

PATIENT INFORMATION

Welcome To Our Office		PLEASE PRINT				Date _____					
Patient's Name		FIRST	MI	LAST	S.S #	MARITAL STATUS			SEX	BIRTH DATE	AGE
STREET ADDRESS		PERMANENT	TEMPORARY	CITY AND STATE		ZIP CODE			HOME PHONE #		
PATIENT'S EMPLOYER					BUS. PHONE # EXT #				HOW LONG EMP.		
EMPLOYERS STREET ADDRESS					CITY AND STATE				ZIP CODE		
EMERGENCY CONTACT NAME						EMERGENCY PHONE					
SPOUSE/LP'S NAME					SS #			BIRTH DATE			
SPOUSE/ LP'S EMPLOYER					BUSINESS PHONE #				HOW LONG EMP.		
EMPLOYER'S STREET ADDRESS					CITY AND STATE				ZIP CODE		
*SPOUSE/LP'S STREET ADDRESS, IF DIVORCED OR SEPARATED					CITY AND STATE			ZIP CODE		HOME PHONE #	

INSURANCE AND BILLING INFORMATION

PERSON RESPONSIBLE FOR PAYMENT, IF NOT PATIENT			STREET ADDRESS			ZIP CODE		HOME PHONE #	
INSURED D.O.B. ◇			CITY		STATE	GROUP #		COVERAGE CODE	
PRIMARY INSURANCE ◇			ID #		EFFECTIVE DATE			GROUP #	
SECONDARY INSURANCE ◇			ID #		EFFECTIVE DATE			GROUP#	
WERE YOU INJURED ON THE JOB? ◇ YES ◇ NO			DATE OF INJURY		WORKER'S COMP. CLAIM #				
ACCIDENT ◇	WAS AN AUTOMOBILE INVOLVED? ◇ YES ◇ NO		DATE OF ACCIDENT		NAME OF ATTORNEY			AUTO INSURANCE	
REFERRED BY					STREET ADDRESS, CITY, STATE			ZIP CODE	PHONE #
PRIMARY CARE PHYSICIAN					STREET ADDRESS, CITY, STATE			ZIP CODE	PHONE #

PLEASE READ THE FOLLOWING CAREFULLY

All major insurance companies including Blue Cross, Medicare, Welfare, and Workman's Compensation accounts are billed routinely by this office on a weekly basis. If the problem for which you are seeing one of our doctors involves litigation, such as may result from an automobile accident, be advised that **we do not wait for payment** until litigation is settled, but we will accept **regular** monthly payment of either \$20.00 minimum or 20% of the balance, whichever is greater. If you have no insurance we will set up the account on a "Budget" basis. This means we expect **regular** monthly payments of either \$20.00 minimum or 20% of the balance, whichever is greater.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policy Holder _____

I hereby authorize Surgical Associates, P. C. to submit a claim to my insurance carrier or to its intermediaries for all services rendered by Surgical Associates, P.C. and DIRECT MY INSURANCE CARRIER OR ITS INTERMEDIARIES TO ISSUE PAYMENT CHECK(S) DIRECTLY to Surgical Associates, P.C.

I hereby authorize Surgical Associates, P.C. to use and disclose all information necessary for the purposes to Treatment, Payment and Healthcare operations. I understand that I am responsible for all charges not covered by said insurance. This will prevent further misunderstanding. Please note that accounts 90 days old are considered delinquent. Accounts 120 days old are considered collection problems and will be handled as such. Please feel free to discuss your account at any time.

Signed _____

A copy of this signature is as valid as the original

FOR MEDICARE PATIENTS	
AUTHORIZATION PERIOD	
FROM: Month _____	Day _____ Year _____
TO: LIFETIME	
I request that payment under the medical insurance program be made to Surgical Associates, P. C. on any bills for services furnished me during the effective period of this authorization and I authorize Surgical Associates, P.C. to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original.	
DATE _____	PATIENT'S SIGNATURE _____
IF YOU HAVE GROUP INSURANCE AND MEDICARE	
Filing with your employer group coverage first is the fast and correct way to get your bills paid. It's also the law. So if you are covered by employer group insurance (other than Medigap or Medicare supplemental) – be sure and let us know so that we may file with your other insurance <i>before</i> Medicare.	

MEDICAL INFORMATION FORM

PATIENT NAME _____

DATE _____

AGE _____ MALE FEMALE

REFERRED BY _____

PRIMARY CARE DOCTOR _____

HAS THE PATIENT PREVIOUSLY BEEN SEEN BY A DOCTOR AT SURGICAL ASSOCIATES?

YES__ NO__ WHO _____ M.D.

CHIEF COMPLAINT

- _____
- _____
- _____

PAST MEDICAL AND SURGICAL HISTORY

OPERATIONS

HOSPITAL & CITY

DATE

- _____
- _____
- _____
- _____

HOSPITALIZATIONS

REASON

HOSPITAL & CITY

DATE

- _____
- _____
- _____

MEDICAL CONDITIONS

Please check all that apply. Give Date and Details when possible

- | | |
|---|--|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Lung Disease/Asthma |
| <input type="checkbox"/> Irregular heart rate | <input type="checkbox"/> Prior Pneumonia |
| <input type="checkbox"/> Chest Pain (Angina) | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Intestinal Bleeding |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis/Jaundice |

Other Illnesses _____

FOR MEDICATIONS & ALLERGIES (Please see other form)

- | |
|--|
| <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Prolonged Bleeding |
| <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Seizures |
| <input type="checkbox"/> "Nervous Breakdown" |

PERSONAL HISTORY

Place of Birth _____

Marital Status Single Married Divorced

Children N Y Ages _____

Tobacco Never None Now Yes Now

How Long _____ How Many per Day _____

Alcoholic Beverages Never Seldom Frequently
Amount _____

Drug Abuse Never In the past Now

Types of drugs _____

FAMILY HISTORY

Please check if any blood relatives have had any of these

- | | |
|---|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancers |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Psychiatric Diseases | <input type="checkbox"/> Obscure Diseases |

BREAST PATIENTS

Please answer all questions. Use a question mark if you do not know the answer.

How old were you when you began to menstruate? _____

How many Pregnancies have you had? _____

How many Children have you had? _____

How many have you had? Abortions _____ Miscarriages _____

What was your age at the birth of your first child? _____

Did you breast Feed? N Y How long? _____

Did you or your doctor find the lump? You Doctor MMG

Do you have a history of prior breast cancer? N Y

Which Side? Right Left

How old were you when it was first diagnosed? _____

Was it treated with Lumpectomy Mastectomy

Were your lymph nodes checked? N Y

Was your breast treated with radiation? N Y

Were you treated with Chemo Tamoxifen

Has anyone in your family had breast cancer N Y

Who _____

Which Breast is your lump in? Right Left

Does the lump hurt? N Y

Is Pain related to your cycle? N Y

Has the lump increased in size? N Y

Do you have nipple discharge? N Y

Have you had a lump in the past? N Y

Have you had a breast cyst drained? N Y

Have you had prior breast surgery? N Y

Have you had prior plastic surgery of the breast? N Y

Have you ever taken hormones? N Y

If "yes" Birth Control Pills Hormone Replacement Fertility



V. Tammy De La Melena, M.D.
Daniel Tseng, M.D.
C. Edwin Irish, M.D.
Ali Khaki, M.D.
Amanda J. Wheeler, M.D.

MESSAGE CONSENT FORM

Please read the following carefully and initial what types of contact you agree to:

• It is okay to leave a detailed message at my home _____

• It is okay to leave a detailed message with the following people: _____

List name(s): _____

• It is okay to call me at work with results _____

• It is okay to email me with medical and appointment information _____

Email address: _____

My preferred method of contact is:

Home phone _____

Cell _____

Email _____

Signature _____

Date _____

Providence St Vincent 9155 SW Barnes Rd. #830 Portland, OR 97124 503.292.1103/503.292.1433(f)	Meridian Park 6485 SW Borland Rd. #C Tualatin, OR 97062 503.218.2011/503.218.2012(f)	Pearl Women's Center 140 NW 14 th Ave Portland, OR 97209 503.218.2011/503.218.2012(f)	Pearl Surgi-Center 120 NW 14 th Ave. #200 Portland, OR 97209 503.292.1103/503.292.1433(f)	Tanasbourne Surgi-Center 18650 NW Cornell Rd #212 Hillsboro, OR 97124 503.292.1103/503.292.1433(f)
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ACKNOWLEDGEMENT and CONSENT

I authorize Surgical Associates, P.C. to use and disclose health information about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses treatments, procedures, prescriptions and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment
- Refer to, consult with, coordinate among and manage along with other health care providers for my care and treatment
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care
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I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____ Date: _____
(Patient)

-OR-

By: _____ Date: _____
Patient Representative
Description of Representative's Authority

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PATIENT'S RESPONSIBILITY FOR PAYMENT

As a service to our patients, Surgical Associates, P. C. will submit charges for medical treatment to the patient's insurance company where applicable, to Medicare. However, the patient is primarily responsible for paying any and all medical expenses incurred at the clinic.

Surgical Associates, P. C. may attempt to verify in advance that the patient's insurance company will pay for specific medical procedures. Occasionally, even though coverage was verified before the medical services were provided, the insurance company denies the claim. If the insurance company denies payment or will only pay a portion of the medical bill, the patient is responsible for payment of the account balance. Likewise, if the patient has not met his or her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible in addition to whatever amounts the insurance company does not pay.

If the patient participates in an HMO or PPO that requires co-payment, the patient **MUST** pay the co-payment at the time of the appointment.

If the patient has a worker's compensation claim, Surgical Associates, P. C. will submit the claim information to the employer's insurance carrier providing the patient provides Surgical Associates with the name of the insurance carrier, the date of injury and if available, the claim number and a copy of the 801 form. Patients must keep track of their own mileage and prescription costs for reimbursement by the insurance provider.

If the patient is involved in a motor vehicle or liability accident, the patient is responsible for paying all medical costs even if there is a pending lawsuit.

CONTRACTUAL AGREEMENT TO PAY MEDICAL EXPENSES

I understand that I am personally responsible for all medical expenses incurred at Surgical Associates, P.C. for medical care and treatment. I agree to pay all medical expenses within 30 days of the date that I am billed for those expenses, unless other arrangements have been made with Surgical Associates, P.C.

If I do have insurance, I authorize release of my medical information to my insurance company that I authorize payment of all medical benefits by my insurance company to Surgical Associates, P.C.

Patient's Signature
(parent or guardian if patient is a minor)

Date of Signature

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