Breckenridge Surgery Center

Denton Watumull, MD
Derek Rapp, MD
Timothy Abigail, DPM
Bruce Byrne, MD
Chirag Mehta, MD
Joshua Lemmon, MD
Chase Derrick, MD

Date: __________________________

PATIENT INFORMATION

Last Name: ____________________ First Name: _______________________ Middle Initial: _____

Marital Status: Married ____ Single ____ Divorced _____ Separated _____ Widow _____
Sex: Female _____ Male _____ Date of Birth ____/_____/_____ Age: ______
Social Security Number: _____________________ Driver's License Number: _________________
Home Address: ____
City: _______________________ State: __________ Zip Code: _______________________
Home Phone: (______) ______-__________ Mobile Number: (______) ______- __________

GUARANTOR (Primary Insured)

Last Name: ____________________ First Name: _______________________ Middle Initial: _____

Guarantor's address (if different from patient): ____
City: _______________________ State: __________ Zip Code: _______________________
Relation to Patient: ____________________________ Sex: Female _______ Male _______
Home Phone: (______) ______-__________ Driver's License Number: _________________
Employer: ____________________________ Work Phone: (______) ______-___________
Address: ____
City: _______________________ State: __________ Zip Code: _______________________
Employment Status: Full-time _____ Part-time _____ Not Employed/Retired ___________
Occupation: _____________________________________

EMERGENCY CONTACT

Name: ________________________________ Relationship to patient: _______________________
Address: ____
City: _______________________ State: __________ Zip Code: _______________________
Home Phone: (______) ______-__________ Mobile Number: (______) ______- __________

Breckenridge Surgery Center

CONTACT CONSENT

I, ____, the undersigned patient, authorize Breckenridge Surgery Center to contact me at the following numbers:

A.) Via Phone
   a. At home Yes_______ No_______ Number: (______) ______-__________
   b. At work Yes_______ No_______ Number: (______) ______-__________
   c. Mobile Yes_______ No_______ Number: (______) ______-__________

B.) Can we leave a message at
   a. At home Yes_______ No_______ Number: (______) ______-__________
   b. At work Yes_______ No_______ Number: (______) ______-__________
   c. Mobile Yes_______ No_______ Number: (______) ______-__________

C.) Person/s we may leave a message with:
   Name: ______________________________ Relationship: ______________________
   Name: ______________________________ Relationship: ______________________

INSURANCE AUTHORIZATIOUN AND ASSIGNMENT (when insurance is applicable):

I hereby authorize Breckenridge Surgery Center to furnish information to insurance carriers concerning my illnesses, accidents and treatments, and also assign to them all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I also understand that any additional co-pay, coinsurance and/or deductibles are due at time of service.

In case of overpayment, I will be refunded after my insurance pays the surgery bill. In addition, any balance not paid in full within 90 days will be subject to an 18% interest fee.

Signature ______________________________________ Date_________________________
(Patient or Responsible Party Signature)

Breckenridge Surgery Center

COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation to the following address:

Department of State Health Services
Attn: Manager, Health Facility Compliance Group
Post Office Box 149347
Austin, Texas 78714-9347
1-888-973-0022

Breckenridge Surgery Center

PATIENT MEDICAL HISTORY

Are you allergic to any medications or food? ____

What medicines do you take every day? ____

Do you take aspirin on a regular basis? ____

Do you have any major medical problems? ____

Do you have any metal implants or jewelry on? ____

Have you or your family ever had trouble with anesthesia? _______________________________

When was your last menstrual period? ____

MEDICAL CONDITIONS

Do you now or have you ever suffered from the following conditions?

Condition			Condition		
AIDS/HIV	____ Yes	____ No	High Blood Pressure	____ Yes	____No
Anemia	____ Yes	____ No	High Cholesterol	____ Yes	____No
Asthma	____ Yes	____ No	Kidney Disease	____ Yes	____No
Bad Scarring/Keloids	____ Yes	____ No	Lung Problems	____ Yes	____No
Bleeding Tendencies	____ Yes	____ No	Melanoma	____ Yes	____No
Cancer	____ Yes	____ No	Mitral Valve Prolapse	____ Yes	____No
Depression	____ Yes	____ No	Seizures	____ Yes	____No
Diabetes	____ Yes	____ No	Stomach Ulcer	____ Yes	____No
Gout	____ Yes	____ No	Stroke	____ Yes	____No
Heart Disease	____ Yes	____ No	Thyroid Disease	____ Yes	____No
Heartburn/Reflux	____ Yes	____ No	Tuberculosis	____ Yes	____No
Hepatitis	____ Yes	____ No	Other ____________________________		

Breckenridge Surgery Center

PRIOR OPERATIONS

Appendectomy	____ Yes ____ No	Heart	____ Yes ____No
Back Surgery	____ Yes ____ No	Hernia Repair	____ Yes ____No
Colonoscopy	____ Yes ____ No	Hysterectomy	____ Yes ____No
Foot/Ankle	____ Yes ____ No	Kidney/Bladder	____ Yes ____No
Gallbladder	____ Yes ____ No	Knee	____ Yes ____No
Gastrointestinal	____ Yes ____ No	Tonsillectomy	____ Yes ____No
Hand/Arm	____ Yes ____ No	Other ____________________________	

Height: __________________________ Weight: ___________________________

Do you smoke? ____ Yes ____ No

How Much? _______________________ How long? ________________________

If you quit smoking, when did you quit? ____

Do you drink alcohol? ____ Yes ____ No

How often do you drink alcohol? ____ Rarely, ____Occasionally, ____Socially, ____Often

Do you wear contacts? ____Yes ____No

Do you wear glasses? ____Yes ____No

Do you have any loose teeth, dentures, crowns, partials? ____ Yes ____No

Please explain: ____

Breckenridge Surgery Center

COMPLIANCE ASSURANCE NOTIFICATION

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patient's inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal healthcare information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain healthcare providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment and healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your healthcare information and information about treatment, payment or healthcare operations in order to provide healthcare that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment or healthcare operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, you may request to refuse all or part of your PHI in the future. You may not revoke actions that have already been taken which relied on this or a previously signed consent.
In an effort to provide appropriate care for you, if you have refused to sign this consent, it may be necessary for us to refuse treatment.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.
You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Your personal health information will be shared in the operating suite. If you do not wish for the personal accompanying you to hear your information, please have them remain in the waiting room. Otherwise, your signature gives consent for anyone in the operating suite with you to be allowed to hear your personal information. This consent may be revoked at anytine in writing.

I understand that I am entitled to receive a copy of this document.

_______________________________   ______________________________   ___________

Patient/Guardian   Print Name   Date
(or personal representative)

Breckenridge Surgery Center

STATE REQUIRED ETTHNICITY AND RACE QUESTIONS

Background Information:

Texas law requires the Texas Health Care Information Council to collect race and ethical background information of outpatient surgery and hospital patients.

The data obtained through this process is used to assist researchers in determining whether or not all Texas citizens are receiving access to adequate healthcare.

If patients fail or refuse to identify this information, facility staff will use its best judgement in making this identification.

NATIONALITY OR ETHICAL BACKGROUND
(Check the box that most accurately identifies the patient's race or ethical background)

_____ Hispanic/Latino
_____ Non-Hispanic/Latino
_____ American Indian/Eskimo/Aleut
_____ Asian or Pacific Islander
_____ Black
_____ Caucasian
_____ Other

_____ I (patient/patient's legal guardian) refuse to answer this question.

_________________________________ _______________________
Patient/Legal Guardian Date