THE SURGICAL GROUP OF ORLANDO
1814 LUCERNE TERRACE
ORLANDO, FL 32806

PATIENT:

Name: _____
Address: _____
_____
City: _____ St: _____ Zip: _____
Home Phone: _____
Business Phone: _____
Cell Phone: _____
Date of Birth: _____ Age: _____
SS# _____ Sex: _____

Occupation: _____
Employed: Yes _____ No _____ Retired _____
Employer Name: _____
Email: _____

Pharmacy Name: _____
Address: _____
_____
Pharmacy Phone: _____

Race: Caucasian_____ Black_____ Hispanic_____ Asian_____ Other _____

Marital Status: Married _____ Single _____ Widowed _____ Divorced _____ Separated _____
Name of Spouse: _____ Employer: _____ Bus Phone: _____

Person to Contact In Case Of Emergency: _____ Relationship: _____
Address: _____ Home Phone: _____ Bus. Phone: _____

Referring Physician Name: _____ Phone: _____
Primary Care Physician: _____ Phone: _____

PRIMARY INSURANCE:

Insurance Co. Name: _____
Policy # _____
Group # _____
Employer: _____
Subscriber Name: _____
Subscriber SS# _____
Subscriber Date of Birth: _____
Patient Relationship to Subscriber: _____
Claims Address: _____
_____
_____

SECONDARY INSURANCE:

Insurance Co. Name: _____
Policy # _____
Group # _____
Employer: _____
Subscriber Name: _____
Subscriber SS# _____
Subscriber Date of Birth: _____
Patient Relationship to Subscriber: _____
Claims Address: _____
_____
_____

I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE SURGICAL GROUP OF ORLANDO FOR SERVICES RENDERED AND THE RELEASE OF NECESSARY MEDICAL RECORDS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I UNDERSTAND THAT THIS IS A LIFETIME SIGNATURE.

PATIENT SIGNATURE: _____ Do you have an advance directive? YES or NO

DATE: _____ Would you like information on advance directives? YES or NO

The Surgical Group of Orlando
1814 Lucerne Terrace
Orlando, Fla. 32806
Phone (407) 730-3627

SGO SURGICAL GROUP OF ORLANDO

- ○ Dr. Chambers
- ○ Dr. Padron
- ○ Dr. Freeland
- ○ Tina Bruefach, PA

PATIENT SURGICAL AND MEDICAL HISTORY FORM

PATIENT INFORMATION Today's Date ____/____/____

Patient Name: _____ Date of Birth ____/____/____ ☐ Male ☐ Female
Primary/referring physician: _____ Office Phone: (____) ____ - ____
Cardiologist: _____ Office Phone: (____) ____ - ____
Reason for today's visit: _____
_____
What tests have been done for this? Where were they performed? _____
_____

PAST SURGICAL HISTORY (PLEASE CHECK ANY / ALL THAT APPLY)

ABDOMEN

- ☐ hernia (groin L / R / both, umbilical / incisional)
- ☐ intestinal resection (stomach / small intestine / colon)
- ☐ cholecystectomy (gallbladder)
- ☐ appendectomy
- ☐ abdominoplasty (tummy tuck)
- ☐ other:

_____

GENITOURINARY

- ☐ bladder
- ☐ kidney stone removal
- ☐ prostatectomy
- ☐ other:

_____

HEART

- ☐ pacemaker
- ☐ defibrillator
- ☐ bypass
- ☐ valve repair / replacement

LUNG

- ☐ type _____

HEAD AND NECK

- ☐ thyroidectomy
- ☐ parathyroidectomy
- ☐ tonsillectomy
- ☐ other:

_____

SPINE

- ☐ fusion
- ☐ discectomy
- ☐ laminectomy

SKIN

- ☐ biopsy(ies)
- ☐ abscess drainage
- ☐ pilonidal cyst

OB / GYN

- ☐ C-section: ___time(s)
- ☐ hysterectomy (partial / total)
- ☐ tubal ligation
- ☐ ovarian

BREAST

- ☐ biopsy
- ☐ lumpectomy
- ☐ mastectomy
- ☐ reduction
- ☐ implants
- ☐ other:

_____

FAMILY HISTORY (CHECK ANY / ALL THAT APPLY)

- ☐ heart disease
- ☐ high blood pressure
- ☐ heart attack
- ☐ thyroid cancer
- ☐ lung cancer
- ☐ colon cancer
- ☐ breast cancer
- ☐ ovarian cancer
- ☐ uterine cancer
- ☐ diabetes
- ☐ irritable bowel diseases (Crohn's / ulcerative colitis)
- ☐ other: _____
- ☐ **none of the above**

SOCIAL HISTORY

TOBACCO ☐ nonsmoker ☐ ex-smoker
☐ smoker: _____ pack(s) per day
ALCOHOL: DRINKS
per week: ____ or per day ____
DRUGS / SUBSTANCE USE
_____

MEDICATION(S)

☐ aspirin ☐ Plavix ☐ Coumadin / warfarin ☐ other: list name(s) & dosage(s)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

FEMALES ONLY

Age you began menstruating: _____ Date of last period ____/____/____
Have you ever been pregnant? ☐ yes ☐ no If yes, how many times? _____
Are you taking hormone replacement? ☐ yes ☐ no

ALLERGIES / REACTIONS ☐ **Yes** (please list) ☐ **NONE**

_____
_____
_____
_____

PATIENT NAME: _____ **DATE OF BIRTH:** _____/_____/_____

MEDICAL HISTORY (SYMPTOMS AND CONDITIONS)

CHECK THE APPROPRIATE BOX(ES) BELOW IF YOU HAVE (OR HAVE HAD IN THE PAST) ***ANY*** OF THE FOLLOWING:

ABDOMINAL
- ☐ hernia: (where? _____)
- ☐ distention
- ☐ nausea
- ☐ vomiting
- ☐ diarrhea
- ☐ constipation
- ☐ pain
  Location:
  - ☐ right upper
  - ☐ right lower
  - ☐ left upper
  - ☐ left lower
  - ☐ umbilical
  - ☐ generalized

  SEVERITY (CIRCLE):
  1 2 3 4 5 6 7 8 9 10
  SLIGHT ◄► SEVERE
- ☐ other: _____
- ☐ **none of the above**

SKIN
- ☐ basal cell cancer
- ☐ squamous cell cancer
- ☐ melanoma
- ☐ rash
- ☐ itching
- ☐ jaundice
- ☐ other: _____
- ☐ **none of the above**

GU / RENAL
- ☐ kidney disease
- ☐ renal failure / dialysis
- ☐ UTI
- ☐ dark urine
- ☐ kidney stones
- ☐ prostate enlargement
- ☐ prostate cancer
- ☐ other: _____
- ☐ **none of the above**

GI / ENDOCRINE
- ☐ thyroid disease (hyper / hypo)
- ☐ hyperparathyroidism
- ☐ diabetes 1 or 2
- ☐ obesity
- ☐ cirrhosis / alcoholism
- ☐ recent steroid use
- ☐ hiatal hernia
- ☐ acid reflux (GERD)
- ☐ indigestion
- ☐ bowel obstruction
- ☐ hemorrhoids
- ☐ diverticulosis / diverticulitis
- ☐ bloody stools
- ☐ dark stools
- ☐ clay-colored stools
- ☐ other: _____
- ☐ **none of the above**

PULMONARY
- ☐ asthma
- ☐ COPD / emphysema
- ☐ history of smoking
- ☐ shortness of breath
- ☐ sleep apnea / CPAP
- ☐ cough
- ☐ wheezing
- ☐ upper respiratory infection
- ☐ other: _____
- ☐ **none of the above**

ANESTHESIA / AIRWAY
- ☐ family history of anesthesia problems
- ☐ recent respiratory infection
- ☐ previous anesthesia complications
- ☐ other: _____
- ☐ **none of the above**

BREAST
- ☐ pain
- ☐ lumps / bumps
- ☐ skin changes / thickening
- ☐ nipple retraction
- ☐ nipple discharge (color: _____)
- ☐ prior abnormal mammogram / ultrasound
- ☐ cancer
- ☐ other: _____
- ☐ **none of the above**

OB / GYN
- ☐ fibroids
- ☐ ovarian cyst
- ☐ other: _____
- ☐ **none of the above**

NEUROMUSCULAR
- ☐ TIA or stroke
- ☐ seizures / epilepsy
- ☐ dementia
- ☐ osteoarthritis
- ☐ rheumatoid arthritis
- ☐ neuromuscular disease
- ☐ syncope /ftainting
- ☐ weakness
- ☐ numbness
- ☐ psychiatric disorder
- ☐ other: _____
- ☐ **none of the above**

HEMATOLOGIC
- ☐ anemia
- ☐ sickle cell disease
- ☐ bleeding disorder
- ☐ DVT / blood clots
- ☐ pulmonary embolism
- ☐ other: _____
- ☐ **none of the above**

CARDIOVASCULAR
- ☐ hypertension
- ☐ angina / chest pain
- ☐ heart attack
- ☐ congestive heart failure
- ☐ arrhythmia / palpitations
- ☐ pacemaker / defibrillator
- ☐ valvular disease
- ☐ bypass surgery stent(s)
- ☐ poor exercise tolerance
- ☐ peripheral vascular disease
- ☐ other: _____
- ☐ **none of the above**

ONCOLOGY / CANCER
- ☐ cancer (type: _____)
  - ☐ chemotherapy?
  - ☐ radiation?
- ☐ **none of the above**

INFECTIONS
- ☐ HIV / AIDS
- ☐ abscesses / boils
- ☐ fevers
- ☐ wound infections / MRSA
- ☐ other: _____
- ☐ **none of the above**

GENERAL
- ☐ fatigue
- ☐ fevers
- ☐ unintentional weight loss
- ☐ chills
- ☐ night sweats
- ☐ other: _____
- ☐ **none of the above**

ADDITIONAL INFORMATION (DETAILS REGARDING ANY BOXES CHECKED ABOVE OR ADDITIONAL SYMPTONS NOT LISTED ABOVE)

_____

_____

_____

THE SURGICAL GROUP OF ORLANDO
1814 Lucerne Terrace
Orlando, FL 32806
Phone – (407) 730-3627
Fax – (407) 423-3817

FINANCIAL POLICY

Providing quality medical care for our patients is our primary concern. As a courtesy to all of our patients, we will bill all insurance for which information is provided whether we are a provider or not.

While we are pleased to be able to provide medical services to you, it is extremely difficult for us to keep track of all the individual requirements of the various insurance plans. Within the same insurance company, the plans differ, depending upon what type of contract your employer has negotiated. Each one has different policies regarding how often services may be rendered, and even more importantly, where those services may be performed.

We are enrolled in numerous insurance programs however; it is your responsibility as the patient, and as the insured, to obtain all authorizations and/or referrals from your primary care physician for all office visits, outpatient tests or referrals to other physicians. It is STRONGLY recommended that you contact your primary care physician personally to be sure that the proper authorizations have been processed PRIOR to all appointments or tests. In the event that you are scheduled for surgery, our office will contact your insurance company for you for authorization. Authorization is not a guarantee of payment from your insurance company.

If you do not have insurance or if we are not a provider for your insurance you will be responsible for services as they are rendered or the difference between what your insurance covers and the doctor's total charges.

You will be responsible for all co-pays and unmet deductibles at the time of your office visit. Elective surgery will require a deposit.

Our office utilizes a third-party collection agency for unpaid patient obligations. In the event that your account is transferred to this third-party agency all reasonable collection costs and/or attorney fees will become your responsibility.

This information is provided for your convenience, so that you will be aware of your financial responsibility for the medical care, which you have or are about to receive. With your cooperation and help, you should be able to receive all of the benefits offered to you, and we will be able to concentrate on caring for your medical needs.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED. I ALSO HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE SURGICAL GROUP OF ORLANDO. I AUTHORIZE THE SURGICAL GROUP OF ORLANDO TO RELEASE ANY INFORMATION REQUIRED TO PROCESS THIS CLAIM TO MY INSURANCE COMPANY.

_____ _____

Signature Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on October 1, 2021 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Pam Hummell. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $ 1.00 for each page and the staff time charged will be $ 20 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on September 1, 2015.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: Our practice does not participate in fundraising. If we did, your written authorization would be required for us to use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $_1.00_ for each page and the staff time charged will be $_20_ per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. **HOW TO CONTACT US:**

Practice Name: The Surgical Group of Orlando Privacy Officer: Pam Hummell

Telephone: (407) 730-3627 Fax: (407) 423-3817

Email: info@surgicalgrouporlando.com

Address: 1814 Lucerne Terrace, Orlando, FL 32806

Acknowledgement: I may request a copy of The Surgical Group of Orlando Notice of Privacy Practices.

Date _____ Signed _____ Print Name _____

If signing as a parent or guardian, please note the name of the patient _____