FAMILY SURGICAL

MEDICAL HISTORY **DATE:** _____

NAME: _____ **DOB:** _____ **AGE:** _____

FAMILY DOCTOR: NAME _____ PRACTICE _____

REFERRING DOCTOR: NAME _____ PRACTICE _____

REASON FOR THIS VISIT: _____

_____

_____

CHILDHOOD ILLNESSES: MEASLES _____ MUMPS _____ CHICKENPOX _____ RHEUMATIC FEVER _____ ASTHMA _____

SEIZURES _____ POLIO _____ OTHER _____

ADULT MEDICAL ILLNESSES: ASTHMA _____ EMPHYSEMA _____ GERD _____ ULCERS _____ KIDNEY STONES _____

KIDNEY DISEASE _____ HEART DISEASE _____ HYPERTENSION _____ STROKE _____ OSTEOARTHRITIS _____

DIABETES _____ HEPATITIS _____ GLAUCOMA _____ DEPRESSION _____ SLEEP APNEA _____

PREVIOUS SURGERIES: TONSILLECTOMY _____ GALLBLADDER _____ APPENDECTOMY _____ BREAST BIOPSY _____

HEART _____ HERNIA _____ C-SECTION _____ HYSTERECTOMY _____ / OVARIES REMOVED? YES NO

OTHER _____

HAVE YOU EVER HAD A COLONOSCOPY? YES NO

CURRENT MEDICATIONS: (Please list "ALL" medications you are taking, including dosage and bring the bottles with you)

_____ _____

_____

_____

MEDICATION ALLERGIES: _____

FAMILY HISTORY: EARLY HEART DISEASE _____ HYPERTENSION _____ STROKE _____ DIABETES _____

CANCER (List type and which family member):_____

OTHER _____

SOCIAL HISTORY: OCCUPATION _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

DO YOU SMOKE? YES NO HOW LONG? _____ YEARS / IF YOU QUIT SMOKING, HOW LONG AGO? _____YEARS

DO YOU DRINK ALCOHOL? YES NO HOW MUCH? _____

DO YOU CONSUME CAFFEINE? YES NO HOW MUCH? _____

ILLICIT DRUGS: YES NO / IF YES, PLEASE LIST _____

PATIENT NAME: _____ **DATE:** _____

REVIEW OF SYSTEMS: (Please circle and/or enter information for all)

GENERAL: **Change in Appetite:** Yes / No - If Yes, Increase / Decrease **Chills:** Yes / No

Fatigue: Yes / No **Fever:** Yes / No **Lightheadedness:** Yes / No

Weight Gain or Loss: Yes / No - If Yes, Gain / Loss, How Much? _____ Over How Long? _____

EYES: **Blurred Vision:** Yes / No **Discharge:** Yes / No **Itching/Redness:** Yes / No **Pain:** Yes / No

EARS/NOSE/THROAT: **Hoarseness:** Yes / No **Thyroid Disease:** Yes / No - If Yes, Overactive? or Underactive?

Decreased Hearing: Yes / No **Difficulty Swallowing:** Yes / No - If Yes, Solids? and/or Liquids?

Swollen Glands: Yes / No

RESPIRATORY: **Cough:** Yes / No **Coughing up Blood:** Yes / No

Shortness of Breath: Yes / No - If Yes, At Rest? or With Movement? **Wheezing:** Yes / No

CARDIOVASCULAR: **Heart Murmur:** Yes / No **Chest Pain:** Yes / No - If Yes, At Rest? or With Movement?

Irregular Heartbeat: Yes / No **Palpitations:** Yes / No

GASTROINTESTINAL: **Stomach Ulcers:** Yes / No **Colon Polyps:** Yes / No

Prior Colonoscopy: Yes / No - If Yes, When? _____ **Food Intolerance:** Yes / No

Abdominal Pain: Yes / No **Blood in Stools:** Yes / No **Constipation:** Yes / No

Diarrhea: Yes / No **Hepatitis:** Yes / No **Heartburn:** Yes / No

Nausea: Yes / No **Rectal Bleeding:** Yes / No **Vomitting:** Yes / No

GENITOURINARY: **Blood in Urine:** Yes / No **Frequent Urination:** Yes / No **Painful Urination:** Yes / No

MUSCULOSKELETAL: **Artificial Joints:** Yes / No - If Yes, Knee? / Hip? / Shoulder?

Painful Joints: Yes / No **Swollen Joints:** Yes / No

PERIPHERAL VASCULAR: **Leg Swelling:** Yes / No **Restless Leg Syndrome:** Yes / No **Blood Clots:** Yes / No

Cold Extremities: Yes / No **Numbness:** Yes / No - If Yes, Hands? / Feet?

Pain/Cramping in Legs: Yes / No - If Yes, At Rest? or With Walking?

Painful Extremities: Yes / No **Leg Ulcers:** Yes / No

SKIN: **Rash:** Yes / No **Skin Cancer:** Yes / No **Skin Lesions:** Yes / No

NEUROLOGIC: **Stroke:** Yes / No **Mini-Stroke(TIA):** Yes / No **Fainting:** Yes / No

Headache or Migraines: Yes / No - If Yes, Headaches? or Migraines?

Seizures: Yes / No - If Yes, when was the last one? _____ **Numbness/Tingling:** Yes / No

WOMEN ONLY:
BREAST: **Lumps:** Yes / No **Pain:** Yes / No **Nipple Discharge:** Yes / No

OTHER:
Number of Pregnancies: _____ **Number of Live Births:** _____ **History of Birth Control Pills:** Yes / No

History of Hormone Replacement: Yes / No **Age at First Pregnancy:** _____ **Age at Last Pregnancy:** _____

Menopause: Yes / No - If Yes, What Age? _____

FAMILY SURGICAL

PATIENT DEMOGRAPHIC INFORMATION
(PLEASE PRINT)

PATIENT NAME: _____ SEX: M / F
First Middle Last Suffix

STREET ADDRESS: _____

CITY, STATE, ZIP CODE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

ETHNICITY/RACE: (CIRCLE ONE) American Indian/Alaska Native / Asian / Black/African American / Hispanic/Latino

Native Hawiian / Other Pacific Islander / White / Other: _____

HOME PHONE #: _____ WORK PHONE #: _____

CELL PHONE #: _____ ALTERNATE PHONE #: _____

WHICH IS THE BEST "DAYTIME" # TO CALL: (CIRCLE ONE) HOME WORK CELL ALT

E-MAIL ADDRESS: _____

PLACE OF EMPLOYMENT: _____

FAMILY DOCTOR: NAME _____ PRACTICE _____

PHONE # _____ FAX # _____

REFERRING DOCTOR: NAME _____ PRACTICE _____

PHONE # _____ FAX # _____

SPOUSE'S NAME: _____
First Middle Last Suffix

SPOUSE'S DATE OF BIRTH: _____ SPOUSE'S SOCIAL SECURITY #: _____

SPOUSE'S PLACE OF EMPLOYMENT: _____

SPOUSE'S PHONE # WITH AREA CODE: _____ (Circle One) Cell / Home / Work

PREFERRED PHARMACY (Name & Location): _____

Please list an emergency contact (someone other than spouse) not living at your address:

NAME OF EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE NUMBER: _____

NAME OF EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE NUMBER: _____

_____
PATIENT SIGNATURE DATE

FAMILY SURGICAL
MEDICAL INFORMATION RELEASE

Patient Printed Name: _____

I understand that as part of my healthcare, this practice originates and maintains records describing my health information and I understand that this information can and will be used to:

Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

Signature of patient or patient's representative: _____

Date: _____

One-Time Authorization for Patients with Medicare Coverage

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. 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 and 31 U.S. C. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply.

Signature of patient or patient's representative: _____

Date: _____

Notice of Privacy Practice Acknowledgement

I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED WITH FAMILY SURGICAL'S NOTICE OF PRIVACY PRACTICES – Effective Date of Notice: January 1, 2015

Signature of patient or patient's representative: _____

Date: _____

Person(s) to whom my medical information can be released

Name: _____ Relationship: _____

_____ _____

_____ _____

_____ _____

_____ _____

Signature of patient or patient's representative: _____

Date: _____

FAMILY SURGICAL
3620 CAPITAL AVENUE S.W. SUITE B
BATTLE CREEK, MI 49015
PHONE: 269-979-6200 FAX: 269-979-6201

MEDICAL INFORMATION FORMS

At Family Surgical we understand that our patients may receive forms from insurance companies, disability carriers, and employers that must be completed by our medical staff during your course of treatment. These forms request confidential medical information about you, including your diagnosis and treatment, your work status, and your recovery. Before we can complete a medical information form or release medical information about you we must have a signed authorization from you.

If you receive a medical information form from your insurance company, disability carrier, or employer that you would like our medical staff to fill out, bring it to our office and speak with a member of our billing staff. You will be asked to sign a consent form authorizing us to release information about you. You will also be asked to pay a fee for completion of certain forms by our medical staff.

Completion of medical information forms such as FMLA and Disability is not a free service; we require payment in advance. The charge for completion of these forms is $20.00 and must be paid prior to the form being completed.

If we receive a form in the mail or by fax requesting medical information about you or asking for a copy of your medical record, we will call and ask you to come into the office, sign a consent form and pay any applicable fees before we can complete the form or copy your medical records.

It generally takes 5 to 7 working days to review your chart and complete your medical information form. Completed forms are held at the front desk for patient pick-up unless you make other arrangements with us when you drop off your form. If you do not receive a telephone call from our office advising you that your completed form is ready, please call us before coming to the office in case your form is not yet completed.

Thank you for your cooperation

family surgical

www.famsurg.com

John D. Koziarski, MD
American Board of Surgery
Fellow American College of Surgeons
General Surgery
Varicose Vein Surgery

Patient Provider partnership:

Our goal at Family Surgical is to establish a partnership between you the patient, your family, caregivers and patient advocate(s), along with the health care team at Family Surgical. Doing so will allow you to make decisions that are respectful of the physician's knowledge and experience, and will ensure the patient's wants, needs and personal preferences are met. Our team at Family Surgical is dedicated to providing the best possible care to every person that entrusts us with their care. We are only able to do this if you, the patient work with our team to accomplish this goal.

Our Promise to You

- Explain diseases, treatments, and test results in an easy-to-understand way
- Listen to your feelings and questions to help you make decisions about your care
- Coordinate the delivery of your services through effective communication, coordination, and integration with your other providers, recognizing your Primary Care Provider as having the overall responsibility for the coordination and integration of your care
- Protect the integrity and confidentiality of your treatments, discussions, and medical records, only disclosing information in a secure manner
- Provide 24 hour access to answer questions about the care we provide to you whenever possible
- Make meeting your care needs easier by the use of computers and health information technology (electronic medical record, patient portal, etc.)
- To care for you to the best of our abilities based on our understanding of current medical methods available in our specialty
- Give you clear directions about medications and other treatments
- End every visit with clear instructions about expectations, treatment goals and future health care plans

What We Expect of You

- Ask questions, share your feelings, and be a part of your care.
- Be honest about your medical history, symptoms, and other important information about your health
- Tell us about any changes in your health and well-being
- Take all of your medicine and follow our advice to you
- If you are unable to follow the advice we provide to you, let us know
- Make healthy decisions about your daily habits and lifestyle
- Keep scheduled appointments or reschedule appointments in advanced whenever possible
- Call us with any problems or questions you have related to the care we provide to you
- End every visit with a clear understanding of our expectations, treatment goals, and future plans for your health care

Cherry Hollow Suites
3620 Capital Avenue, SW
Suite B
Battle Creek, MI 49015
269.979.6200
800.448.3318
Fax: 269.979.6201

Billing Policy

The providers and staff of Family Surgical would like to welcome you and thank you for choosing us for your specialty needs. We would like to provide you with some introductory information concerning the financial aspects of your encounter in hopes of avoiding any confusion or concerns which may be caused by the somewhat complex process of medical billing as it exists today.

If you are a new patient, when you first contact or are contacted by our office, you will likely be questioned about the type of insurance by which you are covered. This will allow our staff to insure that the proper referral documents can be obtained to avoid nonpayment of your visit(s). Rest assured that in no way does insurance coverage or non-coverage affect the type of care you receive.

If you are an established patient you will be asked to update your personal information and notify our office of any changes in insurance coverage since your last visit.

At the time of your visit, you will be responsible for any co-payment portion dictated by your insurance carrier. If you are covered by more than one type of insurance, (for example, Medicare and Blue Cross) please let the receptionist know so the proper carriers can be billed.

As with your office visits, you may be responsible for a portion of the procedure fees (deductibles and/or co-insurance) depending on insurance type and policy coverage. Our Financial Policy states after insurance pays on your claim(s) you will receive a statement from our office once the balance becomes patient responsibility. Any account over 30 days old is considered past due.

Our primary mission at Family Surgical is to deliver the best care possible to our patients. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible. To assist you with your specialty care, we provide the following payment options once your insurance carrier has processed your claim(s):

1. **Cash-Includes money orders and personal checks**
2. **Visa/MasterCard, Discover and American Express**
3. **Care Credit (for Cosmetic procedures only – Vein Treatments, CoolSculpting & Botox)**

Payment plans are available with very specific criteria in some instances. Please speak with the Billing Manager or Administrator if you are unable to pay with the options listed above. Arrangements must be made in advance.

In closing, we would like to provide you some information about our physician and his chosen field of expertise. In spite of the term general, we assure you that general surgeons are specialists in the truest sense of the word. This specialty training requires nine or perhaps ten years following graduation from college and is considered by many the most difficult of all the specialty training fields. In addition, surgeons continually participate in medical education opportunities in order to provide the most up-to-date care possible. In view of this, we at Family Surgical have arrived at a fee schedule which we feel is fair and appropriate for the care provided and the level of responsibility assumed to provide that care.

Thank you once again for choosing us for your specialty medical care. We will assist you in whatever way possible and we ask that you assist us by understanding your insurance policy and the coverage it provides. Although we make every effort to be accurate and concise in our billing process, oversights do at times occur. Please do not hesitate to contact our billing department to answer your questions. Our goal is a lifelong commitment to you and your family for your specialty surgical needs.

Providers and Staff of Family Surgical

Billing Policy Confirmation

I have received and read the Billing Policy provided to me by Family Surgical.

I understand I am responsible for any co-payment, co-insurance, and/or deductible amount dictated by my insurance carrier. I understand the payment options available to me.

Patient Signature_____Date_____

_____Date_____
Signature of Responsible Party (if patient is a minor)