SURGICAL ASSOCIATES
of Western New York, P.C.

surgicalassociateswny.com Phone: (716) 677-5500 Fax: (716) 677-5008

General Surgery | Advanced Laparoscopic/Minimally Invasive Surgery | Abdominal Wall Reconstruction
In-Office IRC Hemorrhoid Treatment | State-of-the-Art Robotic Surgery

**APPOINTMENT DATE:** _____ **TIME:** _____

## Please arrive 15 minutes early for your appointment

## Please bring your COVID vaccine card - it is needed for surgery

**Welcome to Surgical Associates of Western New York - We look forward to serving you!**
Please visit **surgicalassociateswny.com** to learn more about our practice, our surgeons, and the services we offer.

**Being prepared for your first office visit is very important. Please bring all of the following items with you to your first appointment (DO NOT mail in):**

1. **General Health Information Form & Patient Acknowledgement Form** - Please fill out the attached forms before your appointment. Also, make a list of your current medications & dosages. Bring all of this information to your appointment.

2. **Insurance Cards & Government-Issued Photo I.D** – We do most surgeries at Catholic Health System Hospitals (CHS) and it is important that you make sure those hospitals, and your surgeon, are participating in your insurance network. If you are unsure, call your health plan. If we or CHS does not participate with your insurance, you will be responsible for significantly higher out-of-pocket expenses. Also, please know that we must verify insurance and identity of all patients.

3. **Any co-payment, co-insurance, or deductible** required by your health plan. If you have a deductible, outstanding balance or if we are unable to verify your insurance/referral/deductible, we require a deposit of $120 per office visit. If you have a high-deductible health plan or are responsible for paying co-insurance, we require an additional Service Deposit, determined on a case-by-case basis, to be paid prior to scheduling any surgical procedure. All Time-of-Service payments and any required deposits are due at check-in. If you are not prepared, your appointment will need to be rescheduled.

4. **A referral from Your Primary Care Doctor (*if required by your health plan*).**
Your health plan may require you to get a referral from your Primary Care Physician (PCP) before your first visit to our office. If you are unsure, call your health plan. Please understand it is YOUR responsibility to get required referrals before you come to our office.

5. **Radiology films or discs related to the problem you are seeing us for-** bring them with

## Thank you for choosing Surgical Associates of Western N.Y.

**Timothy R. Rasmusson**, MD, FACS | **Richard D. Bloomberg**, MD, FACS, FRCSC | **Kenneth H. Eckhert III**, MD, FACS
**Rurik C. Johnson**, MD, FACS | **Robert S. Armstrong**, MD, FACS | **Karee Chella**, ANP-BC, RNFA | **Briana Kelley**, RPA-C

West Seneca Office
Western New York Medical Park
550 Orchard Park Road, A103
West Seneca, New York 14224

Kenmore Office
2780 Delaware Avenue, Suite 201
Kenmore, New York 14217

Derby Office
Derby Professional Park
7060 Erie Road, Suite 400
Derby, New York 14047

# GENERAL HEALTH INFORMATION FORM

**NAME:** _____ **DATE:** _____

Chief complaint/Reason for coming to the office: _____

Height: _____ Weight: _____ Age: _____ Date of Birth _____

**DRUG/FOOD ALLERGIES:** _____

## MEDICATIONS:

Name: _____ Dose: _____ Name: _____ Dose: _____
Name: _____ Dose: _____ Name: _____ Dose: _____
Name: _____ Dose: _____ Name: _____ Dose: _____

***Are you currently taking Methadone, Suboxone or being treated by a pain management provider?**
☐ Yes ☐ No

## FAMILY HISTORY: ☐ NONE KNOWN **Indicate which family member has the following:**

☐ Heart Disease _____
☐ Stroke _____
☐ COPD _____
☐ Cancer _____
☐ Colon polyps _____
☐ Other: _____

## SOCIAL HISTORY:

Ever used tobacco ☐ Yes ☐ No
If yes, _____ packs per day x ___years
Quit Date _____
Deaf or serious difficulty hearing: ☐ Yes ☐ No
Blind or serious difficulty seeing: ☐ Yes ☐ No

**Alcohol intake:** ☐ Yes ☐ No
Amount consumed: _____
**Caffeine intake:** ☐ Yes ☐ No
Amount consumed: _____
**Illicit drugs:** ☐ Yes ☐ No
If Yes, Current Use _____
Former Use _____

**Advance Directive** ☐ Yes ☐ No
**Medical Power of Attorney** ☐ Yes ☐ No

**Marital Status** Married Single Divorced Separated Widow

## PAST SURGICAL HISTORY: ☐ NONE Date of Last Colonoscopy: _____

Type: _____
Type: _____
Type: _____
Type: _____

## CHRONIC HEALTH PROBLEMS ☐ NONE KNOWN

☐ Diabetes
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Other: _____

☐ Stomach Ulcers
☐ GERD
☐ Arthritis
☐ Stroke

☐ Cancer _____
☐ Thyroid Disease
☐ Depression/Anxiety
☐ Colon Polyps

☐ Crohn's
☐ Diverticulitis

SURGICAL ASSOCIATES OF WESTERN NY, P.C.

# Patient Acknowledgement & Authorization Form

**Patient Name:** _____

**This Form serves to document patient understanding and approval related to the following seven (7) issues:**

**1. Receipt Acknowledgement for Notice of Privacy Practices**
I was provided a copy of the Notice of Privacy Practices (hereinafter "NPP") for Surgical Associates of Western NY, PC (hereinafter "Surgical Associates"). I understand the NPP document provides a description of possible uses and disclosures of my health information. If at any time now or in the future I disagree with any portion of the NPP, or wish to restrict or revoke the use or disclosure of my Protected Health Information, I will provide notice of such disagreements, restrictions, or revocations according to the processes outlined in the NPP. Barring such notice, my full consent according to the documents shall be assumed.

**2. Authorization to Release Information**
I authorize Surgical Associates to release any clinical, demographic, billing, and/or claim-related information as required by law or for purposes of claims administration, provision of healthcare services, business operations, and/or compliance with carrier rules to the following applicable parties: Any and all health care providers who Surgical Associates reasonably believes is participating in my healthcare; Third party health insurance carriers or benefit administrators; U.S. Social Security Administration, or its Carriers; U.S. Centers for Medicare & Medicaid Services, or its Carriers; Workers Compensation Board, Compensation Insurance Carrier(s), my Employer; any No-Fault or Disability Insurance Carrier(s).

**3. Assignment of Benefits**
I authorize payment of medical and surgical benefits by third party carriers to be made directly to Surgical Associates. ***[If covered under Medicare medical insurance program(s):*** I certify that the information given by me in applying for benefits under Title XVIII of the Social Security Act is correct and request payment for authorized benefits be made on my behalf by Medicare and/or its authorized Carriers directly to Surgical Associates.

**4. Financial Responsibility for Rejected Claims, Non-Covered Services, Account Balances, and Pre-Service Deposits**
I was provided a copy of Surgical Associates Patient Account & Pre-Service Deposit Policy, and I agree to the terms therein. If a third-party payor denies/rejects claims for services rendered, said services are determined to be non-covered benefits, healthcare providers are deemed out of network, I have an unmet deductible or co-payment or, I am otherwise uninsured, I understand that I am personally responsible for immediate payment in full for services rendered by Surgical Associates. I agree there are circumstances, as outlined in Patient Account & Pre-Service Deposit Policy, where a Pre-Service Deposit will be required of me prior to services being rendered and/or scheduled. I further agree that Surgical Associates may charge additional reasonable legal and collections fees, and additional interest (1.5% per month) associated with obtaining payment from me on delinquent account balances.

**5. Responsibility to Comply with Rules & Procedures of My Health Benefits Carrier or Insurance Company**
I will comply with all rules and procedures required of me by my health benefits carrier including, but not limited to: Providing valid and verifiable government-issued photo identification and insurance information ***prior to*** obtaining services from Surgical Associates; Ensuring that my healthcare providers and facilities are in the participating network of my insurance carrier; Obtaining all required Referrals or Authorizations ***prior to*** obtaining services from Surgical Associates; Providing full payment at time of service for any co-payment, co-insurance, pre-service deposit, and/or deductible required from me. Non-compliance may cause my care to be re-scheduled, delayed, or terminated.

**6. Miscellaneous Fees Not Covered by Health Insurance**
I agree to promptly pay the following applicable charges that are not covered by my insurance:

| | |
|---|---|
| Missed Appointment Fee (without providing us 24 hours advance notice) | $30 |
| Returned Check Fee | $40 |
| Form Fee {for processing any forms requiring provider signature} | $10 each |
| Records Copying or Retrieval for Patient or Attorney Office | $.75/page + postage (if applicable). |

**7. Other Important Policies of Surgical Associates**
I understand and agree to the following additional policies: Surgical Associates only accepts and processes prescription refill requests during normal business hours; Surgical Associates staff may not assist in lifting/transferring/transporting patients under any circumstances. Should I require such assistance, I will timely arrange and provide for such services independently; If Surgical Associates, in the opinion of its clinical staff, is unable to accommodate my physical needs/limitations, I may be required to be seen at, or transferred to, a hospital for the provision of my health care services; Surgical Associates occasionally offers limited-time, free screening services, and arising from such, I may be referred for additional billable services or diagnostic testing. I am not required to obtain such services from Surgical Associates or its subsidiaries/affiliates, and a list of other area providers of such services is available to me upon request.

**I UNDERSTAND, AUTHORIZE, AND AGREE TO THE ABOVE:**

**X** _____ _____
**Patient Signature** (or Guardian/Representative*) **Date**

*Required if patient is a minor or an adult who is unable to acknowledge receipt.

_____ {Relationship of Guardian/Representative to Patient of Guardian/Representative to Patient}