PATIENT INFORMATION

REFERRING DR.________________________________ CHOICE OF LANGUAGE_______________________________________

PHARMACY OF CHOICE/ CITY, STATE____

LAST NAME_________________________________FIRST NAME_____________________________________MIDDLE.________

STREET ADDRESS ____ APT OR LOT___________

MAILING ADDRESS ____ APT OR LOT___________

CITY/STATE/ZIP____

HOME PH________________________WORK PH ___________________________CELL PH __________________________

EMPLOYER NAME & ADDRESS____

DATE OF BIRTH_____/_____/_______ SOCIAL SECURITY#____M____F____

MARRIED__ WIDOWED__ DIVORCED___ SINGLE___ SPOUSE'S NAME________________________________

EMERGENCY CONTACT (THAT DOES NOT LIVE WITH YOU)

NAME.____(RELATION)__________________(PH)_____________

Do we have your permission to:

Leave a message on your cell phone? **Yes:**__________**No:**__________**N/A**________

Leave a message on your home answering machine? **Yes:**__________**No:**__________**N/A**________

Leave a message at your place of employment? **Yes:**__________**No:**__________**N/A**________

Send emails concerning appointments/ medical condition **Yes:**__________**No:**__________**N/A**________

E-mail address ____

Discuss your medical condition w/any member of your household 01· family? Yes:____ No:_____

If YES, please give the following information:

NAME(S):____**RELATIONSHIP**___________________________

____ ___________________________

____ ___________________________

IF PATIENT IS A MINOR IND/CATE RELATIONSHIP:

PAREN'I'________,GUARDIAN_________ ,OR OTHER.______________________________

LAST NAME,_____________________________________FIRSTNAME.__________________________________MIDDLE.________

DATE OF BIRTH_____/_____/_______ SS#________________________HOME( )__________________WORK( ),________________

ADDRESS____

PLEASE PRESENT INSURANCE CARDS & PHOTO ID TO THE RECEPTIONIST SO COPIES MAY BE MADE.

******INSURANCE OR MEDICARE JNFORMATJON******

MEDICARE#:______________________________ MEDICAID#:_______________________________________

INSURED:_____________________________________ RELATION TO PT.:________________________DOB:____/____/______

INS.CO.:________________________________SS#:_________________GRP#:__________________POLICY#:_________________

EMPLOYER NAME& ADDRESS____

******SECOND OR OTHER INS. JNFORMA11ON******

INSURED:___________________RELATION TO PT:______________________ DOB:___/___/____

INS.CO.:________________________________SS#:_________________GRP#.:_________________POLICY#:.________________

EMPLOYER NAME & ADDRESS.____

DATE: _________________________________ **SIGNATURE:**____

David L. Spencer, MD, FACS
William T. Avara, III, MD, FACS
John D. Bailey, MD, FACS
Edward I. Dvorak, MD
Jeremy J. Simpler, MD
Jason Payne, MD
Nicholas Fayard, MD
Matthew Scott Brashier, DO
Lorraine Rauls, FNP-BC
Brooks Gray, MD

FINANCIAL POLICY

Thank you for choosing South Mississippi Surgeons, PA (SMS) as your healthcare provider. We are committed to providing you the best possible service at the lowest possible price. Following is a statement of our financial policy which we require you to read and sign prior to treatment.

SMS accepts payment for professional services in the form of cash, check, credit card or patient financing. All patients will be required to establish a financial arrangement when services are rendered. In addition, we accept insurance from major insurance companies. ***PLEASE BE AWARE THAT FEW INSURANCE COMPANIES ATTEMPT TO COVER ALL MEDICAL COSTS. EACH PATIENT IS REQUIRED TO MAKE A DEPOSIT PRIOR TO SURGERY.*** Your insurance coverage is a contract between you and your insurance carrier. We will assist you in maximizing your insurance benefits and in obtaining necessary pre-certifications. As a courtesy we will review your insurance coverage, estimate your insurance payment, review your insurance form and file your claim with the carrier. To avoid any misunderstanding, we will require you to assign all insurance benefits for professional services directly to our office. If you request your insurance company to pay you directly, we will require full payment from you at the time of service. You will be notified when the insurance carrier remits payment to our practice. We will apply this payment to your account and refund any credit balance within 30 days.

If an insurance problem occurs you will be asked to assist us in contacting your insurance carrier. We feel it is necessary to work together to resolve any insurance problem. ***YOU WILL BE RESPONSIBLE FOR ANY PORTION OF YOUR BILL WHICH IS DENIED OR NOT PAID BY YOUR INSURANCE CARRIER.***

If this bill is not paid within the ninety (90) day period from demand or billing, SMS may add a collection fee of up to 30% or $10.00 whichever is higher. If the account is turned over to a collection agency or attorney, a 30% fee will be added to the account.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and good communication. Our staff has been instructed to make every effort to clarify any misunderstandings you have concerning your balance. If you have any questions concerning our financial policy or need any assistance, please contact our practice immediately at 769-2069.

I have read, understand and agree to the financial policy.

______________________________________ ____________________

Signature of Patient or Responsible Party Date

1124 Oakleigh Rd., Ocean Springs, MS 39564 Phone: 228-875-3778 Fax: 228-875-9335
2525 Telephone Rd., Pascagoula, MS 39567 Phone: 228-762-4483 Fax: 228-762-3147
147 Reynoir St, Ste 306, Biloxi, MS 39530 Phone: 228-432-1116 Fax 228-432-1119

Revised: 01/27/201G sk

David L. Spencer, MD, FAGS
William T. Avara, III, MD, FAGS
John D. Bailey, MD, FAGS
Edward I. Dvorak, MD
Jeremy J. Simpler, MD

Jason Payne, MD
Nicholas Fayard, MD
Matthew Scott Brashier, DO
Lorraine Rauls, FNP-BG
Brooks Gray, MD

Consent For Treatment

This consent is **not** to be used or considered an informed consent for operation or surgical procedures. This is to certify that the undersigned authorizes the examination and/or treatment as may be necessary or advisable completed within the office of South Mississippi Surgeons, P.A.

1. I consent to my photograph to be taken by South Mississippi Surgeons, P.A. for identification purposes.
2. The undersigned as the patient or his/her authorized legal representative do hereby authorize South Mississippi Surgeons, P.A. to release to my insurance company or other appropriate agencies, information necessary to validate this claim for billing purposes.
3. South Mississippi Surgeons, P.A. is also hereby authorized to release to any other physicians or medical entity information as needed for treatment, care of the insured.
4. I hereby authorize any medical and/or health insurance company to pay the proceeds of any benefits due me directly to South Mississippi Surgeons, P.A. A copy of this form can be considered as an original for insurance purposes. I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or the indicated person for whom I am financially responsible. Although I have requested the doctors to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance company, I further agree to make arrangements for prompt payment of the bill.
5. **I have read this agreement and understand the contents.**

____

PATIENT'S NAME (print) Date PATIENT'S NAME (signature)

____

Responsible Party NAME (print) Relationship Responsible Party NAME (signature)

6. **STATEMENT TO PERMIT PAYMENT OF MEDICARE/MEDICAID BENEFITS TO SOUTH MISSISSIPPI SURGEONS, P.A.**

Medicare#:___________________________and/or Medicaid#:__________________________

BENEFICIARY:____________________________

I request that payment of authorized MEDICARE/MEDICAID benefits be made on my behalf to South Mississippi Surgeons, P.A. for services furnished me by physicians associated with South Mississippi Surgeons, P.A. I authorize South Mississippi Surgeons, P.A. to release Health Care Financing Administration/ or Medicaid and its agents any information needed to determine these benefits or the benefits payable for related services.

____

Patient/Responsible Party Signature

1124 Oakleigh Rd., Ocean Springs, MS 39564
2525 Telephone Rd, Pascagoula, MS 39567
147 Reynoir St., Ste 306, Biloxi, MS 39530

Revised: 01/28/2016 sk

South Mississippi Surgeons, P.A.

David L. Spencer, MD, FAGS
William T. Avara, III, MD, FAGS
John D. Bailey, MD, FAGS
Edward I. Dvorak, MD
Jeremy J. Simpler, MD

Jason Payne, MD
Nicholas Fayard, MD
Matthew Scott Brashier, DO
Lorraine Rauls, FNP-BC
Brooks Gray, MD

Authorization to Obtain Medication History

Patient Name: ______________________________

DOB: ______________________________

SSN: ______________________________

Address: ______________________________

By signing below, I hereby authorize South Mississippi Surgeons, P A. to obtain Medication History related to the patient above, from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment.

____

Date of Authorization

____

(Print Name) Patient/Legal Representative or Parent/Legal Guardian

____

(Signature) Patient/Legal Representative or Parent/Legal Guardian

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except *to* the extent that action has already been taken on this authorization. South Mississippi Surgeons, P.A. may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

1124 Oakleigh Rd., Ocean Springs, MS 39564 | Phone: 228-875-3778 | Fax: 228-875-9335
2525 Telephone Rd., Pascagoula, MS 39567 | Phone: 228-762-4483 | Fax: 228-762-3147
147 Reynoir St., Ste 306, Biloxi, MS 39530 | Phone: 228-432-1116 | Fax: 228-432-1119

Revised: 01/28/2016 sk