

Eric O. Kortz, M.D.

Richard L. Tillquist, M.D.

Thomas G. Heffron, M.D.

PATIENT INFORMATION

Patient E-mail Address: _____

Requesting/Referring Physician _____ **Primary Care Physician** _____

Name (legal): Mr. Mrs. Ms. First Name _____ MI _____ Last _____

Address: _____ City: _____ St: _____ Zip: _____

Phone: Home _____ Work _____ Cell/Pager _____

SS#: _____ Date of Birth: _____ Age: _____ Sex: M F Marital Status: S M W D

Patients Occupation: _____ Patients Employer: _____

Employer's Address: _____ Work Phone #: _____

Spouse/Parent Name: _____ SS# _____ Date of Birth _____

Address (if different from patient): _____ City: _____ St: _____ Zip: _____

Spouse/Parent Employer: _____ Spouse/Parent Work Phone #: _____

Person Responsible for Payment of Services (if different from patient): _____

Emergency Contact: Relative/Friend, **not living with you** (in case we are unable to contact you, or need to contact someone regarding your care in an emergency).

Contact: _____ Phone #: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Long Term Contact: Relative/Friend, **not living with you** (Should we need to contact you in future years if you have moved from the address given in patient info above).

Contact: _____ Phone #: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Legible Copy of Ins. Card

Copy of Drivers License

PRIMARY Insurance Company: _____ Subscribers Name: _____

Address or P.O. Box (for claims): _____ City: _____ State: _____ Zip: _____

Phone #: _____ Group #: _____ Subscriber ID #: _____

Relationship: Self _____ Spouse _____ Child _____ Other _____ **Employer Carrying Insurance:** _____

IF ACCIDENT: Work Comp Auto: Date of Injury _____ Claim No. _____

SECONDARY Insurance Company: _____ Subscribers Name: _____

Address or P.O. Box (for claims): _____ City: _____ State: _____ Zip: _____

Phone #: _____ Group #: _____ Subscriber ID #: _____

Relationship: Self _____ Spouse _____ Child _____ Other _____ **Employer Carrying Insurance:** _____

IF ACCIDENT: Work Comp Auto: Date of Injury _____ Claim No. _____

* I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES THIS OFFICE, AS A SERVICE TO ME, WILL BILL MY INSURANCE. I FURNISH THIS OFFICE WITH ALL INFORMATION NECESSARY TO BILL MY INSURANCE. ANY BALANCE AFTER INSURANCE HAS PAID OR DENIED IS DUE BY ME. ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE REASONABLE COST OF COLLECTION, TO INCLUDE ANY ATTORNEY FEES.

* I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN/SUPPLIER FOR THESE SERVICES AND ALL FUTURE CLAIMS. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ALL FUTURE CLAIMS.

SIGNATURE _____ (signed) Date: _____

SurgOne, P.C.

Dr. Eric O. Kortz

Dr. Richard Tillquist

Dr. Thomas Heffron

Today's Date: _____

Patient Name: _____ Age: _____ Weight: _____ Height: _____

Requesting/Referring Physician: _____ Primary Doctor _____

Reason for visit (Chief Complaint) _____

History of the Present Illness: _____

List of all Significant Medical Problems

Please List all Medications and their doses

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____

List All past surgeries you've had and approx. date

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Reproductive History (please indicate number of pregnancies and births)

Pregnancies _____ Births _____ Lost Pregnancies _____

Allergies (please list) are you allergic to any medicine, latex, tape, etc.

Social History:

Do you smoke? _____ (if so, how much per day) _____ If you have smoked, when did you quit? _____

Do you drink alcohol? _____ (if so, how many drinks per day?) _____

Do you use any non-prescribed drugs? _____ (if so, what?) _____

Are you on any type of special diet? (If so, please describe) _____

What is/was your occupation? _____

Family History- Please indicate if any family member (including Grandparents, Parents, Siblings) had/does have the following:

Gallbladder problems _____

Reaction to Anesthesia _____

Bleeding or Clotting _____

Breast Cancer _____

Heart attacks _____

Ovarian Cancer _____

Diabetes _____

Colon Cancer _____

Any other Cancer _____

Anything else your Physician should know about your family's health? _____

SurgOne,P.C.-Medical history/Review of symptoms

Have you been diagnosed with and/or are currently having any of the following symptoms (in the last six months)

****Place a check mark ONLY by those that apply****

Neurological/Head, Ears, Nose, Throat

Do you have any of the following **NO YES** if yes please indicate below

Numbness/Tingling _____
Loss of Strength _____
Stroke(CVA/TIA) _____
Headaches-type _____
MS _____
Ear problems _____
Eye problems _____
Nose/Sinus problems _____
Throat problems _____

Musculoskeletal/Skin

Do you have any of the following **NO YES** if yes please indicate below

Back/Neck/Joint problems _____
Loss of Sensation _____
Rash/Skin Breakdown _____
Arthritis _____
Fractures _____
Osteoporosis _____
Joint Replacement _____

Endocrine

Do you have any of the following **NO YES** if yes please indicate below

Tired/Sluggish _____
Shortness of Breath _____
Bloody Cough _____
Bronchitis _____
Pneumonia _____
Pulmonary Embolism _____
Tuberculosis _____

Cardiac

Do you have any of the following **NO YES** if yes please indicate below

Heart Murmur _____
Chest Pain (angina) _____
Palpations/Heart Racing _____
Congestive Heart Failure _____
Heart attack _____
High blood pressure _____
Pacemaker _____
Artificial heart valve _____
Rheumatic fever _____

Communicable Diseases

Do you have any of the following **NO YES** if yes please indicate below

Malaria _____
Aids/HIV _____
Hepatitis _____
Sexual Trans Disease _____
Tuberculosis _____

Digestive

Do you have any of the following **NO YES** if yes please indicate below

Abdominal Pain _____
Nausea/Vomiting _____
Constipation/Diarrhea _____
Colitis _____
Diverticulitis _____
Hiatal Hernia _____
Reflux Esophagitis _____
Irritable Bowel _____
Ulcers _____
Pancreatitis _____
Rectal Bleeding or Pain _____
Change in bowel habits _____
Cirrhosis _____
Jaundice _____
Hemorrhoids _____
Gallstones _____

Genitourinary/GYN

Do you have any of the following **NO YES** if yes please indicate below

Kidney Problems _____
Bladder Infections _____
Kidney Failure _____
Prostate Infections _____
Uterine Problems _____
Ovarian Problems _____

Breast

Do you have any of the following **NO YES** if yes please indicate below

Nipple Discharge _____
Lumps _____
Pain _____
Prior Surgery _____

Blood/Immune System

Do you have any of the following **NO YES** if yes please indicate below

Swollen Lymph Glands _____
Anemia _____
DVT/Phlebitis/Clots _____
Lupus _____

Cancer

Do you have any of the following **NO YES** if yes please indicate below

Type _____
Treatment _____
Location _____

Psychologic (Emotional)

Do you have any of the following **NO YES** if yes please indicate below

Nervousness _____
Anxiety _____
Depression _____
Other _____

Constitutional

Do you have any of the following **NO YES** if yes please indicate below

Fever _____
Chills _____
Weight Loss _____
Night Sweats _____

SURGONE, P.C. FINANCIAL POLICY

Thank you for choosing SurgOne, P.C. for your healthcare. In order to achieve our goal of providing and maintaining a good physician-patient relationship, we believe it is important to have solid financial policies in place. We also believe that these policies will allow us to provide our patients with high quality, cost-effective care. We ask that you carefully read and sign the following SurgOne, P.C. Financial Policy prior to your treatment.

- Upon arrival, please sign in at the front desk and present your current health insurance card as well as your driver's license or another acceptable form of ID. You may be asked to present both of these items at each visit for proper identification.
- If you do not have health insurance coverage, choose to bill your own insurance, or if our physicians do not participate in your insurance plan, payment IN FULL is due at the time of service. Acceptable forms of payment are cash, check, VISA and MasterCard.
- You are responsible to make available to SurgOne, P.C. complete insurance information for accurate filing of claims. Complete insurance information includes current benefit cards (primary and secondary), proper identification, and referrals from other providers if applicable.
- You are responsible for checking with your insurance plan regarding any co-payment, deductible or co-insurance that you may owe at the time of service.
- Co-payments are due at the time of your visit and are collected prior to service.
- If the insurance information that you provide at the time of your visit is incorrect, you will be responsible for payment of your visit and to submit the charges to the correct plan.
- For indemnity-type health insurance plans, insurance payments received by SurgOne, P.C. will be applied to your account and you agree to pay the balance.
- If you have a HMO or PPO health insurance plan and our SurgOne, P.C. physicians participate in your plan, we will accept payment from the carrier for services covered by your benefit plan.
- If you have a surgical procedure that requires the use of a surgical assistant, SurgOne, P.C. does not bill for those services. You will receive a separate statement from the surgical assistant. These services may or may not be covered by your health insurance plan.
- SurgOne, P.C. is committed to providing the best treatment for our patients, however, you are responsible for any unpaid balance regardless of your insurance company's arbitrary determination of usual and customary rates.
- For scheduled appointments, prior balances must be paid prior to the visit.
- We require 24-hour notice for canceling any appointments.

- A \$20 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
- A \$35 fee is required for the completion of patient forms regarding disability insurance, life insurance and FMLA.
- Not all services provided by our office are covered by every plan. Any service determined NOT to be covered by your plan will be your responsibility.
- **It is your responsibility to know your healthcare benefits and coverage limitations.**

We will be happy to address any questions you may have after reading our Financial Policy.

I have read and understand SurgOne, P.C.'s Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as outlined in the above policy. I agree to pay for all services rendered not covered by my insurance and to notify this office should there be any change to my health insurance coverage.

Patient's Printed Name

Patient Signature

Date

Legal Guardian Printed Name

Relationship to Patient

Legal Guardian Signature

Date

SurgOne, P.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have questions about this notice or want more information, please contact: Karel Mitchell at SurgOne, P.C. The effective date of this notice is April 14, 2003.

To appropriately treat you and receive payment for the services we provide, we need to obtain information from you including your full name and address, insurance company, family medical history, current medical history, and current medical condition. We will use and disclose this information and other information we collect in the ways described below. To help you understand how we will use and disclose your information we have put the different uses and disclosures into categories and give examples of each. All of the ways we use or disclose your information will fit into one of the categories listed below, but we cannot list all of the uses and discloses in each category.

We may use and disclosure your health information for treatment, payment, and health care operations.

- **Treatment** We may use and disclose your information to provide you with medical treatment and services. Your information may be disclosed to individuals providing care to you and different departments in the hospital. These individuals and departments need your information to provide care, and to coordinate and provide services (such as prescriptions, lab tests, meals, and x-rays). We may also disclose your information to individuals outside the hospital that may be involved in your care after you leave.
- **Payment** We may use and disclose your information to receive payment for the services and treatment provided to you. We use your information to create a bill and disclose your information when we send the bill to your insurance company, you, or a third party. The individual or entity paying the bill may request more information to determine whether the bill is covered by your insurance. We may tell your health plan about a treatment you are going to receive to get approval for payment or to determine whether your health plan will cover the treatment.
- **Health Care Operations** We may use and disclose your information for health care operation purposes. Health care operations includes review of the care you receive for quality assessment, educational, business planning, and compliance plan purposes.

We may disclose and use your health information and you authorize us to use and disclose your information for:

- **Appointment Reminders** We may provide appointment reminders to you. You may request in writing that we send reminders to a confidential or alternative address.
- **Treatment Alternatives** We may provide you with information about treatment alternatives and other health related benefits and services.

We may also disclose your health information to outside entities without your consent or authorization in the following circumstances:

- **Required by Law** We disclose information as required by law. For example, we are required to report gunshot wounds to the police.
- **Public Health Purposes** We disclose information to health agencies as required by law for preventing or controlling disease. Examples are reporting of sexually transmitted, communicable, and infectious diseases.
- **To Prevent a Serious Threat to Health or Safety** We may disclose information about you to law enforcement or an identified victim to prevent a serious threat to your health or safety or the health or safety of another individual or the public.
- **Research** Your information may be used by or disclosed to researchers for research approved by a privacy board or an institutional review board.
- **Health Oversight Activities** Your health information may be disclosed to governmental agencies and boards for investigations, audits, licensing, and compliance purposes.
- **Judicial and Administrative Proceedings** We may be required to disclose your health information to a court or for an administrative proceeding.
- **Law Enforcement Activities** We may be required to disclose your information as required by law, pursuant to a court order, warrant, subpoena, or summons.
- **In Emergency Circumstances**
- **Deceased Individual** We may disclose information for the identification of the body or to determine the cause of death.
- **Military and Veterans** If you are a member of the armed forces we may release information about you as required by military command authorities. We may also release information about foreign military personnel to the appropriate foreign military authority.
- **Inmates** If you are an inmate of a correctional institution or under the custody of a law enforcement official. This release must be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety or security of the correctional institution.
- **Protective Services for the President and Others**
- **Organ and Tissue Donation** If you are an organ donor, we may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ bank, as necessary to facilitate organ or tissue donation.
- **Workers' Compensation** We may release medical information about you for workers' compensation or similar programs.
- **National Security and Intelligence Activities** We may release information about you to authorized Federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

We will give you the opportunity to object to the following uses and disclosure of your information:

- **Notification** We may tell your friends, relatives and other caretakers information which is relevant to their involvement in your care.
- **Disaster Relief** We may disclose information about you to public or private agencies for disaster relief purposes.

Your Rights

- You have the right to request a restriction on how information about you is used and disclosed. If you want to request a restriction of a use or disclosure of your information, contact the Medical Records Department at the Highline Surgical office of SurgOne, P.C. (303/789-1877) to obtain the form to make your request. **We are not required to agree to any restriction on the use or disclosure of your information.**
- You have the right to request communications with you be made at an alternative address or phone number. To request that communications be made at a different address or phone number, contact the Front Desk Department at the Highline Surgical office of SurgOne, P.C. (303/789-1877) to obtain the form to make your request.
- You have the right to inspect and obtain a copy of your medical record. To inspect and obtain a copy of your medical record a request must be made in writing on the form provided by Practice. To obtain a form, contact the Medical Records Department at the Highline Surgical office of SurgOne, P.C. (303/789-1877).
- If you believe the information we have about you is incorrect or incomplete you may request that we amend your medical record. To amend your medical record your request must be made in writing on the form provided by Practice. To request a form, contact the Nursing Department at the Highline Surgical office of SurgOne, P.C. (303/789-3751).
- You have the right to receive an accounting of disclosures, a list of individuals and entities that received your health information for reasons other than treatment, payment, or healthcare operations. You may receive one (1) free accounting during a twelve (12) month period. If you request more than one (1) accounting you will be charged a fee of \$20.00 for a one (1) year accounting and \$20.00 for each additional year up to six (6) years. An accounting is not provided for disclosures prior to April 14, 2003. To request an accounting of disclosures, contact the Medical Records Department at the Highline Surgical office of SurgOne, P.C. (303/789-1877) to obtain the form to make your request.
- You have the right to request a paper copy of this Notice.

Our Duties

- We are required by law to maintain the privacy of protected health information and to provide individuals with this Notice of our legal duties and privacy practice regarding health information.
- We are required to follow the terms of the current Notice.
- We may change the terms of this Notice and the revised Notice will apply to all health information in our possession. If we revise this Notice, a copy of the revised Notice will be posted in our office and a copy may be requested from the Front Desk Department at the Highline Surgical office of SurgOne, P.C.

Complaints

If you believe your privacy rights have been violated you may contact:

Karel Mitchell at SurgOne, P.C. (303/957-1310) or the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Eric Kortz, MD

Richard Tillquist, MD

Thomas Heffron, MD

SurgOne, PC

Notice of Privacy Practices Acknowledgement

I acknowledge that I am in receipt/or am aware of the Notice of Privacy Practices for SurgOne, PC.

Print Name

Signature

Date

SurgOne, PC

Eric Kortz, M.D.

Thomas Heffron, M.D.

Richard Tillquist, M.D.

RELEASE OF INFORMATION FORM

- 1. Your surgeon may request an assistant to help with your surgery. Some insurance companies may not pay for the assist. **It is the patients responsibility** to check with his/her insurance company to verify this benefit. If your insurance company does not pay for the assistant, **you will be responsible** for this expense.

- 2. I give permission for this office to leave messages on my answering machine, with my spouse, or other specified contacts regarding the following:

YES NO

- ___ ___ **Specific information regarding my surgery**
- ___ ___ **Test/Surgery scheduling appointments**
- ___ ___ **Test/Surgery results**
- ___ ___ **Other specified contacts**_____

Patients Signature Date

Witness Date