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_____

How did you hear about Dr. Maynard? □ MD office □ Friend □ Internet Search □ Website □ Other_____

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 _____

****

Emergency Contact: Name: _____ Relation: _____Phone#: _____

PCP:_____ Phone # _____Referring Doctor: _____ Phone # _____

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Were you injured in an accident? □Auto □Work related □Other_____ Date of injury_____

IF YES, PLEASE SPEAK WITH OUR STAFF IMMEDIATELY BEFORE COMPLETING ANY ADDITIONAL PAPERWORK.

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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 # _____
Policy Holder _____Member ID # _____ Group # _____

SECONDARY INSURANCE
Insurance Company _____ Phone # _____
Policy Holder _____Member ID # _____ Group # _____

PLEASE READ AND SIGN THE ACKNOWLEDGEMENT OF THE FOLLOWING INFORMATION:

I hereby authorize Surgical Associates of Metro Atlanta, LLC to provide me with medical and/or surgical treatment and understand that I am responsible for all services rendered and any monies due at the time of service. 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: _____

CONSENT TO RECEIVE TEXT MESSAGE APPOINTMENT REMINDERS

By signing below, I authorize Surgical Associates of Metro Atlanta, LLC to contact me by automated SMS text message for appointment reminders.

I understand that message/data rates may apply to messages sent by Surgical Associates of Metro Atlanta, LLC under my cell phone plan. **My text/mobile phone number is: _____** ☐ Patient Initials

I know that I am under no obligation to authorize Surgical Associates of Metro Atlanta, LLC to send me text messages. I may opt-out of receiving these communications at any time by calling the Office @ (770) 602-1292, or by responding STOP. Please allow 2-3 business days for processing.

I understand that text messaging is not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in text messages may include your first name, date/time of appointments, name of physician, and physician phone number, or other pertinent information. By signing below, I indicate I am the primary user for the mobile phone number listed above, I accept the risk explained above and consent to receive text messages via automated technology from Surgical Associates of Metro Atlanta, LLC to the phone number that I have provided.

Patient Signature: _____ Date: _____

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

An advance directive is a legal document that explains how you want medical decisions about you to be made if you cannot make the decisions yourself.

Surgical Associates of Metro Atlanta, LLC

IMPORTANT INFORMATION TO KNOW

PLEASE INITIAL EACH SECTION THAT YOU UNDERSTAND THE INFORMATION PROVIDED

PATIENT NAME_____DATE OF BIRTH_____DATE OF CONSULTATION_____

FINANCIAL POLICY

WHAT IS MY FINANCIAL RESPONSIBILITY FOR SERVICES? You are responsible for paying your co-payment, coinsurance, deductibles, and any responsible patient balance. **CO-PAYMENT IS ALWAYS DUE AT THE TIME OF SERVICE**. If you cannot pay your co-payment at the 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.**

All services are paid at the time of service unless we have a contractual agreement with your insurance company. It is the patient's responsibility to be familiar with their healthcare coverage and its coverage and benefits. We will submit claims for those plans with which we are contracted. 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. Please bring your current health insurance card with you at the time of service. We cannot file insurance without a current insurance card, resulting in rescheduling your appointment.

CANCELLING YOUR SURGERY *PATIENT OR GUARDIAN'S INITIALS*_____

- If you find it necessary to cancel your surgery for any reason, you must contact our office within 48 hours of your scheduled surgery. Failure to do so may result in a non-cancellation fee of up to $100.00

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

- If your insurance company requires payment of a deductible or coinsurance, it must be taken care of with the front office staff before 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 PROVIDE 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 the availability of light duty must be received in our office before surgery. **This is your responsibility**. Your employer may fax the above-requested information to 770-602-1296.

PROCESSING AND COMPLETION OF ALL FORMS *PATIENT OR GUARDIAN'S INITIALS*_____

Many of our patients request that we complete various forms to continue to receive income while they are out of work due to surgery. Our office fully understands the importance of completing 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. THIS VISIT USUALLY OCCURS TWO WEEKS AFTER SURGERY.** Due to the overwhelming request and the significance of time required by our office staff to complete the forms effective 06/01/2015, we will begin charging for the **completion of the initial disability form a fee of $35.00**. If additional forms must be completed, there will be a $10.00 fee for completion. 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 before releasing the completed forms. Our staff is dedicated to completing the required forms within **3-5 business days** of receipt of the forms. However, all necessary information may still be forthcoming, and a delay can occur. Our staff will notify you of the delay and the approximate date of completion. Please do not hesitate to contact our Practice Manager, Donna Edwards, if you have any questions.

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

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_____	Blood 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

Surgical Associates of Metro Atlanta, LLC

Donald A. Maynard, MD, FACS

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_____

Surgical Associates of Metro Atlanta, LLC

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

MEDICAL RECORDS RELEASE FORM

please initial

_____ I hereby authorize Surgical Associates of Metro Atlanta, LLC to **OBTAIN** my healthcare information from all medical providers.

****

please initial

_____ I hereby authorize Surgical Associates of Metro Atlanta, LLC to **RELEASE** my healthcare information from all medical providers/myself.

****

I understand this authorization includes releasing 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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PATIENT ACKNOWLEDGEMENT FORM

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

Patient name: _____Date of Birth: _____SSN: _____

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, handle billing and payment, and 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 who 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 would 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 specific 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, 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 a 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 the patient if signed by anyone other than the patient

Surgical Associates of Metro Atlanta, LLC

PRE-SURGICAL INSTRUCTIONS

PLEASE INITIAL EACH SECTION THAT YOU UNDERSTAND THE INFORMATION PROVIDED

PATIENT NAME_____DATE OF BIRTH_____

PLEASE FOLLOW THESE IMPORTANT INSTRUCTIONS BEFORE SURGERY. 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 (4:00 pm or later) the day before 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 BEFORE 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, your surgery will be canceled.
- 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.

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 before your procedure if possible. **If these medications were prescribed to you by a physician, please contact the prescribing physician BEFORE stopping the blood thinner to make sure he approves 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 cash, jewelry, and credit cards at home or leave them with a family member or friend for safekeeping.

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

Patient's Signature_____Date_____

This form becomes a part of your medical chart that is maintained in our office. Private and Confidential-Without Prejudice-Not for Publication