Office: 912.354.6303 Fax: 912.355.8655
7001 Hodgson Memorial Dr. Suite 1 | Savannah, GA 31406
455 South Main St. Ste. 203 | Hinesville, GA 31313
12-B Arley Way, Ste. 102 | Bluffton, SC 29910

PATIENT INFORMATION

MARITAL STATUS: S W D M (circle one) AGE _____ SS# ______________________

RACE________________ ETHNICITY_________________ LANGUAGE_________________

NAME___________________________________ DATE OF BIRTH______________________

MAILING ADDRESS____

CITY__________________________ STATE ____________________ ZIP _______________

HOME PHONE ______________WORK PHONE____________CELL PHONE_____________

EMAIL ADDRESS ____

EMPLOYER ____

EMPLOYERS ADDRESS ____

OCCUPATION____

SPOUSE/GUARDIAN _______________________ RELATION TO PATIENT______________

SPOUSE'S SS# _________________________ EMPLOYER___________________________

SPOUSES'S DOB_________________________

EMERGENCY CONTACTS

NAME____ PHONE_____________________

NAME____ PHONE_____________________

MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE? _____YES _____NO

PRIMARY CARE PHYSICIAN________________________ PHONE_____________________

GASTROENTEROLOGIST__________________________ PHONE_____________________

GYNECOLOGIST _________________________________ PHONE_____________________

CARDIOLOGIST __________________________________ PHONE_____________________

WHO REFERRED YOU FOR THIS PROBLEM?

DOCTOR'S NAME _______________________________ PHONE______________________

ADDRESS ____

SouthCoastHEALTH
SURGERY

PATIENT NAME: ____ DOB________________

INSURANCE INFORMATION

PRIMARY INSURANCE: ____

ADDRESS____

PHONE ________________ID#_______________________GROUP#__________________

INSURED'S NAME___________________________ EMPLOYER______________________

SECONDARY INSURANCE: ____

ADDRESS____

INSURED'S NAME___________________________ EMPLOYER______________________

IS THIS WORK RELEATED (Worker's Comp)? _____YES _____NO

SURGERIES / HOSPITALIZATIONS	DATE	DOCTOR

HAVE YOU EVER HAD A PROBLEM WITH ANESTHESIA? _____YES _____NO

ALLERGIES TO MEDICATION, LATEX, OR FOOD: __________________________________

____

CURRENT MEDICATIONS	DOSE	FREQUENCY

DO YOU TAKE ASPRIN OR ANY OTHER BLOOD THINNERS? ________________________

DO YOU ACCEPT BLOOD PRODUCTS (IN CASE OF LOSS OF BLOOD) _____YES ____NO

SouthCoastHEALTH
SURGERY

TODAY'S DATE ______________________

PATIENT NAME: ____ DOB________________

REVIEW OF SYSTEMS

Are you currently, or have you had, problem with:

	CIRCLE ONE	
Constitutional		
Fever	YES	NO
Weight Loss	YES	NO
Excessive Fatigue	YES	NO
Night Sweats	YES	NO
Eyes		
Wear Glasses	YES	NO
Infections	YES	NO
Injuries	YES	NO
Glaucoma	YES	NO
Cataracts	YES	NO
Ear, Nose, Throat and Mouth		
Wear Hearing Aids	YES	NO
Hearing Loss	YES	NO
Trouble with Balance	YES	NO
Nose Bleeds	YES	NO
Cardiovascular		
Chest Pain or Angina	YES	NO
High Blood Pressure	YES	NO
Irregular Pulse	YES	NO
Heart Murmur	YES	NO
Pacemaker	YES	NO
History of Phlebitis	YES	NO
Respiratory		
Asthma	YES	NO
Chronic Cough	YES	NO
Emphysema	YES	NO
Shortness of Breath	YES	NO
Bronchitis	YES	NO
Pneumonia	YES	NO
Lung Cancer	YES	NO
Bloody Sputum	YES	NO

(Continued on next page)

SouthCoastHEALTH
SURGERY

TODAY'S DATE ______________________

PATIENT NAME: ____ DOB________________

Gastrointestinal

Indigestion or Pain with Eating	YES	NO
Nausea	YES	NO
Vomiting	YES	NO
Blood in Your Vomit	YES	NO
Liver Disease	YES	NO
Jaundice	YES	NO
Change in Bowel Habits	YES	NO
Colon Cancer	YES	NO
Blood in Stool	YES	NO
History of Hepatitis	YES	NO

Urinary

Urinary Tract Infection	YES	NO
Difficulty Starting or Stopping Stream	YES	NO
Incontinence	YES	NO
Kidney Stones	YES	NO
Prostate Cancer (males)	YES	NO
Endometriosis (females)	YES	NO
Uterine or Cervical Cancer (females)	YES	NO
Passage of Air in Urine	YES	NO

Skeletal

Back Pain	YES	NO
Arm or Leg Pain	YES	NO
Joint Pain or Swelling	YES	NO

Integumentary

Skin Disease	YES	NO
Do you form keloid after surgery?	YES	NO
Skin Cancer	YES	NO
Breast Pain, Tenderness or Swelling	YES	NO
Nipple Discharge	YES	NO

Date and Result of Last Mammogram ________________________________

Neurological

Fainting Spells or Blacking Out	YES	NO
Seizures	YES	NO
History of stroke	YES	NO

Psychiatric

Anxiety	YES	NO
Depression	YES	NO
Other Psychiatric Disorder/Treatment ____________________	YES	NO

(Continued on next page)

SouthCoastHEALTH
SURGERY

TODAY'S DATE ______________________

PATIENT NAME: ____ DOB________________

Endocrine

Diabetes	YES	NO
Thyroid Disease	YES	NO
Recent use of Cortisone or Prednisone	YES	NO
Hormone Problems	YES	NO

Hematologic/Lymphatic Anemia

Hemophilia	YES	NO
Bleeding Tendencies	YES	NO
Blood Transfusion	YES	NO

If yes, when? __________________________________

Allergic/Immunologic

Immunologic Disorders	YES	NO
AIDS or tested positive for HIV status___________________	YES	NO
Exposure to aids or someone HIV positive	YES	NO

Social History

Who lives at home with you?____

Occupation?____

Do you smoke? _____YES _____NO

If yes, how many cigarettes per day? __________ How long____________________________

Do you drink alcohol? _____YES _____NO

If yes, how much? ________________________ How often?___________________________

Family History

Family Member	Alive/Deceased	Age	Health Status/Cause of Death
Father	A D		
Mother	A D		
Brother/Sister	A D		
Brother/Sister	A D		
Brother/Sister	A D		
Brother/Sister	A D		

The above information is accurate to the best of my knowledge.

Patient Signature___________________________________ Date ______________________

I have reviewed the above information with the patient.

Signature ____ Date ______________________

SouthCoastHEALTH
SURGERY

Patients Rights and Responsibilities

To better educate you of your rights and responsibilities we have written this policy for you. If you have any questions about what is written in this policy please speak with the office manager or collection manager. Our practice is dedicated to giving you the best possible care and to assist with any problems that may arise during your treatment and for you to completely understand your rights and responsibilities and how they are an essential part of your care and treatment.

Responsibilities To You:

All Patients have a right to:

- Confidentiality of records and know that they will only be shared with the hospitals and doctors that are participating in your treatment.
- To refuse treatment of your illness and be informed by this physician of the consequences of that decision.
- To an estimate of the charges for the services that you will receive and to know how we expect you to take care of that expense.
- To let us know of your concerns or complaints concerning this office and for you to be able to address these with the appropriate people in our office.

Patients Responsibilities To This Office:

- You are responsible for your account being kept current; balance must be taken care of in a timely fashion. Your insurance policy is a contract between you and your insurance company. If your account should be sent to a collection agency you will be responsible for all associated FEES as well as the balance.
- We will file your insurance as a courtesy to you and will assign payment to be sent to this office. If your insurance company doesn't pay within a reasonable length of time (90 days), we will then turn to you for payment. We do participate with a number of insurance companies, and if your company is one, we will file your claim and comply with the guidelines of that company. Co- payments must be paid at the time of visits.

Rights and Responsibilities:

- If we do not participate with your insurance company we will file the claim for you. If the insurance company does not pay the claim or pays benefits to you, you are then responsible for the balance in full. If you do not have insurance coverage, payment arrangement must be made for any charges or must be paid at the time of service.
- We will be happy to set up payment arrangements if requested. Statements are mailed monthly and are due upon receipt, unless insurance is pending.
- In the event of surgery we will obtain any pre-certification that is required by your insurance company, BUT you are responsible for obtaining referral numbers for any office visits and must be presented prior to being seen by the physician.
- In some surgical cases, in addition to the physician's charges, there will be a charge for the physician assistant who aids the physician in your treatment.
- Parents and or guardians will be responsible for services rendered to minor patients that are treated.
- When appointments are scheduled you are responsible for bringing the X-RAY FILMS and RECORDS pertinent to your problem you are being seen for.

SouthCoastHEALTH
SURGERY

Auto Accidents/Other Accidents
SouthCoast Health cannot be expected to wait for the conclusion of long-tern court cases or settlement of a disputed insurance claim before being paid. The staff will be glad to file all insurance. If your insurance company denies any charges, it will immediately become your responsibility.

Worker's Compensation
Patients who are injured on the job should report the injury directly to their employer. The employer will be responsible for directing the employee to a doctor who is listed on their PANEL OF PHYSICIANS. Before we will be able to see you as a patient, we will require you to fax or bring a letter verifying that your employer will accept responsibility for services rendered. The staff has been instructed to reschedule all workers' compensation patients that are unable to provide us with the information requested.

Medicaid
Please bring a copy of your Medicaid card to each visit: otherwise we will have to bill you directly. You will be responsible for all services not covered by Medicaid. This will include certain supplies and any office visits made after your authorization has expired.

Authorization For Services
The signature below serves as authorization for services rendered by SouthCoast Health for the below named patient, and provides release of information necessary to file insurance and assign benefits otherwise payable to policy holder to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by the insurance carrier—a copy of the signature is valid as the original.

Authorization: Release Of Information
The signature below serves as authorization for SouthCoast Health to release or receive medical information for the purpose of patient referral. A copy of this signature is as valid as original.

This certifies that I have read and understand the PATIENT RIGHTS and RESPONSIBILITIES of SOUTHCOAST HEALTH SURGERY and agree to abide by its terms and know it is in compliance with HIPPA and the OFFICE OF THE ATTORNEY GENERAL.

____

Signature of Patient or Guardian   Date

NOTE: Copy available upon request.

PATIENT ACKNOWLEDGEMENT FORM

Patient Acknowledgment of Understanding of SouthCoast Health-Surgery Privacy Practices

PATIENT NAME: ____ DOB________________

I understand that the patient's health information is private and confidential. I understand that SouthCoast Health-Surgery has to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that SouthCoast Health-Surgery 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 unusual. One example would be if a patient threatened to hurt someone.

SouthCoast Health-Surgery 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.

SouthCoast Health-Surgery may update this Acknowledgment and "Notice of Privacy Practices". If I ask, SouthCoast Health-Surgery will provide me 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 use of information; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods or alternative location.

SouthCoast Health-Surgery has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist SouthCoast Health-Surgery 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 SouthCoast Health-Surgery "Notice of Privacy Practices".

____

Patient or legally authorized individual signature   Date

____

Relationship to patient if signed by anyone other than the patient

SouthCoastHEALTH
SURGERY

SOUTHCOAST HEALTH FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Patients are expected to cancel appointments at least 24 hours in advance. A $25 fee will be charged to your account if you “no-show” for an appointment or if you fail to notify us 24 hours in advance when canceling an appointment. For Imaging Center services, a $100 no-show fee will apply.

Payment is due at the time services are rendered unless other arrangements have been made in advance by either you or your insurance company. For your convenience, we accept cash, check, money order, Visa, MasterCard and Discover. This policy applies to all of our patients. Co-payments must be paid on the date service is received. A $10.00 billing fee will be charged to your account if the co-pay is not paid on the applicable date of service. Patients are responsible for their deductibles or charges not reimbursed by insurance and you will be asked to pay these on the date service is received. As a courtesy we will automatically file your insurance claims, therefore we request a copy of your insurance card at the time of each visit.

Deposits for surgeries/procedures will be refunded within 30 days after the insurance carrier processes the charge unless you have any outstanding balance to the organization. Deposits will be applied to any outstanding balance.

Patients having health insurance will be expected to contact their insurance carrier for explanation of why your payment may have been delayed or not made. Please understand that insurance is a contract between you and your carrier, therefore, you are ultimately responsible for your bill. If you have difficulty paying your account, please contact the office manager to make payment arrangements.

SouthCoast Health sends out monthly statements to patients that have personal balances (amounts remaining after your insurance company have processed your claim). If your account is not paid within 30 days after receiving a statement it will be considered past due and you will be charged a finance charge of 1.33% per month until the personal balances have been paid. In cases of divorce, the parent who brings the child/children in for treatment is responsible for payment; there are no exceptions.

Any check that is returned to SouthCoast unpaid will be sent to Check Care for collection. There will be a fee of 48.00 for any unpaid check.

In the event your account is turned over to a collection agency, a charge equal to twenty-five percent (25%) of the outstanding account balance will be added to your account to cover the additional collection costs and fees.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice. I authorize the release of any medical information necessary to process my insurance claim.

Signature of Patient or Responsible Party Date

SouthCoastHEALTH
SURGERY

Patient Contact Information

Patient Name ____

Date of Birth ____

Contact Name ____

Relationship ____

Phone Number 1: ______________________ Phone Number 2: ______________________

Full Disclosure

I hereby grant permission for SouthCoast Health to contact, disclose and discuss my health information with the person named above. I understand that I am waiving privacy rights afforded to me under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") which became effective April 14, 2003.

Patient Signature ______________________________________ Date ________________

Parent/Guardian ______________________________________ Date ________________

OR

Appointments Only

I hereby grant permission for SouthCoast Health to contact, disclose and discuss my health in information relating to appointments only; requesting, changing and canceling with the person named above. I understand that I am waiving privacy rights afforded to me under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") which became effective April 14, 2003.

Patient Signature ______________________________________ Date ________________

Parent/Guardian ______________________________________ Date ________________

AND/OR

Insurance and Billing Only

I hereby grant permission for SouthCoast Health to contact, disclose and discuss my health in information relating to insurance and billing issues with the person named above. I understand that I am waiving privacy rights afforded to me under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") which became effective April 14, 2003.

Patient Signature ______________________________________ Date ________________

Parent/Guardian ______________________________________ Date ________________

SouthCoastHEALTH
SURGERY

AUTHORIZATION FOR REQUEST OF HEALTH INFORMATION

This form applies only to the release and disclosure of your health information from another medical provider. It is not intended for any other purposes.

By signing this form, I authorize SouthCoast Health to obtain protected health information needed for my treatment from:

PROVIDER NAME: ____

ADDRESS: ____

I authorize copies of my medical information to be sent to SouthCoast Health to the attention of Dr. Yeager, Dr. Mandel, Dr. Jillard at:

SouthCoast Health Surgery
7001 Hodgson Memorial Dr., Suite 1
Savannah, Georgia 31406

I understand that this information may include any history of or references to acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

Patient's Signature____________________________________ Date______________________

SS# ____ DOB: ____________________

If the signature above is not that of the patient, I am acting for the patient because:

____

My relationship to the patient is:

____

Signature ____

SouthCoastHEALTH
SURGERY

Out of Network Provider

Please be aware that all patients are responsible for any charges not covered by insurance.

With insurance constantly changing and the Implementation of the Affordable Care Act our office is unable to assure that our practice and providers are In Network with all the different types of insurance products on the market today.

We ask that all of our patients assist us with assuring that your policy covers the providers and facility. Please contact the customer service number listed on your insurance card for verification of In Network Providers and Facilities.

Patient Name (Print) ______________________ Account Number ______________________

Patient/Legal Guardian Signature ______________________ Date ______________________