MIDDLE GEORGIA SURGICAL INSTITUTE

EXCELLENCE IN GENERAL,
ROBOTIC, & LAPAROSCOPIC SURGERY

Confidential Patient Intake: NEW PATIENT

Name:_____ **Today's Date:** _____

Referring Provider: (☐N/A)_____

Reason for Visit:_____

DOB:_____ Sex: Male / Female / _____

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐ Separated

Mailing Address: _____

City:_____ **State:**_____ **Zip:**_____

Preferred Phone:_____ ☐ **Receive text notifications from our office**

Email Address:_____@_____ ☐ **Receive emails from our office**

Preferred Method of Communication: ☐Phone Call ☐Text ☐Email

Do you wish to participate in our Patient Portal? ☐Yes ☐No

Preferred Pharmacy

Name:

_____

no mail-order pharmacies, please

Address:_____

City:_____State:_____

Next of Kin

Name:_____ Relation to pt:_____

Next of Kin Phone:_____

Emergency Contact (if Different from Next of Kin) Name and Phone: (☐N/A)_____

Primary Insurance

Insurance Co Name _____
Policy Number _____
Group Number _____
Policy Holder Name _____
Policy Holder SSN _____-_____-_____
Relationship to Patient _____
SPECIALIST COPAY: $_____

Secondary Insurance

Insurance Co Name _____
Policy Number _____
Group Number _____
Policy Holder Name _____
Policy Holder SSN _____-_____-_____
Relationship to Patient _____
SPECIALIST COPAY: $_____

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Patient History Intake

Patient Name_____ DOB:____/____/_____ Today's Date: ____/____/_____

Place a check in the box if you have had any of the following:

Neurological
- ☐Seizures
- ☐Headaches/Migraines
- ☐Stroke/TIA
- ☐Dementia
- ☐Other:_____

HEENT
- ☐Wear Glasses/Contacts
- ☐Wear Hearing Aids
- ☐ Seasonal Allergies
- ☐Dentures
- ☐Sinus infections

Endocrine
- ☐Type II DM
- ☐Thyroid Disease
- ☐Other:_____

Cardiovascular
- ☐Aneurysm
- ☐Chest pain/Angina
- ☐DVT/Blood Clots
- ☐ Irregular Heart beats
- ☐High blood pressure
- ☐Heart Attack/MI
- ☐Peripheral vascular Dz
- ☐Other_____

Skin/Wounds
- ☐Psoriasis
- ☐Eczema
- ☐Chronic Wounds (location(s):_____
_____

Respiratory
- ☐COPD
- ☐Pneumonia
- ☐Asthma
- ☐Lung Cancer

Musculoskeletal
- ☐Osteoarthritis
- ☐Gout
- ☐Other_____

Genitourinary
- ☐Prostate Enlargement, Benign
- ☐Prostate Cancer
- ☐Chronic Kidney Disease
- ☐On Dialysis
- ☐Recurrent UTIs
- ☐Other:_____

Gastrointestinal
- ☐Abnl colonoscopy
- ☐Colon Cancer
- ☐Constipation
- ☐GERD
- ☐Cirrhosis
- ☐Irritable Bowel
- ☐Crohns Disease
- ☐Ulcerative Colitis
- ☐Diverticulitis
- ☐Hernia (Type:_____)

Psychiatric
- ☐Depression
- ☐Anxiety
- ☐Other:_____
_

Other Not Listed

☐Anemia ☐Cancer:_____Treatment received:_____

☐HIV (treated by:_____)

☐Other:_____

What is your Blood Type: _____ or ☐Unknown

List all Surgeries and year:

_____

_____

Family Health History: ☐ Unknown

Mother_____ Father _____

Siblings_____ Children_____

Other_____

Do you smoke, vape, or use tobacco in any way? ☐ yes ☐no What and for how long?_____

Have you used tobacco in the past? ☐yes ☐no If so, how long since you quit? _____ years/months

Do you drink alcohol? ☐yes ☐no If so, how often? ☐daily ☐weekly ☐twice a month ☐monthly ☐rarely

Do you use any illicit drugs or prescription drugs in a manner other than which they are prescribed? ☐yes ☐no

If so, what? _____

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REVIEW OF SYSTEMS

Patient Name_____ **DOB:**____/____/_____ **Today's Date:** ____/____/_____

When was your last colonoscopy:_____

Which Doctor?_____ Any Abnormals?_____

When was your last Mammogram? _____

Where was it done?_____Any Abnormals?_____

Place a check in the box by any symptoms you are CURRENTLY experiencing and describe

☐Heart Burn	☐Abdominal Pain	☐Blood in Stools	_____
☐Bowel Changes	☐New Bulges (hernia)	☐Vomiting	_____
☐Breast Lumps	☐Skin Lesions/Wounds	☐Skin Ulcers	_____
☐Weight Change	☐Fever/Chills	☐Fatigue	_____
☐Ear Pain	☐Sinus Pain	☐Nasal Congestion	_____
☐Swallowing Difficulty	☐Sore Throat	☐Vision Changes	_____
☐Chest Pain	☐Shortness of Breath	☐Swollen Legs/Feet	_____
☐ Cough	☐Wheezing	☐Respiratory Infections	_____
☐Painful Urination	☐Urinary Frequency	☐Urinary Hesitancy	_____
☐Joint Pain	☐Neck Pain	☐Back Pain	_____
☐Weakness	☐Recent Falls	☐Headache	_____
☐Anxiety	☐Depression	☐Suicidal Thoughts	_____
☐Bruising	☐Bleeding	☐Hot/Cold Sensitivity	_____

Over the past 2 weeks have you felt down, depressed, or hopeless? ☐yes ☐no

Over the past 2 weeks have you felt little interest or pleasure in doing things? ☐yes ☐no

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Medications

Patient Name_____ DOB:___/___/_____ Today's Date: ___/___/_____

Name of Medication & Dose)	Frequency	Notes
(Ex. Aspirin 81mg	Once a day	For my heart)

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HIPAA AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION PURUANT TO 45 CFR 164.508

Patient Name_____DOB:____/____/_____SSN:____-____-_____

PLEASE SELECT ONE:

☐ I **DO AUTHORIZE** and request the disclosure of protected information for the purpose of review and evaluation in connection with a surgical need. I expressly request covered entities under HIPAA to disclose the full and complete protected medical information including the following:

All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. The information released in response to this authorization may be re-disclosed to other parties. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

☐ I authorize and request the disclosure of all protected information EXCEPT: _____

☐ I authorize and request the disclosure of all protected information EXCEPT to the following entity/entities:

_____

☐ I **DO NOT AUTHORIZE** nor do I request the disclosure of protected information for the purpose of review and evaluation in connection with a surgical need. I understand that the risks of not releasing medical records may increase my risk of health damages including illness and death. I, and my heirs, do not hold Dr. Narh-Martey, Middle Georgia Surgical Institute, or the staff therein liable for any negative impact my decision to withhold the release of information may cause on my health or life. I understand that the decision to not share protected information does not affect my eligibility to undergo surgical services.

By signing below I understand that a copy of the HIPAA NOTICE OF PRIVACY PRACTICES is available for my review and Copies of the Notice are available upon request at Middle Georgia Surgical Institute or at www.dph.georgia.gov.

_____ _____

Patient Printed Name **Patient Signature**

_____ _____

Date **Relationship to Patient if Not Self**

_____

Witness

_____

Date

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Payment/Insurance Policy

Thank you for choosing Middle Georgia Surgical Institute. It is the policy of our practice that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit. Professional fees, services fees, copayments and deductibles are NOT refundable. There will be a $20 fee for returned checks.
This does not apply for surgical procedure office visits that may still be covered in a global coverage period during which no deductible, copay, or coinsurance may be required

As a courtesy, our staff verify your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will be processed according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received.

If you are a Medicare patient with a secondary insurance to your Medicare plan, it is your responsibility to provide both insurance identification cards. If the office does not have the proper information for a secondary insurance, the secondary will not be billed.

As the patient/guarantor, it is your responsibility to know your insurance benefits and to provide our office with accurate and current insurance information. At the conclusion of your visits with us you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly.

Patient Responsibility:
I understand and agree that I am financially responsible for all charges for any and all services rendered. I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance. I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full. I agree to inform the office of any changes in my insurance coverage. If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement. By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent.

Patient Printed Name	**Patient Signature**
Date	**Relationship to Patient if Not Self**

☐ Check here if you need to talk to someone about payment plan options

Middle Georgia Surgical Institute

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Patrick Nardi-Martey, MD, FACS

24 Hour Cancellation & No Show Notice

Recognizing that everyone's time is valuable and the appointment time is limited, we ask that you provide 24 hour notice if you are not able to keep your appointment. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, the Physicians of Middle Georgia Surgical Institute reserves the right to charge a $50.00 fee for each missed or (No Show) appointment, which is, absent for a compelling reason, and is not cancelled within a 24 hour advance notice.

"NO SHOW" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "NO SHOWS" in any 12 month period will result in being dismissed from the practice.

Thank you for your anticipated cooperation.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____

Print, Last Name, First Name _____ Date

_____

Signature