Date _____/_____/_____ Appointment with Dr. _____

Acct # _____

PATIENT REGISTRATION FORM
Rochester General Surgery

PATIENT INFORMATION

Last Name _____ First _____ MI _____

Address _____ Apt. #_____

City _____ ST_____ZIP_____ E-mail address_____

Home Phone_____ Cell Phone_____ Work Phone_____

Date of Birth_____ Sex: Male ☐ Female ☐ Age_____ SS#_____-_____-_____

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Preferred Language: English ☐ Other _____ **Ethnicity:** Hispanic ☐ Latino ☐ Not Hispanic or Latino ☐

Race: African American or Black ☐ American ☐ American Indian or Alaskan ☐ Asian ☐ Native Hawaiian or Other ☐

Other Race ☐ White ☐

Patient Employed By_____ Occupation_____

Employer Address_____ City_____ State_____ Zip_____

Business Phone_____ _____, Ext._____ If student, school name_____

Is student: Full Time ☐ Part Time ☐

GUARANTOR/SPOUSE INFORMATION (if not above)

Name _____ Relationship_____ Phone Number_____

Address _____ City _____ ST_____ Zip _____

Date of Birth _____ Sex: Male ☐ Female ☐ Age_____ SS#_____-_____-_____

REFERRING PHYSICIAN

Physician's Name_____ Phone Number_____

Address _____ City _____ ST_____ Zip _____

PRIMARY CARE PHYSICIAN IF DIFFERENT FROM REFERRING PHYSICIAN

Physician's Name_____ Phone Number_____

Address _____ City _____ ST_____ Zip _____

Emergency Contact Name_____ Relationship to You _____

Work Phone Number _____ Home Phone Number _____

Is the injury / illness related to work? Yes No If yes, date of injury_____

Is the injury / illness due to an accident? Yes No If yes, date of injury_____

Type of Accident Motor Vehicle (MVA) Other (please explain)_____

Referral Source: Family ☐ Friend ☐ Insurance Company ☐ Phone Book ☐ Other ☐

Name and Address of referral source:_____

Can we leave appointment reminders on the home number provided? Yes ☐ No ☐

Can we contact you via e-mail? Yes ☐ No ☐ Can we text to your cell phone? Yes ☐ No ☐

……

Insurance Authorization and Assignment: I hereby assign, to Rochester General Surgery, PLC payment of medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization.

Financial Agreement: I understand that I am financially responsible for all charges whether or not they are covered by my insurance as well as any co-payment and co-insurance. In the event of non -payment for any of these costs, I understand I will be legally responsible for all costs involved with the collection of this account including all court costs, attorney fees, and any expenses incurred, should this be required.

Consent to Treat: I request and give consent to my physician to provide and perform such medical/surgical care, tests, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the result or cures have been made to me or relied upon by me.

Medicare Certification: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Rochester General Surgery, PLC for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.
I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

……

TELEPHONE CONSUMER PROTECTION ACT OF 1991

By signing this document, I agree, in order for Rochester General Surgery, P.L.C. to service my account or to collect any amounts I may owe, Rochester General Surgery, P.L.C. and its third party billing and/or debt collection service providers may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which may result in charges to me. Additionally, I authorize contact via text messages or emails, using any email address I provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, if applicable.

I/We have read this disclosure and authorize express consent that Rochester General Surgery, P.L.C. its affiliates and third party service providers may contact me/us as described above.

Patient's Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

ROCHESTER GENERAL SURGERY

Medical Information Form

Name _____ **Date** _____

Name preferred to be called: _____

List of Doctors: _____

Reason for Visit: _____

Past Medical History: (check all that apply): # Pregnancies _____ # Deliveries _____

- ○ High Blood Pressure
- ○ Coronary Artery Disease
- ○ Heart Attack
- ○ Tuberculosis
- ○ Reflux
- ○ Diabetes Mellitus
- ○ Insulin Use
- ○ Pacemaker
- ○ Lung Disease
- ○ Asthma
- ○ Seizures
- ○ Peripheral Vascular Disease
- ○ Kidney Disease
- ○ Cancer
- ○ Ulcers
- ○ Stroke
- ○ Irregular Heart Beat
- ○ Congestive Heart Failure
- ○ Hepatitis
- ○ Thyroid
- ○ Other: _____

Past Surgery(s): _____

_____

_____

Medications (Doses): _____

_____

_____

Drug Allergies: _____ **Latex Allergy** _____

Alcohol: Yes No Type/Quantity _____ Frequency _____

Smoking Status: Please fill in blanks with when you started, how much, and/or when you quit.

- ○ Every day: _____
- ○ Former: _____
- ○ Some day: _____
- ○ Never
- ○ Status unknown
- ○ Unknown if ever smoked

Drug Use: Yes No Type/Quantity _____ Past Use _____

Height: _____ **Weight:** _____

Family History: If any apply, please state the relationship of the family member.

- ○ Heart Disease _____
- ○ Bleeding Disorders _____
- ○ Diabetes _____
- ○ Cancer/Type _____
- ○ Other: _____
- ○ None _____

System Review:

- ○ Shortness of Breath
- ○ Cough
- ○ Fevers/Chills
- ○ Dizziness
- ○ Fatigue/Weakness
- ○ Nausea/Vomiting
- ○ Diarrhea
- ○ Visual Disturbance
- ○ Hearing Problems
- ○ Weakness in Extremities
- ○ Chest Pain
- ○ Altered Bowel Habits
- ○ Altered Bladder Habits
- ○ Poor Appetite/Weight Loss
- ○ Other

Other medical information you wish to provide _____

_____

ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have reviewed or received a copy of this office's Notice of Privacy Practices Form.

Patient's Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Documentation of Failure to Obtain Signed Acknowledgment

On _____ , 20__, _____ presented this Acknowledgment of Receipt of Notice of

_____

Privacy Practices Form to (the "Patient). The Patient refused to provide a signature when requested.

.....

CONSENT FOR USE AND DISCLOSURE
OF YOUR HEALTH INFORMATION

Our purpose in asking you to sign this form is to document that we have informed you that this office may use and disclose all your

health information in our possession (collectively "Protected Health Information").

The uses and disclosures by this office of your Protected Health Information are necessary and will be used by this office in connection with your treatment, our obtaining payment for treatment and services that this office provides to you and so that this office can conduct its health care operations.

For a more complete description of how this office may use and disclose your Protected Health Information, please carefully review the Notice of Privacy Practices Form that this office has prepared and is furnishing to you today. Please also see our Notices of Privacy Practices Form for a mor detailed discussion of the meanings of "treatment", "payment", and "health care operations".

YOU HAVE THE RIGHT TO REVIEW OUR NOTICE OF PRACY PRACTICES FORM PRIOR TO SIGNING THIS CONSENT. PLEASE BE ADVISED THAT THE NOTICE OF PRIVACY PRACTICES FORM MAY BE REVISED BY THIS OFFICE FROM TIME TO TIME. ANY SUCH REVISED NOTICE OF PRIVACY PRACTICES FORM WILL BE MADE AVAILABLE TO YOU BY CONTACTING DANIEL

M. SULLIVAN, M.D.

YOU SHOULD ALSO REVIEW CAREFULLY THE NOTICE OF PRIVACY PRACTICES FORM BECAUSE IT CONTAINS A LIST OF RIGHTS THAT ARE AVAILABLE TO YOU WITH RESPECT TO THIS OFFICE'S USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION. THESE RIGHTS INCLUDE YOUR RIGHT TO REQUEST RESTRICTIONS ON OUR USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION.

YOU HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME. IF YOU WISH TO REVOKE THIS CONSENT, YOU MUST DO SO IN WRITING.

BY SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND THIS CONSENT AND THIS OFFICE'S NOTICE OF PRIVACY PRACTICES FORM. YOU FURTHER ACKNOWLEDGE THAT YOU HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES FORM TO TAKE WITH YOU.

Patient's Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

AUTHORIZATION FOR THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION

By signing below, I hereby authorize my health information, as more specifically described as follows: (the "Protected Health Information"), to be used or disclosed for the following purposes: _____ _____. *[If the use or disclosure is at the patient's request, insert "At the Patient's Request" instead of a specific purpose.]*

The specific person or class of persons who are authorized to use or disclose my Protected Health Information are:

The person or class of persons to whom this office may use or disclose my Protected Health Information are:

This Authorization shall expire on: _____

I understand that I have the right to revoke this Authorization, if the revocation is in writing, except if

- This office has taken action in reliance upon this Authorization; or
- This Authorization was given as a condition of obtaining insurance coverage and the insurance company has the right to contest a claim made under the insurance policy.

I understand that I may revoke this Authorization by delivering written notice to Daniel M. Sullivan, M.D.

I understand that my Protected Health Information that is used or disclosed pursuant to the Authorization may be subject to redisclosure by the person(s) you have disclosed it to, and the privacy of my Protected Health Information will no longer be protected.

I acknowledge that I have read and understand this Authorization. I authorize the use of disclosure of my Protected Health Information in accordance with the terms of the Authorization.

Patient Signature of Authorized Representative Signature _____ Date Signed _____

Description of authorized Representative's authority to sign for the patient:_____