COLUMBUS SURGICAL SPECIALISTS, LLC
1900 10TH Avenue
Suite 201
Columbus, Georgia 31901
Phone: 706-984-7400 Fax: 706-984-7401

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____ SEX: Male/Female

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE NUMBER: _____ WORK PHONE NUMBER: _____

MOBILE NUMBER: _____ EMAIL: _____

MARITAL STATUS: (Circle) Married, Single, Widowed, Divorced

RACE: (Circle) Asian. Black or African American, Hispanic, White, Other _____

ETHNICITY: Asian, Black or African American, Hispanic, White, Other_____

LANGUAGE: _____

EMPLOYER: _____ EMPLOYER PHONE NUMBER: _____

EMERGENCY CONTACT NAME: _____ TELEPHONE NUMBER: _____

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____
PHARMACY: _____

PRIMARY INSURANCE CARRIER: _____ SUBSCRIBER: _____

POLICY NUMBER: _____

SUBSCRIBER'S RELATIONSHIP TO PATIENT: _____ SUBSCRIBER'S DATE OF BIRTH: _____

SECONDARY INSURANCE CARRIER: _____ SUBSCRIBER: _____

POLICY NUMBER: _____

SUBSCRIBER'S RELATIONSHIP TO PATIENT: _____ SUBSCRIBER'S DATE OF BIRTH: _____

POLICY NUMBER: _____

PATIENT'S SIGNATURE: _____ DATE: _____ or

GUARDIAN'S SIGNATURE: _____ DATE: _____

COLUMBUS SURGICAL SPECIALISTS, LLC
1900 10th Avenue
Suite 201
Columbus, Georgia 31901

This acknowledgment of Notice of Consent authorizes **COLUMBUS SURGICAL SPECIALISTS, LLC** to use and disclose health information about you for treatment, payment and other healthcare related services.

Please initial before each of the following:

_____ **Payment for Services:** As a courtesy to our patients, we will promptly file your insurance claims, however, we ask that you be prepared to pay required co-pays, deductibles or services not covered by your insurance plan at the time of your visit. If you do not have insurance coverage, payment is expected at the time of service unless other arrangements have been made in advance.

_____ **Authorization of Payment:** I hereby authorize that payment may be made to my physician for Medicare or other insurance benefits for services rendered. I understand that I am financially responsible for any charges not covered by my insurance and agree to pay for those services.

_____ **Authorization for Release of Information:**
I hereby authorize the designated physician to furnish or obtain any medical information requested by any physician assisting with my care, insurance companies with whom I have coverage or any agency which may be assisting in my medical care or in payment for my medical care. **Columbus Surgical Specialists, LLC** is committed to respecting the confidentiality of your protected health information (PHI) as necessary in providing you with surgical treatment and services.

_____ **Authorization for Treatment:** I hereby authorize examinations, x-rays, treatments, medications, and minor surgical procedures as may be prescribed by the physician in charge of my care.

_____ **Notice of Fees: Columbus Surgical Specialist, LLC** reserves the right to charge a $25.00 fee for any appointment that is missed. There is a $25.00 fee to the patient for completion of FMLA, short term disability and/or any other miscellaneous forms and is payable at the time paperwork is left for completion.

_____ **Notice of Appointment Policy:** As a courtesy, we provide reminder calls for upcoming appointments. Please ensure that we have the correct telephone number on file.

_____ **Notice of Privacy Practices:** We are required by the Health Insurance Portability and Accountability Act (HIPPA) to inform our patients of their rights and duties regarding the privacy of their health information.

_____ **Right to Make Amendments:**
We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information obtained prior to the changes.

_____ **Returned Check Fee:** We will charge a fee of $35.00 for a check returned for insufficient funds. We also reserve the right to request cash for future appointments

I acknowledge that I have received a copy of the Notice of Privacy Practices regarding the use and disclosure of my Protected Health Information.

I authorize Columbus Surgical Specialists, LLC to release medical information, which relates to my care, to the following individuals:

1. _____ _____ _____
   Name **Relationship** **Telephone Number**

2. _____ _____ _____
   Name **Relationship** **Telephone Number**

_____ _____
Patient's Signature **Date**

_____ _____
Parent's Signature (if patient is a minor) **Date**

Patient Name: _____ **DOB:** _____

Columbus Surgical Specialists PATIENT INTAKE FORM

Patient Name: _____ Date of Birth: _____

PATIENT HISTORY

	YES	NO		YES	NO
Breast Cancer			Liver Disease		
Breast Lumps/Masses			Thyroid Disease		
Stomach Ulcers			High Blood Pressure		
Reflux			Heart Disease		
Pancreatitis			Heart Attack		
Colorectal Cancer			Diabetes		
Colon Polyps			Asthma		
Diverticulitis			Lung Disease		
Ulcerative Colitis/Crohns			Kidney Disease		
Bowel Obstruction			Stroke		
Anal fissure					

PERTINENT FAMILY HISTORY

	MOTHER	FATHER	SISTER	AUNT	GRANDMOTHER
Breast Cancer					
Ovarian Cancer					

	MOTHE	FATHER	SIBLING	GRANDPARENT
Gastric Cancer				
Pancreatic Cancer				
Esophageal Cancer				
Colorectal Cancer				
Thyroid Cancer				
Endometrial Cancer				
Bladder Cancer				

PAST SURGICAL HISTORY

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

ONLY CHECK THOSE THAT APPLY:

Cold Intolerance		Breast Mass		Easy Bruising		Constipation	
Heat Intolerance		Nipple Discharge		Swollen Glands		Diarrhea	
Chest Pain		Wheezing		Swollen Glands in the Neck		Heartburn	
Irregular Heart Beat		Cough		Blood Clots		Nausea	
Palpitations		Shortness of Breath		Rash		Red blood in Stools	
Difficulty Breathing lying down		Short of Breath on Exertion		Itching		Black Tarry Stools	
Fever Chills		Sleep Apnea (CPAP)		Hives		Joint Pain	
Loss of Appetitie		Double Vision		Jaundice		Joint Swelling	
Weakness		Eye Inflammation		Sore Throat		Joint Stiffness	
Recent Weight Gain		Confused		Dizziness			
Recent Weight Loss		Headache		Hoarseness		Last Mammogram	
Pain on Urinamtion		Seizures		Anxiety		Last Colonoscopy	
Urinary Incontinence		Leg Weakness		Depression		Height	
Flank Pain		Arm Weakness		Abdominal Pain		Weight	
Breast Pain		Easy Bleeding		Vomiting			

Signature: _____ Date: _____

Patient Medication list

Patient Name: _____ **Date of Birth:** _____

Medication Name	Prescribing doctors name	Reason for taking medication	Dose	How often?

Pharmacy Name: _____

Pharmacy Location: _____

Do you have a LATEX allergy? YES/NO _____ Are you allergic to TAPE? YES/NO _____

Are you allergic to any medications? If yes, please list all allergies to medications below.

Name	Type of reaction, such as a rash or breathing difficulties

Smoking History:

Never Smoked _____

Quit Smoking _____ _____ packs per day for _____ years

Current Smoker _____ _____ packs per day for _____ years

Patients Signature: _____ Date: _____

STAFF: *SCREENING*_____ *DIAGNOSTIC:* _____

NURSE NOTE: _____

HIPAA Notice of Privacy Practices

Columbus Surgical Specialists, LLC

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**