Columbia Surgical Partners

DRS. OXLEY & VERTREES

Name:_____
Today's date:_____Date of birth:_____
Have you been seen here before? _____
Reason for visit _____
How long have you had this problem? _____
Primary Care Physician _____
Age _____ Height _____ Weight _____ In pain today? _____
Pharmacy and location_____

What **ILLNESSES** do you or have you had? Check all that apply.

__ Stroke
__ Heart disease
__ Lung disease
__ Gastric reflux
__ Bleeding problems
__ Diverticulitis
__ Hemorrhoids
__ Cancer (type?)
__ Kidney failure
__ Thyroid disease
__ Stomach ulcers
__ HIV/AIDS
__ Parkinson's disease
__ Alzheimer's disease
__ Poor circulation
__ Liver problems
__ Blood clots
__ Aneurysm
__ Seizures
__ Hepatitis (A, B, C)
__ High cholesterol
__ High blood pressure
__ Diabetes
__ Other _____

What **SURGERIES** have you had? Check all that apply

__ Brain
__ Eyes, cataracts
__ Face, nose, ears
__ Tonsillectomy
__ Thyroid gland
__ Parathyroid glands
__ Lung
__ Heart
__ Breast
__ Appendectomy
__ Abdominal
__ Gallbladder
__ Hysterectomy/ovaries
__ Cesarean section
__ Kidney/bladder
__ Prostate
__ Dialysis access graft
__ Other _____
__ Aneurysm repair
__ Artery bypass
__ Carotid artery
__ Varicose veins
__ Amputation _____
__ Hernia repair _____
__ Hemorrhoidectomy
__ Pacemaker

When was your last colonoscopy? _____

What **MEDICINES** do you take? If you have a long list, please review with the nurse

__ Blood thinners
__ Over the counter meds
__ Others _____
___ Aspirin/NSAIDs
__ Supplements
__ Insulin

Are you **ALLERGIC** to any medications? ___ No ___ Yes (please list medication and reaction)

Do you have a **FAMILY HISTORY** of any of the following?

__ Heart disease
__ High blood pressure
__ Diabetes
__ Cancer (What kind?) _____
___ Adopted/don't know family
Other _____

Do you **SMOKE?** ___ No ___ Yes, ____ packs per day for ____ years. Quit _____ years ago
Vape? _____ Smokeless tobacco? _____ Marijuana? _____
Do you drink **ALCOHOL**? ____ No ___ Occasionally How much daily _____
Do you do **DRUGS**? ___ No ___ In the past ___ Currently (what kind?) _____
What is your **OCCUPATION**? __ None (__ retired __ disabled)
Type of work _____ Heavy lifting (>25lbs) _____
During the **PAST 6 MONTHS**, have you had any of the following problems? Check all that apply?

General
___ Fevers/chills
___ Weight loss (>20 lbs)
___ Night sweats
___ Decreased appetite
___ Recent foreign travel

Eyes
___ Double/blurred vision
___ Sudden loss of vision

Head and Neck
___ Neck mass/swelling
___ Headaches/migraines
___ Hearing loss
___ Frequent nosebleeds

Lungs
___ Shortness of breath
___ Cough
___ Wheezing
___ Pain with breathing
___ Sleep apnea ___ mask

Heart/Vascular
___ Rapid/skipped beats
___ Chest pain
___ Vascular disease
___ Blood clots

Gastrointestinal
___ Abdominal pain
___ Nausea/vomiting
___ Heartburn/reflux
___ Diarrhea
___ Constipation
___ Bloody/tarry stools
___ Crohns disease/colitis

Hematologic/Lymphatic
___ Bruise/ bleed easily
___ Swollen lymph nodes

S**kin**
___ Lumps/sores/ulcers
___ New/enlarging moles

Genitourinary
___ Blood in the urine
___ Burning urination
___ Leaking urine
___ Difficulty urinating
___ Erectile dysfunction

Musculoskeletal
___ Pain in joints
___ Muscle aches/cramps
___ Back pain
___ Fibromyalgia
___ Osteoporosis/penia

Neurologic
___ Fainting/passing out
___ Difficulty walking
___ Paralysis (weak/numb)
___ Seizures
___ Dizziness

Endocrine
___ Heat/cold intolerance
___ Abnormal blood sugar
___ Change in hair/skin texture

Breast
___ Breast pain/soreness
___ Lumps in the breast
___ Nipple discharge
___ Nipple inversion

Psychiatric
___ Depression
___ Frequent memory loss
___ Sleeping problems

T:_____ BP:_____ Pulse:_____ Weight:_____

Welcome form

Personal Information

Name:_____ Name you wished to be called: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Home phone: _____ Cell Phone: _____ Work: _____
Patient Social Security:_____ Birthday: _____

- ❑ Male Marital Status: _____ Email:_____
- ❑ Female

Race: White Black Asian Hispanic Other:_____
_____

Insurance (PLEASE FILL OUT IF YOU ARE NOT THE PRIMARY)

Primary Insurance:_____ ID:_____ Group:_____
Name of Insured:_____ Relation to patient: _____
Insured Birthday: _____ SSN: _____

Secondary Insurance:_____ ID:_____ Group:_____
Name of Insured:_____ Relation to patient: _____
Insured Birthday: _____ SSN: _____

Emergency Contact

Name: _____ Relationship: _____
Home:_____ Work:_____ Cell:_____
_____

Telephone Permission

I _____ agree to allow Columbia Surgical Partners to call and leave a message
(check all that apply)

- ❑ Exclusively with me
- ❑ On my answering machine
- ❑ With _____

Regarding:

- ❑ An appointment
- ❑ Pending test results
- ❑ Billing information
- ❑ Referrals
- ❑ RX Information
- ❑ Other _____

Columbia Surgical Partners Payment Agreement:

AUTHORIZATION, ASSESSMENT, AND RESPONSIBILITY OF ACCOUNT

The patient or Guarantor is responsible for payment in full of all services rendered by the physicians or employees of Columbia Surgical Partners. I understand that my copay is due in full at the time of service. No Exceptions. Any other necessary financial arrangements must be made prior to service. I understand that if I do not pay for my services within ninety (90) days, then my account could/will be sent to collections. I understand that the patient will not be seen until the balance in collections is paid in full, or a payment plan is arranged and followed. Non- payment of accounts will result a referral to an outside collection agency that could impact the patients credit record. Legal fees and collection cost incurred to collect outside accounts will be the patients responsibility

- I hereby authorize Columbia Surgical Partners, to release to any insurance company and/or other intermediaries and/or carriers of any medical or other information needed for claims reimbursement.
- I hereby assign, transfer and set over to Columbia Surgical Partners, all of my rights, title and interest to medical reimbursement under my insurance policy with the above documented insurance companies.
- I hereby acknowledge Columbia Surgical Partners may perform a Pharmacy Check if warranted
- I hereby acknowledge the receipt of the Notice of Privacy Practices given to me by Columbia Surgical Partners

_____ _____

Signature of Patient/Guardian Date

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1708 Alpine Dr
Columbia, TN. 38401
P: 931-283-6629
F: 931-223-5881

PATIENT PAYMENT POLICY

Copays: We require payment of co-pays at the time of service, and we reserve the right to reschedule the appointment, and/or refuse treatment

No Insurance: If you have no insurance, we collect a $150.00 deposit for the initial visit and also for the follow up visits. This deposit is put toward your visit, since at the time of check in we are not sure of what services will be rendered. If your visit ends up being over the $150.00 deposit, we will send you a bill for the remainder. If your visit is less, we will issue a refund or put the credit towards your next visit.

Outstanding balances: We may refuse to see patients with outstanding balances until a payment plan arrangements have been made.

Surgery Deposits: It is our policy that payment is due in full prior to the date of surgery. However, we understand that occasionally patients may need to make a temporary payment agreement while receiving necessary surgical care. Your health is our first concern, and we are willing to extend the following payment agreement: If your deductible has not been met for the year we will collect half of the estimated surgery cost BEFORE your surgery date. The other half is due the day of your two week follow up appointment. If you are uninsured, we will collect half of the estimated surgery cost BEFORE the date of surgery. The other half can be paid at the first follow up or you can make payment arrangements with our accounts manager. Surgery charges from this office are the physicians ONLY. When you have a procedure at the hospital you will still receive other statements from Maury Regional Hospital, anesthesia, and pathology if applicable.

Signed: _____

Date:_____