakness

Respiratory:

- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath

Cardiovascular:

- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Swelling in extremities
- ☐ Blood clots

Gastrointestinal:

- ☐ Vomiting/ nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain/ cramping
- ☐ Black/ bloody stools
- ☐ Changes in appetite
- ☐ Heartburn

When was your last colonoscopy? _____

Genitourinary:

- ☐ Pain with urination
- ☐ Blood in urine
- ☐ Difficulty urinating
- ☐ Frequent urination

Musculoskeletal:

- ☐ Bone/ joint pain
- ☐ Bone/ joint swelling
- ☐ Muscle aches

Neurologic:

- ☐ Change in mood
- ☐ Change in memory
- ☐ Depression
- ☐ Anxiety

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

Signature: _____ Date: _____

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Financial Policy

Welcome to Far North Surgery (FNS). We understand that many patients find financial matters surrounding their medical care to be very complex and often confusing. We will do our best to answer your questions, but we recommend calling your insurance carrier if you are unsure of your coverage.

1. **Insurance-** It is your responsibility to know your insurance benefits. If you are unsure of your benefits, please contact your insurance carrier with questions. All patients with insurance coverage of any type must show their insurance card for us to bill your insurance. If you do not provide proof of insurance, you will be expected to pay in full at the time of service and will be considered as a self-pay patient until the appropriate billing information is provided to our office.

2. **Co-Payment, Deductible, and Fees-** Co-pays, deductible, and/ or coinsurance is collected at each visit without exception. This is part of your contractual obligation with your insurance company. You will be billed for any amount not covered by your plan in addition to your deductible, and/or co-insurance amounts not collected at the time of service.

3. **Self-Pay, Uninsured Patients**- FNS offers a discount for patients who may not have health insurance coverage. Patients who have no insurance coverage will be responsible for the total cost of services rendered at the time of service. If needed, arrangements may be made on an individual basis with the office manager **prior** to your visit.

4. **Surgeries/ Procedures**- If surgery is scheduled, you may be asked to make a down payment prior to surgery. If needed, the office manager is happy to assist you in developing a payment plan prior to services being rendered.

5. **Workers Compensation**- We accept Workers' Compensation (WC) claims, your claim must be open and accepted with the WC entity. You must provide your carrier's information including company, adjustor, phone number, claim number and date of injury. No payment is required at the time of service.

6. **Claims Submission-** As a courtesy we will submit claims to your insurance carrier on your behalf for services rendered. Please understand that the balance of your unpaid claim(s) is your responsibility.

7. **Payment Plans-** Payment plans must be established through FNS's office manager. Please note our payment plans are determined on an individual basis.

8. **Missed Appointments-**Unless they are cancelled at least 24 hours in advance, our policy is to charge $50.00 for missed appointments. This fee is not covered by your insurance plan and is your responsibility.

9. **Prompt Payments-** Balances are due within 30 days of your first statement. You will receive 2 statements over a 90-day period. Unless you have established a payment plan with our office manager, any remaining balance at 90 days can be sent to a collection agency. If your insurance company pays you directly by check for services provided by FNS, **you are legally obligated to bring it to us promptly**. If not, you will be sent to Cornerstone Collection Agency.

My signature below verifies that I have been notified of and agree to the financial policies of Far North Surgery.

_____	_____	_____
Guarantor/ Patient Signature	Printed Name	Date Signed