PATIENT PROFILE INFORMATION

PATIENT'S LAST NAME: ______________________ FIRST NAME: ______________________ MIDDLE: __________

DATE OF BIRTH: ______________________ SS#: ______________________ SEX: ______

ETHNICITY: Hispanic Non-Hispanic Patient Declined

RACE: African-American Asian Caucasian Chinese Filipino Indian Japanese Middle Eastern Vietnamese Multiracial Patient Declined Other

PRIMARY LANGUAGE: ______________________

ADDRESS: ______________________ CITY: ______________ STATE: ______ ZIP CODE: __________

May we leave a message?

HOME PHONE: ______________________ Yes No

CELL PHONE: ______________________ Yes No

WORK PHONE: ______________________ Yes No

MARITAL STATUS: Single Married Divorced Widowed Life Partner EMAIL ADDRESS: ______________________

EMPLOYMENT STATUS: Employed______ Unemployed______ Retired______ Disabled ______Self Employed______

EMPLOYER NAME: ______________________ OCCUPATION: ______________________

Here at Trinity Surgical Consultants, our surgeons strive to provide excellent communication with your physicians. Dr. Jeyarajah, Dr. Osman and Dr. Cho, ask that you please provide our office with a list of your doctors, including but not limited to, your Primary Care Physician, Gastroenterologist (GI), Cardiologist, Pulmonologist, Oncologist, Referring Physician, etc. Thank you.

REFFERRING PHYSICIAN: ______________________ OFFICE NUMBER: ______________________

REASON FOR REFFERAL: ____

PRIMARY CARE PHYSICIAN: ______________________ OFFICE NUMBER: ______________________

GASTROENTEROLOGIST (GI): ______________________ OFFICE NUMBER: ______________________

CARDIOLOGIST: ______________________ OFFICE NUMBER: ______________________

PULMONOLOGIST: ______________________ OFFICE NUMBER: ______________________

ONCOLOGIST: ______________________ OFFICE NUMBER: ______________________

OTHER: ______________________ OFFICE NUMBER: ______________________

2805 E. President George Bush Hwy, Richardson, Tx. 75082 Office 972.619.3500 Fax 214.272.8985

If the patient is not the subscriber of the insurance, please be sure to fill out the subscriber's full name, date of birth and social security number in the space provided below.

PRIMARY INSURANCE: PPO HMO

NAME OF INSURANCE: ______________________________

ID #: ____________________ GROUP NUMBER: ____________________

CLAIMS ADDRESS: ______________________________

PHONE NUMBER: ____________________

NAME OF SUBSCRIBER: ____________________

RELATIONSHIP TO SUBSCRIBER: ____________________

SUBSCRIBER'S DOB: ____________________ SUBSCRIBER'S SSN: ____________________

SECONDARY INSURANCE: PPO HMO

NAME OF INSURANCE: ______________________________

ID #: ____________________ GROUP NUMBER: ____________________

CLAIMS ADDRESS: ______________________________

PHONE NUMBER: ____________________

NAME OF SUBSCRIBER: ____________________

RELATIONSHIP TO SUBSCRIBER: ____________________

SUBSCRIBER'S DOB: ____________________ SUBSCRIBER'S SSN: ____________________

TERTIARY INSURANCE: PPO HMO

NAME OF INSURANCE: ______________________________

ID #: ____________________ GROUP NUMBER: ____________________

CLAIMS ADDRESS: ______________________________

PHONE NUMBER: ____________________

NAME OF SUBSCRIBER: ____________________

RELATIONSHIP TO SUBSCRIBER: ____________________

SUBSCRIBER'S DOB: ____________________ SUBSCRIBER'S SSN: ____________________

PATIENT NAME: ______________________________ **DOB:** ______________________________

DATE: __________________________

Please tell us why you are here to see the doctor today: ____

____

Check illness that applies to you:

_______ Diabetes
_______ Heart Disease
_______ Kidney Disease
_______ Nephritis
_______ High Blood Pressure
_______ Stroke
_______ Lung Problems
_______ Tuberculosis
_______ Epilepsy
_______ Arthritis
_______ Cancer – If yes, what type?
_______ Stomach or Colon Problems
_______ Mitral Valve Prolapse
_______ Vascular Disease
_______ Other ____________________________________

List Medications (Prescriptions and OTC)

____
____
____
____
____
____
____
____
____
____
____
____
____
____

Do you currently smoke cigars, cigarettes, pipes, or other?__________If yes, how much?__________
Have you previously smoked cigars, cigarettes, pipes, or other? __________ If yes, when did you quit? __________
Do you currently consume alcohol? __________ If yes, how much and how often? __________
Do you have any food allergies? __________ If yes, please list: __________
Do you have any drug allergies? __________ If yes, please list: __________
Are you allergic to LATEX? __________ If yes, what is your reaction? __________
Do you have a pacemaker or defibrillator? __________ If so, what brand? __________
What surgeries have you had in the past? ______________________________

____

If so, did you have any complications from bleeding or anesthesia? __________
Have you ever been hospitalized for any serious injury or other illnesses? __________
If yes, please explain: __________ ______________________________
Have you ever been advised to have a surgery that has not yet been done? __________
If yes, please explain: ______________________________

Have you had a recent colonoscopy? □N/A □ No □ Yes If yes, when? __________
Have you had a recent mammogram? □ N/A □ No □ Yes If yes, when? __________
Have you had a recent pap smear? □ N/A □ No □ Yes if yes, when? __________

2805 E. President George Bush Hwy., Richardson, Tx. 75082 Office 972.619.3500 Fax 214.272.8985

TSC Surgical Group, PLLC
FINANCIAL POLICY

TSC Surgical Group, PLLC believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. **PAYMENT** is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of you visit. We do ask for a copy of an ID card and license due to the many cases of identity theft in the news lately. (Please do not be offended!)

2. **INSURANCE** We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.

   If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with you insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one.

   Not all insurance plans cover all services. In the event you're insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

   Patients who insist on "day of" urgent/emergent scheduling or care after hours or on days the clinic is closed will be assessed an additional urgent care or after hours fee. These fees will be billed to your insurance carrier or collected as part of the office charges for self-pay patients.

3. **LATE CHARGES** of 12% annually will be applied to all patient balances 90 days old or greater.

4. **RETURNED CHECKS** will incur a $30.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Hays County.

5. **ACCOUNTING PRINCIPALS** Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

6. **FORMS FEES:** Completing insurance forms, copying medical records, etc... Requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $40 per occurrence plus and applicable postage or notary fees. Postage is additional and payment is required in advance. Copying fees for Medical Records is $25 for the first twenty (20) pages and $0.50 per page in excess of twenty. TSC Surgical Group, PLLC will have 15 business days in which to copy records before making them available for patient to pick up, and these 15 days will commence after payment for copying has been received and after patient has signed this form authorizing records' release.

7. **BILLING OFFICE:** If you have questions in regards to any of your billing statements, our accounts receivable staff is available to assist you. Call 972-616-4011 with any billing concerns.

TSC Surgical Group, PLLC
FINANCIAL POLICY

8. **CANCELLATIONS OR MISSED APPOINTMENTS:** If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $25 missed appointment fee.

9. **RESPONSIBILITY FOR PAYMENT:** I understand that I, personally, am financially responsible to **TSC SURGICAL GROUP, PLLC** for charges not covered by the assignment of insurance benefits.

10. **ASSIGNMENT OF INSURANCE BEBEFITS:** I hereby assign, transfer, and set over directly to **TSC SURGICAL GROUP, PLLC** sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize TSC Surgical Group, PLLC to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to TSC Surgical Group, PLLC. I authorize TSC Surgical Group, PLLC to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

11. **SELF PAY PATIENTS:** A 20% prompt pay discount is applied to all full pay payments received at the time of service. This means anyone willing to/or needing to pay in full at the time of service will receive the 20% discount off of the evaluation and management service codes only. Charges for supplies, tests, immunizations, medications, or procedures are never discounted. TSC Surgical Group, PLLC does not extend credit. All services are expected to be paid in full at the time of service. By signing below I agree to pay in full.

12. **RELEASE OF INFORMATION:** I hereby authorize the and direct **TSC SURGICAL GROUP, PLLC** to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

13. **COLLECTION FEES:** I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

14. **DIVORCED PARENTS of PATIENTS:** By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

I have read and understand the practice's financial policy and I agree to be bound by its terms.
I also understand and agree that such terms may be amended by the practice from time to time.

____________________________________ __________________
Signature of Patient (or Guarantor, if applicable) Date

____
Please print the name of the patient

Authorization to Disclose Health Information

I hereby authorize ____, or its agents, to disclose information from the medical record of:

Patient name: ____________________ Medical Record #:____________________

Date of Birth: ____________________ Social Security#: ____________________

To: Trinity Surgical Consultants
2805 E President George Bush Hwy
Richardson, TX 75082
Phone#: (972) 619-3500 | Fax: (214) 272-8985

Please Release the following:

_______ Problem List
_______ Progress Notes
_______ History / Physical Exam
_______ Medication Lists
_______ List of Allergies
_______ Demographic / Insurance
_______ All Medication Records
_______ X-Ray/Imaging Reports from ____________ to ____________
_______ X-Ray Films
_______ Lab results from ____________ to ____________
_______ EKG Reports
_______ Pathology Reports
_______ Pathology Slides
_______ Records from ____________________ to Present Only
_______ Other ____

For the purpose of: Continuation of Care______________________________________

I understand that the information in my health record my include information relating to sexually transmitted disease, acquired immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. _______ YES. I consent to the release of this information. _______ No. I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have the right to revoke this authorization at any time. I understand the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: ________ If I fail to specify and expiration date, event, or condition, this authorization will expire in six months. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the TSC office directly at 972.619.3500.

Signature of Patient or Legal Representative:____________________ **Date:** ____________

Relationship to Patient: ____________________ **Witness:** ____________________

Patient Name: ______________________ **DOB:** ______________________

Office Policy for Medical Records Request and Completion of Medical Forms

Please note that there is a $40 fee for the completion of disability or medical leave of absence forms. These are commonly known as FMLA and short term disability forms but includes any forms requiring the patient's medical status and/or the physician's signature. Each individual requesting completed form will have a separate fee as well as new forms completion for a new diagnosis. Please keep in mind that we do require a minimum of 7 working days for the completion of the forms after payment of $40 has been made to our office. It is imperative that you provide your form(s) to our office as quickly as possible to avoid any delays with your employer or insurance company.

For any medical records request, there is a $25 fee. Please note, if our office refers you to an outside physician, we will electronically fax your records to their office with no additional charge to the patient. If you are moving or seeking a second opinion, our office has 5 to 7 days after the $25 charge is paid to prepare your records for office pick-up or by mail.

I acknowledge that I have read and understand the office policy for medical records request and completion of medical forms.

Patient Signature: ______________________________ Date: ______________

Patient Name: ______________________________ **DOB:** ____________________

Trinity Surgical Consultants
Patient Consent for Treatment Form
Acknowledgement of Privacy Practices

I voluntarily request that my doctor at Trinity Surgical Consultants, and such associates, treat my condition as they deem necessary. I understand that I will be given opportunity to ask questions about my condition such as treatment options, risks of non-treatment, surgical options and risks involved. I also give my permission for the physicians in post-graduate medical education training, personnel/students of medical, nursing, and other clinical training programs affiliated with Dr. Jeyarajah and/or Dr. Osman to participate in my care.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information otherwise known as PHI. You have the right to review our notice. As provided in our notice, the term of our notice may change. If we change our notice, you may obtain a revised copy by requesting one from the desk personnel. You have the right to request that we restrict how protected health information (PHI) about you is disclosed for treatment. We are not required to agree to this restriction, but if we do, we are bound by agreement.

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information (PHI) as set forth herein with such disclosures as treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Signature of Patient:______________________________Date:______________________________

Personal Representative able to speak on my behalf: (please print name)

Name of Representative: ____

Relation: ____________________________ Phone Number: ______________________

Trinity Surgical Consultants
Consent for Use of Email Communication

To better serve our patients, our office has established an email address for some forms of communication. Your doctor may also provide you with their direct email address. For routine matters that do not require immediate response, please feel free to contact us at trinitysurgical@tscsurgical.com. Please remember however, that this form of communication is not appropriate for use in an emergency. We strongly recommend that you do not use email as a way to contact your doctor or the office as this is not the safest and most secure way to communicate. We offer every patient access to the secure patient portal which enables you to message not only the office staff directly, but also to your doctor. The EZAccess Patient Portal is the most secure way to contact our office although we understand that there are times when you may choose to use email. The turnaround time for routine patient communications is 24 hours for a message sent Monday through Thursday and messages sent on Friday may not have a response sent until the following Monday or business day. These response times do not include holidays and weekends. The service provider may delay message delivery. **Should you require urgent or immediate attention, this medium is not appropriate.**

When sending an email, please put the subject of your message in the subject line so we can process it more efficiently. Also, be sure to put your name and return telephone number in the body of the message. We also ask that you acknowledge receipt of emails coming from this office.

PLEASE DO NOT SEND REQUESTS FOR PRESCRIPTION REFILLS.

Communications relating to diagnosis and treatment will be filed in your medical record.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to me, my staff and/or colleagues would have access to this information. Emails may also be viewed from cell phones, laptops, or tablets so there may be responses with misspellings or may not be available to read the entire length of the message.

I understand that this office will not be responsible for information loss or delay, or breaches in confidentiality that are due to technical factors beyond this office's control. I understand and agree to the above email policy.

By signing below, you are agreeing that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

______________________________ ______________________________
Patient signature Date

2805 E. President George Bush Hwy., Richardson, Tx. 75082 Office 972.619.3500 Fax 214.272.8985