The Surgery Clinic, LLC
Drs. Newman III, C. Newman & Nordness
419 S. 5th Street Gadsden, AL 35901 (256)547-6331

Assignment of Benefits

I hereby assign all medical/surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, Blue Cross & Blue Shield, Medicaid, Medigap or any other health plan to The Surgery Clinic, LLC. I understand that I am financially responsible for all charges including non-covered charges.

Authorization to Release Information

I hereby authorize the release of all medical information necessary to secure payment for claims, complete disability forms, cancer policies & family medical leave forms that are presented to The Surgery Clinic. I authorize the physician to release & fax information & also request/receive information pertaining to the treatment of my health.

Medicare/Medigap Authorization (Crossover Claims)

I authorize release to the Social Security Administration & Health Care Financing Administration or its intermediaries or carriers & information needed for this or related Medicare claims. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act & 31 U.S.C.3801-3812 Providers penalties for withholding this information.) I authorize any holder of medical or other information needed, to be released to The Surgery Clinic for this or any related Medigap claim. I request payment of medical insurance benefits to either myself or to the party who accept assignment.

X _____ _____

Patient or Parent/Guardian Signature **Date**

Patient's Name_____ **Patient Date of Birth** _____

Address_____ **Height** _____ **Weight** _____

City/Zip_____ **Home Phone**_____

Social Security Number _____ **Cell Phone**_____

Employer_____ **May we text appointment reminders? Y/N**

Work Phone_____ **May we contact you at work? Y/N**

Primary Emergency Contact Name: _____

Relationship: _____ **Contact Number(s):** _____

Second Emergency Contact Name: _____

Relationship: _____ **Contact Number(s):** _____

Medication (please list meds with the dosage) **Preferred Pharmacy:** _____

○ List Provided at Reception ○ None

_____

_____

_____

_____

_____

The Surgery Clinic, LLC

Drs. Newman III - C. Newman - Nordness

419 South 5th Street, Gadsden, AL 35901

Name: _____ Date of Birth: _____ Date: _____

Primary Care Phys. _____ Referrring Phys. _____

CHECK HERE IF YOU HAVE ANY OF THESE SYMPTOMS:

	YES	NO
GENERAL REVIEW OF SYMPTOMS		
FEVER		
WEIGHT LOSS / WEIGHT GAIN		
H.E.E.N.T.		
PAIN/DIFFICULTY SWALLOWING		
RECENT CHANGE IN VOICE		
LUMPS/BUMPS IN THROAT		
CARDIOVASCULAR		
PREVIOUS HEART ATTACK		
CHEST PAIN		
IRREGULAR HEARTBEAT		
HYPERTENSION (HIGH BLOOD PRESSURE)		
LEG SWELLING / EDEMA		
LEG PAIN AFTER WALKING		
RATE YOUR PAIN (MILD) 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE)		
DURATION OF PAIN:		
NEUROLOGICAL		
NUMBNESS/TINGLING EXTREMITIES		
GENITOURINARY		
PAIN/DIFFICULTY URINATING		
RATE YOUR PAIN (MILD) 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE)		
DURATION OF PAIN:		
BLOOD IN URINE		
GENITOURINARY (MALE)		
TROUBLE STARTING/STOPPING		
FREQUENT NIGHTTIME URINATION		
GENITOURINARY (FEMALE)		
(FEMALE) VAGINAL DISCHARGE		
(FEMALE) LEAK URINE		
BREAST		
BREAST LUMPS OR MASSES		
NIPPLE DISCHARGE		
BREAST CANCER		
BREAST PAIN		
RATE YOUR PAIN (MILD) 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE)		
DURATION OF PAIN:		

	YES	NO
PULMONARY		
CHRONIC COUGH		
COUGHING UP BLOOD		
GASTROINSTESTINAL		
CHRONIC DIARRHEA		
BLOOD IN STOOLS		
PAIN WITH BOWEL MOVEMENT		
NAUSEA / VOMITTING		
CONSTIPATION		
RECENT CHANGE IN STOOLS		
ABDOMINAL PAIN		
RATE YOUR PAIN (MILD) 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE)		
DURATION OF PAIN:		
TROUBLE WITH SPICY/FATTY FOOD		
SKIN		
NEW SKIN LESIONS		
MOLES CHANGING COLOR/SIZE		
BLEEDING MOLES		
LOCATION(S):		

ALERT		
UNDER PAIN MANAGEMENT		
SMOKING/TOBACCO USE		
DRUG USE		
ALCOHOL USE		
PACEMAKER		
TAKING ASPRIN / BLOOD THINNERS		
PREGNANT / PLANNING PREGNANCY		
AIDS / HIV POSITIVE		
HEPATITIS (please circle) A B C		
ALLERGY TO LATEX		
ALLERGY TO ADHESIVE		

M.D. SIGNATURE: _____

DATE REVIEWED: _____

The Surgery Clinic, LLC

Drs. Newman, Jr. - Newman III - C. Newman - Nordness
419 South 5th Street, Gadsden, AL 35901

Patient Name: _____ *Date of Birth:* _____

Past Medical History (please check all that apply)

	YES	NO
Chronic Anemia		
Anxiety		
Depression		
Breast Cancer		
Heart Disease		
High Blood Pressure		
Coronary Artery Disease		
Irregular Heartbeat		
Deep Vein Thrombosis		
Pulmonary Embolism		
Diabetes		
Cholesterol		
Kidney Disease		

	YES	NO
GERD		
Colon Cancer		
Other Colon Issue		
Hepatitis		
Thyroid Disease		
COPD		
Lung Cancer		
Lung Disease		
Morbid Obseity		
Arthritis		
Sleep Apnea		
Neuropathy		
Stroke		

OTHER MEDICAL CONDITIONS :

Allergies

_____

_____

_____

_____

Past Surgical History (please check all that apply)

	YES	NO
Appendix		
Breast: _____		
Heart: _____		
Kidney: _____		
Skin / Benign lesion removal		
Skin / Basal or Squamous cell		
Skin / Melanoma		

	YES	NO
Gallbladder		
Pancreas		
Prostate		
Rectum		
Hysterectomy		
Ovary		
Colon: _____		

OTHER SURGICAL HISTORY :

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

FAMILY HISTORY	MOM	DAD	BROTHER	SISTER	GRANDPARENTS (MATERNAL OR PATERNAL)	AUNT	UNCLE
Asthma							
Cancer							
Depression							
Diabetes Mellitus							
Heart Disease							
High Cholesterol							
Hypertension							
Liver Disease							
Pulmonary Disease							
Renal Disease							
Seizure Disorder							
Thromboembolic Disease							
Thyroid Disease							
Medical History unknown							
Other:							

Have you had any recent hospitalizations with-in the past 6 months? ☐ Yes ☐ No

If you answered yes, please give additional details

Name of Hospital Facility	Date of hospitalization	Reason for hospitalization

Recent Routine Diagnostics:

When was your last Colonoscopy: _____ Mammogram: _____

Have you had a recent fall? ☐ Yes ☐ No

Are you a current smoker? ☐ Yes ☐ No
If YES _____# Packs/Day for Approx. _____# Yrs

Preferred Hospital: ☐ Riverview Regional ☐ Gadsden Regional ☐ Gadsden Surgery Center

Release of Medical Information

I allow the following person(s) to receive and/or discuss medical information at any time:

**Please include any individual (spouse/children/other guardians or caregivers of minor children/etc.) or organization with whom we have permission to speak as part of your care team. *You do not have to list referring or primary care physicians.*

_____ _____

_____ _____

THE SURGERY CLINIC, LLC

Patient Portal User Agreement

The Surgery Clinic, LLC provides a patient portal to enhance patient-physician communications. All users must be established by a previous office visit.

The Patient Portal can provide the following services:

Update patient demographics	Request or look up appointments
Contact a nurse with a non-emergency call	View Clinical Summaries

We strive to keep all of the information in your records correct & complete. If you identify any discrepancy on your record, you agree to notify us immediately. Additionally, by using the Patient Portal, the user agrees to provide factual & correct information. Once you have signed the Patient Portal Consent Agreement & have provided us with a legitimate e-mail address that is secure, you will be e-mailed a welcome invite with a link to our portal with a generated temporary password for you to create a new password. You will then be able to use this information to access portions of your medical records & to communicate securely with our office. Keep your ID & password secure.

Patient Acknowledgement & Agreement

I acknowledge that I have read & fully understand this consent form. I acknowledge that using the Patient Portal in entirely voluntary & will not impact the quality of care I receive from The Surgery Clinic, LLC. I have been proactive about asking questions related to this consent agreement. All my questions have been answered with clarity.

X **E-mail Address:** _____

X _____ _____ _____

Print Patient Name | Patient or Parent/Guardian Signature | Date

Consent to the Use & Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare this practice (The Surgery Clinic, LLC) originates & maintains health records describing my health history, symptoms, examination & test results, diagnoses, treatment & any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care & treatment.
- A means of communication among the many healthcare professionals who may contribute to my care.
- A source of information for applying my diagnosis & treatment information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality & reviewing the competence of healthcare professionals.

I understand & have been provided access with a **Notice of Privacy Practice** that provides a more complete description of information uses & disclosures. I understand that I have the right to review the Notice prior to signing this consent. I understand the organization (The Surgery Clinic, LLC) reserves the right to change its notice & practices. I understand that I have the right to object to the use of my healthcare information for directory purposes. I understand that I have the right to request restrictions as to how my healthcare information may be used or disclosed to carry out treatment, payment, or healthcare operations & that the organization (The Surgery Clinic, LLC) is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to the use of my health information:

_____

I fully understand and ☐ accept ☐ decline the terms of this consent.

X _____ _____

Patient or Parent/Guardian Signature | Date