Surgical Associates
of Metro Atlanta, LLC

Donald A. Maynard, MD FACS

Patient Information

Patient Name ________________________________ Birthdate____________ M F Date_______________

Address: _____________________________________City__________________ State _______Zip___________

SS# ___________________________Home phone# ______________________Cell Phone#________________

Occupation ____________________Pt. Employer _________________________Work# _________________

Marital Status Single Married Divorced Widowed Daytime #__________________________________

Spouse Name ____________________________ E-mail Address_______________________________________

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Ethnicity: Non-Hispanic Hispanic Preferred Language_______________________(Please specify)

Race(s): African or African American Asian or Asian American Caucasian or European American

Native American or Native Alaskan Native Hawaiian or Other Pacific Islander Other Race ______________

Advanced Directive on File yes no If yes, please specify location______________________________

If no, would you like for our staff to provide you information? yes no

How did you hear about Dr. Maynard? MD office Friend Internet Newspaper T.V Radio

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Emergency Contact **(Relative or friend not living in the same household)**

Name: __________________________________ Relation: ________________Phone#: __________________

Family Doctor: _____________________________________ Phone # _________________________________

Referring Doctor: ___________________________________ Phone # _________________________________

****

Were you injured in an accident? Auto Work related Other__________ Date of injury____________

If WORK related, name & phone # of supervisor: ____

Describe how you were injured: ____

Insurance Information

Private Pay-I understand and agree that I need to make arrangements with office staff prior to seeing the physician to handle pre-payment for services.

____________***Please initial that you understand the above statement.***

Health Insurance-I understand and agree that I will need to provide a current copy of my insurance card to the office staff at the time of service.

____________***Please initial that you understand the above statement.***

Pre-Authorization-I understand and agree that if my insurance requires a pre-authorization that I must obtain this prior to seeing the physician. If a pre-authorization is not obtained I further understand and agree that the amount owed is my responsibility.

____________***Please initial that you understand the above statement.***

PRIMARY INSURANCE

Insurance Company ______________________________________ Phone # ______________________________

Claims Mailing Address ____

Policy Holder ____________________Member ID # ______________________ Group # ___________________

SECONDARY INSURANCE

Insurance Company ______________________________________ Phone # ______________________________

Claims Mailing Address ____

Policy Holder ____________________Member ID # ______________________ Group # ___________________

Financial Policy

All services are paid at the time of service unless we have a contractual agreement with your insurance company. Since there are hundreds of insurance plans, we ask our patients to make sure you are familiar with your own healthcare coverage and its limits. We are, of course, happy to submit claims for those plans with which we are contracted. However, the basic responsibility for payment lies with the patient. If your insurance company requires a co-payment for visits, you must pay at the time of service. We provide a variety of payment options by accepting American Express, VISA, MasterCard and Discover, in addition to cash or check. Please bring your current health insurance card with you at the time of service. We cannot file insurance without a current insurance card and this could result in rescheduling your appointment.

HOW MAY I PAY? We accept payment by cash, check, money order, and all major credit cards.

DO I NEED AN INSURANCE REFERRAL? If you have a HMO/ POS insurance plan with which we are contracted, you will need an insurance referral authorization from your Primary Care Physician. If you have any questions regarding your insurance authorization referral, please give our office a call prior to your scheduled appointment time. **If you are unable to obtain the insurance referral authorization by your appointment time, your appointment will have to be rescheduled.**

WHAT IS MY FINANCIAL RESPONSIBILITY FOR SERVICES? You are responsible for the payment of your copayment, coinsurance, deductibles, and any patient responsible balance. **COPAYMENT IS ALWAYS DUE AT TIME OF SERVICE**. If you cannot pay your copayment at time of service we will be glad to reschedule your appointment. Remember payment responsibility belongs to the patient. SHOULD IT EVER BECOME NECESSARY TO USE THE SERVICES OF AN OUTSIDE COLLECTION AGENCY TO COLLECT YOUR ACCOUNT BALANCE, YOU WILL BE RESPONSIBLE FOR ANY COST INCURRED FOR THAT PURPOSE.

PLEASE READ AND SIGN THE ACKNOWLEDGEMENT OF THE FOLLOWING INFORMATION:

SURGICAL ASSOCIATES OF METRO ATLANTA, LLC. WILL NOT FILE ANY MANAGED CARE INSURANCE THAT WE PARTICIPATE WITH IF THE PATIENT DOES NOT PROVIDE US WITH THEIR MOST CURRENT INSURANCE INFORMATION. I HAVE COMPLETED THIS FORM ACCURATELY, TRUTHFULLY AND COMPLETELY, AND CERTIFY THAT I AM THE PATIENT OR DULY AUTHORIZED GENERAL AGENT OF THE PATIENT AUTHORIZED TO FURNISH THE INFORMATION REQUESTED. **OFFICE POLICY:** I UNDERSTAND AND AGREE THAT I WILL BE RESPONSIBLE FOR ANY BALANCES NOT COVERED. ANY NSF/RETURNED CHECKS WILL BE ASSESSED A $35 FEE.

I HEREBY AUTHORIZE SURGICAL ASSOSCIATES OF METRO ATLANTA, LLC. TO PROVIDE ME WITH MEDICAL AND/OR SURGICAL TREATMENT AND UNDERSTAND THAT I AM RESPONSIBLE FOR ALL SERVICES RENDERED. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION, INCLUDING INFORMATION RELATED TO PSYCHIATRIC CARE, DRUG AND ALCOHOL ABUSE, AND HIV/AIDS CONFIDENTIAL INFORMATION, FOR INSURANCE, DIAGNOSIS, OR TREATMENT PURPOSES AND REQUEST INSURANCE PAYMENTS TO BE PAID DIRECTLY TO SURGICAL ASSOCIATES OF METRO ATLANTA, LLC.

Patient Signature: ______________________________________ Date: ___________________

Processing And Completion Of All Forms

Many of our patients request that we complete various forms so that they may continue to receive income while they are out of work due to surgery. Our office fully understands the importance of the completion of the forms in a timely manner. **PLEASE BE AWARE THAT ALL SHORT TERM AND LONG TERM DISABILITY INSURANCE FORMS OR ANY OTHER INSURANCE RELATED FORMS WILL BE COMPLETED AFTER YOUR FIRST POST-OPERATIVE VISIT TO OUR OFFICE.** Due to the overwhelming requests we receive and the significant of time required by our office staff to complete the forms, effective 6/1/2015, we will begin charging for the **completion of the initial disability form a fee of $25.00**. If it is necessary that additional forms be completed there will a $10.00 fee for completion for each form. As we are sure you are aware, your insurance carrier does not cover this charge. It will be necessary that you pay for the completion of the forms prior to the release of the completed forms.

Our staff is dedicated to making the effort to complete the necessary forms within **3-5 business days** of receipt of the forms after your **AFTER YOUR FIRST POST-OPERATIVE VISIT TO OUR OFFICE.** It is the ***patient's responsibility*** to provide to the staff all forms needing completion as well as a job description and a supervisor's name and number regarding if light duty is available. A staff member must speaker with the supervisor prior to completion of all forms. All completed forms will be mailed or faxed to the appropriate party.

However, all necessary information may still be forth coming and a delay can occur. Our staff will notify you of the delay and an approximate date of completion.

Please do not hesitate to contact our Practice Manager, Donna Edwards if you have any questions.

Patient Name Printed____

Patient Name Signature____

Date of Initial Visit____

Surgical Associates of Metro Atlanta, LLC

Donald A. Maynard, MD FACS
2151B WEST SPRING STREET, SUITE 240
MONROE, GA 30655-3115
770-602-1292 (Tel.) 770-602-1296 (Fax)

MEDICAL RECORDS RELEASE FORM

____ To **OBTAIN** records from another provider
I hereby authorize Surgical Associates of Metro Atlanta, LLC to obtain my records from:
Doctor: All physicians

Address: ____

____

____

****

____ To **RELEASE** records to another provider/Myself
I hereby requests Surgical Associates of Metro Atlanta, LLC to send my records to:
Doctor: All physicians

Address: ____

____

____

****

I understand this authorization includes release of all medical records including HIV, Psychiatric, Drug/Alcohol abuse, Venereal disease & any other statutory protected diseases records. I understand that I may revoke this authorization and consent at any time except to the extent that action has previously taken in reliance hereof.

Patient Name (Print): ____

DOB: ______________________ SSN: ______________________

Signature: ______________________ Date: ______________________

Legal Guardian Name (if not patient): ______________________________

Relation to Patient: ____

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Surgical Associates of Metro Atlanta, LLC

PRE-SURGICAL INSTRUCTIONS

PLEASE INITIAL EACH SECTION THAT YOU UNDERSTAND THE INFORMATION PROVIDED

PATIENT NAME____DATE OF BIRTH_________________________

HOSPITAL PREFERENCE: ☐ROCKDALE MEDICAL CTR ☐ NEWTON MEDICAL CTR ☐CLEARVIEW REGIONAL MEDICAL CTR
OTHER ________________________

PLEASE FOLLOW THESE IMPORTANT INSTRUCTIONS BEFORE SUGERY. IF YOU FAIL TO FOLLOW THESE INSTRUCTIONS, YOUR SURGERY MAY BE CANCELLED. PLEASE INITIAL EACH SECTION THAT YOU UNDERSTAND THE INFORMATION PROVIDED.

SURGERY SCHEDULING *PATIENT OR GUARDIAN'S INITIALS*_____________

- Our staff will contact you with the date and approximate time of your surgery. (Dates and times are made in accordance with the availability of the surgeon and the hospital's schedule). You will also be notified by the hospital in the late afternoon (4:00pm or later) the day prior to your surgery of the arrival time for the surgery day. **DR. MAYNARD DETERMINES AT THE TIME OF YOUR CONSULTATION IF A LETTER OF MEDICAL CLEARANCE IS NEEDED PRIOR TO SURGERY FROM YOUR PRIMARY CARE PHYSICIAN. PLEASE UNDERSTAND YOUR SURGERY WILL NOT BE SCHEDULED UNTIL MEDICAL CLEARANCE IS RECEIVED BY OUR OFFICE**.

PRE-ASSESSMENT *PATIENT OR GUARDIAN'S INITIALS*_____________

- All patients having surgery are required to have a pre-assessment. Based on the hospital's protocol it may be possible to have your pre-assessment evaluation the morning of your surgery. If the hospital protocol calls for your pre-assessment to be any other time other than the morning of your surgery, our staff will schedule the appointment for you. Our staff will contact you with the day and time of your pre-assessment. You must be on time for this appointment. If you do not go for your pre-assessment appointment you surgery will be cancelled.
- Please take with you to your pre-assessment appointment a list of all prescription and over-the-counter medications you take, including vitamins and herbs. This includes the name, dosage and why you take each medication.
- If you find it necessary to cancel your surgery for any reason it is **IMPERATIVE** that you contact our office within 48 hours of your scheduled surgery. Failure to do so may result in a non-cancellation fee up to $100.00

DAY OF SURGERY *PATIENT OR GUARDIAN'S INITIALS*_____________

- Ask your physician if you should take your routine morning medications. If your physician says yes, you should take medications with a sip of water before going to the hospital. If you are taking any blood thinning products such as Coumadin, Aspirin, Plavix, etc, you should stop taking these for a minimum of 7 days prior to your procedure if possible. **If these medications were prescribed to you by a physician please contact that prescribing physician BEFORE stopping the blood thinner to make sure he approved your stopping the medication**.
- If you are scheduled for an outpatient procedure you must have a driver with you who can be responsible for safely getting you home.
- Do not eat (this includes sucking on hard candy or mints) drink, chew gum or smoke after midnight on the night before the surgery. You may brush your teeth, but please do not swallow any water.
- Wear comfortable, loose-fitting clothing and low-heeled shoes to the hospital on the day of surgery.
- If you wear contacts, bring a container for the lenses or wear your glasses to the hospital on the day of your procedure.
- Leave all valuables, large amounts of case, jewelry and credit cards at home or leave them with a family member or friend for safekeeping.

PAYMENT PRIOR TO SURGERY *PATIENT OR GUARDIAN'S INITIALS*_____________

- If your insurance company requires payment of a deductible or co-insurance, it must be taken care of with the front office staff prior to the surgery or it may be necessary to reschedule your procedure.

MISSING WORK *PATIENT OR GUARDIAN'S INITIALS*_____________

- If your employer requires documentation of missed work, you must contact our office with the name and fax number. The staff will fax all work excuses directly to your company representative. A job description and written documentation of availability of light duty must be received in our office prior to surgery. This is your responsibility. Your employer may fax the above requested information to 770-602-1296.

I have carefully read and fully understand the above provided information.

Patient's Signature____Date___________________________________

Surgical Associates
of Metro Atlanta, LLC

Donald A. Maynard MD FACS

PATIENT ACKNOWLEDGEMENT FORM

Patient acknowledgment of understanding of Surgical Associates of Metro Atlanta, LLC. Office's Privacy Practices

Patient name: ______________________________Date of Birth: ________________

SSN: _____________________ Previous Name: ____________________________

I understand that the patient's health information is private and confidential. I understand that Surgical Associates of Metro Atlanta, LLC. works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Surgical Associates of Metro Atlanta, LLC. may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. (In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be a patient threatened to hurt someone.)

Surgical Associates of Metro Atlanta, LLC. has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgment. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

Surgical Associates of Metro Atlanta, LLC. may update this Acknowledgment and "Notice of Privacy Practices". If I asked, I will be provided with the most current "Notice of Privacy Practices".

Within this Notice of Privacy Practices is contained a complete description of my privacy & confidentiality rights. These rights include, but aren't limited to, access to my medical records, restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

Surgical Associates of Metro Atlanta, LLC. has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgment, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Surgical Associates of Metro Atlanta, LLC. by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of Surgical Associates of Metro Atlanta, LLC.'s "Notice of Privacy Practices".

_______________________________________ ______________ ______________

Signature of patient or legally authorized individual Date Time

____

Relationship to patient if signed by anyone other than the patient

Surgical Associates of Metro Atlanta, LLC

Donald A. Maynard, MD

PLEASE FILL OUT THIS MEDICAL HISTORY COMPLETELY

Patient Name:________________________________ DOB:____________ Today Date: ____________

Current Medical Problem: ____

PRESENT MEDICATIONS

NAME & STRENGTH			HOW OFTEN?	HOW LONG?	WHAT IS IT FOR?
OTHER MEDICATIONS	YES	NO	HOW OFTEN?	HOW LONG?	WHAT IS IT FOR?
Aspirin, Tylenol or other pain meds					
Eye Drops/Nose Drops					
Laxatives					

PAST MEDICAL HISTORY

Check any of the following that you have had and indicate the approximate year

Diabetes	Year________	Bood Disease	Year________	Kidney Stones	Year________
Cancer	Year________	Asthma	Year________	Thyroid Disease	Year________
Heart Attack	Year________	Lung Problems	Year________	Ulcers	Year________
Heart Disease	Year________	Liver/Jaundice	Year________	Glaucoma	Year________
High Blood Pressure	Year________	Seizure/Epilepsy	Year________	Arthritis	Year________
Stroke/Paralysis	Year________	Gallstones	Year________	Blood Transfusion	Year________
Recent Wt change	Year________	Other ________________________________			Year________

PAST SURGICAL HISTORY

TYPE OF OPERATION	DATE	WHERE

ALLERGIES

	YES	NO	DATE
Penicillin			_____
Sulfa			_____
Other			_____

IMMUNIZATIONS

	YES	NO	DATE
Diptheria/Pertusis/Tetanus			_____
Tetanus			_____
Hepatitis			_____

FOR WOMEN

# of pregnancies_______Miscarriages________Live births_______Last menstrual period_________________

Last PAP smear______________Any abnormal PAP smears_____________If YES, when________________

Date of last mammogram____________________ Normal Abnormal

Do you currently use any Birth Control method?___________________________________

Is there any other past or present medical information that you would like to make the doctor aware of before your appointment?____

____

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DATE: ___/___/___ NAME: __________________________ AGE: ______BIRTHDATE: ___________
OCCUPATION: ____________________ MARITAL STATUS: S M W D STATES LIVED: ______
List family members with history of heart disease, cancer, stroke, high blood pressure, diabetes, other:
____
ALLERGIES (drug and food): ____
Have you ever had a reaction to iodine, shellfish, or x-ray dye: ____________________________

DO YOU HAVE OR HAVE YOU EVER HAD: (Please circle Y or N and specific disease)

Y	N	Do you smoke? How much: ________________How long: ____________When quit? __________
Y	N	Do you use alcohol or habit-forming drugs? What: ________________ Frequency: ______________
Y	N	Change in activity level: weight loss/gain, unexplained fever, night sweats
Y	N	Allergic reaction, such as hives, eczema, sneezing, conjunctivitis
Y	N	Heart disease, heart attacks, chest pain, angina, irregular heartbeat, murmur, congestive failure, other: ____
Y	N	Shortness of breath, asthma, emphysema, pneumonia, bronchitis, chronic cough, wheezing, TB
Y	N	Stroke, TIA's, seizures, neuro disorders, slurred speech, paralysis of limb, trembling of extremities
Y	N	High or low blood pressure, fainting, dizziness, frequent headaches
Y	N	Thyroid disease, difficulty swallowing, enlarged glands, recurrent sore throats
Y	N	Skin disease, itching, inability to tolerate hot/cold, breast lump, breast pain, nipple discharge
Y	N	Diabetes: How long: ___________ Diet or medication controlled: ____________________ Type of diet: ____
Y	N	Kidney or bladder: Recurrent infections, pain, difficulty, urinating, stones, leakage of urine
Y	N	Liver disease: Hepatitis – A, B, C, anemia, jaundice, sickle cell, bleeding disorders, easy to bruise, easily-bleeding gums, blood transfusion (before 1985 or after 1985)
Y	N	Cancer: When: ________________ Type: ________________Treatment: ___________________
Y	N	Indigestion, hiatal hernia, reflux, gallbladder disease, stomach ulcers, frequent nausea/vomiting
Y	N	Arthritis, bone or joint disease or swelling, broken bones, muscle cramps, activity limited by leg pain, back or neck injuries
Y	N	Eyes: pain, change in vision, blindness, drainage, double or blurred vision, wear glasses
Y	N	Ears: drainage, decreased hearing, pain, ringing, wear hearing aid
Y	N	Wear dentures or have partial bridge, sores in mouth, dental or gum disease
Y	N	Bowels: change in frequency, color, texture, blood noted, pain with movement
Y	N	FEMALE: Last menstrual period: ___________ Age of menses: ______ Last pelvic and pap: _______ Vaginal discharge color: __________, breast disease, present or past use of hormones, number of pregnancies: _______ Vaginal: _______C-Section _______ Miscarriages: _______
Y	N	MALES: Discharge from penis, prostate disease
Y	N	Sexually-transmitted diseases, HIV positive, AIDS, homosexual partners, IV drug abuse, multiple sexual partners, blood transfusions: When: ________________________________
Y	N	History of psychiatric conditions and any treatments, nervous breakdown
Y	N	Do you have a cardiologist? If so, who? _____________________________________
Y	N	Are you pregnant? Due date: ____
Y	N	Do you take diet drugs? What type? ______________________________________

Updated ______________ Updated ______________ Updated ______________

PATIENT'S SIGNATURE__________________________________

20 Year Diet Weight Loss Program History Worksheet

Please complete as accurately as possible prior to your first appointment. Please use back of this form if additional space is needed.

Patient Name____________________________________ **Date of Birth**__________________________

DIET/PROGRAM NAME	YEAR	HOW LONG	WEIGHT LOSS	WEIGHT RE-GAIN	DIET/PROGRAM COST
☐ Jenny Craig/Weight Watchers					
☐ NutriSystem/Quick Weight Loss Ctr.					
☐ Atkins Diet/South Beach Diet					
☐ Slim Fast/ OptiFast					
☐ Cabbage Soup Diet/Grapefruit Diet					
☐ Dexatrim/Metabolife					
☐ Xenedrine/Phenterimine					
☐ Low Carb. Diet/Low Fat Diet					
☐ Richard Simmons					
☐ MD Supervised #_______Calorie Diet					
☐ Fasting/Decrease Eating					
☐ Over Eaters Anonymous					
☐ Other					
☐ Other					
☐ Other					

WEIGHT AT EACH AGE LISTED BELOW

12	18	25	30	35	40	45	50

Surgical Associates of Metro Atlanta, LLC

20 Year Exercise Program History Worksheet

Please complete in chronological order as accurately as possible prior to your first appointment. Please use back of this form if additional space is needed.

Patient Name______________________________ **Date of Birth**______________________

EXERCISE PROGRAM	YEAR	HOW LONG	WEIGHT LOSS	WEIGHT RE-GAIN	MONTHS TO REGAIN WEIGHT	COST

COMMENTS____

____

____

IMPORTANT INFORMATION TO KNOW PRIOR TO YOUR BARIATRIC APPOINTMENT

PLEASE CAREFULLY REVIEW THE FOLLOWING ITEMS:

- Your first initial visit will consist of very detailed information concerning our bariatric program. This consultation will last a minimum of two hours.
- It is very important that your major supporter and any other individual (family member, close friend, etc) you so choose be present at this first visit.
- We respectfully ask that you do not bring any children to this visit. The information we share is vital to your success and will need your undivided attention during the consultation.
- If any portion of the pre-registration forms is not complete and/or missing, your visit will be rescheduled for a later date.
- If you are more than 10 minutes late for your initial visit, your visit will be rescheduled for a later date.
- It is your responsibility to determine your insurance benefits and eligibility coverage for a comprehensive weight loss and surgery program prior to scheduling an appointment for a consultation.
- **IT IS IMPERATIVE THAT YOU CONTACT OUR OFFICE 48 HOURS PRIOR TO YOUR SCHEDULED APPOINTMENT TO RESCHEDULE OR CANCEL. FAILURE TO NOTIFY OUR OFFICE WILL RESULT IN A $100.00 NO SHOW FEE. THIS WILL ALSO ENABLE US TO HONOR OUR WAITING LIST BY OPENING THESE APPOINTMENTS**.

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Surgical Associates of Metro Atlanta, LLC

Prior to your initial consultation please take a few moments and describe below why you have made the decision to have weight loss surgery. Please include any medical conditions, family history or personal issues that have contributed to your decision. Please bring this with you to your first visit with our office.

Name________________________________Date_______________________________