ROCKWALL SURGICAL SPECIALISTS

Dr. David Ritter ▪ Dr. Ashley Egan ▪ Dr. Jon Harris

Phone (972) 412-7700 Fax (972) 412-7710

PATIENT REGISTRATION FORM

Patient's name (Last, First, Middle Initial) _____ Sex (M or F) _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

May we leave a detailed message: Yes or No If so, where: Home or Cell May we email you: Yes or No

Marital Status _____ Social Security Number _____ Driver's License Number _____

Race _____ Ethnicity _____ Preferred Language Spoken _____

Emergency Contact Name _____ Relationship _____ Phone number _____

Employer's Name _____ Employer's Phone Number _____ Is this Worker's Comp? YES NO

Employer's Address _____ City _____ State _____ Zip _____

What is your occupation? _____ How long? _____

1.) Name of Insurance Company _____ ID Number _____

Policy Holder's Name _____ DOB for Policy Holder _____ Relationship to Patient _____

Policy Holder's Employer _____ Phone Number _____

2.) Name of Secondary Insurance Company _____ ID Number _____

Policy Holder's Name _____ DOB for Policy Holder _____ Relationship to Patient _____

Policy Holder's Employer _____ Phone Number _____

Signature:_____ ***Date:***_____

PATIENT MEDICAL HISTORY/INFORMATION

Name: _____ DOB: _____

PCP/referring provider: _____ Chief complaint:_____

Do you have a history of:

___High Blood Pressure	___Heart disease	___Hepatitis	___Blood clots
___Cancer	___Breast disease	___HIV/AIDS	___Pulmonary embolism
___Diabetes	___High cholesterol	___Blood transfusion	___Sleep apnea

____Other: Please specify _____

Family History (Please list): _____

Please List ALL of your previous surgeries:

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

Last colonoscopy? _____ Last EGD? _____

Please list ALL current medications, dose, amt/day:

1._____	5._____
2._____	6._____
3._____	7._____
4._____	8._____

Do you take any blood thinners (such as Coumadin, Plavix, Xarelto, Aspirin, etc..):_____

Please list your drug allergies: _____

Pharmacy Preference: _____

Location/Town: _____ Phone number: _____

Do you:

___ Smoke? How long? _____
___ Drink alcohol? How much?_____
___ Diet pills? What kind? _____
___Have you ever smoked? How long? _____
___Do drugs? What? _____

Have you recently had any of the following?

___Nausea/Vomiting	___Weight loss	___Weight gain	___ Chest pain
___Fever/Chills	___Seizure	___Change in appetite	___Heart palpitations
___Weakness	___Double vision	___Abdominal pain	___Heart murmur
___Bleeding problems	___Vision changes	___Blood in stool	___Leg swelling
___Swollen glands	___Earache	___Constipation	___Edema
___ Difficulty swallowing	___Headache	___Hemorrhoids	___Nipple discharge
___Acid reflux/heart burn	___Nose Bleeds	___Abdominal mass	___Breast lump
___Depression	___Hearing loss	___Blood in urine	___Rash
___Painful joints	___Itching	___Painful urination	___Change in mole
___Neck pain	___Hay fever	___Shortness of breath	___ Immune problems
___Jaundice	___Pneumonia	___Asthma	___ Allergy to iodine

Sign: _____ Date: _____

PLEASE NOTIFY US IF ANY OF THE ABOVE INFORMATION CHANGES AT FUTURE VISITS.

HIPAA PATIENT ACKNOWLEDGMENT FORM

In signing this HIPAA Patient Acknowledgment form, I acknowledge and authorize, that I hold harmless this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring from this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state laws has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I may inspect a copy of my PHI to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated authorization shall be as effective as the original.

Consent to release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Rockwall Surgical Specialists must have my consent, therefore, I authorize Rockwall Surgical Specialists to disclose my PHI as described in the above forms, to the recipients listed below:

Description of the information to be disclosed (Check all that apply):

___All procedures ____Test results ____Appointments ____Other ___Surgeries ___Billing/Account information

Name(s) of the person(s) authorized to obtain the above mentioned information. (e.g. Physician other than your referring doctor, family members and other specified person(s))

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I authorize Rockwall Surgical Specialists to contact me at the with results or questions and acknowledge if I chose to have my information emailed there is a risk of breach.

Patient name: (Print and Sign) _____

Date: _____

Patient representative: (Print name and sign) _____

Relationship to patient:_____

Date: _____

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ASSIGNMENT OF BENEFITS

I consent for Dr. David Ritter, Dr. Ashley Egan, Dr. Jon Harris and staff to render consultation and treatment. I understand that if I am a minor, a parent or legal guardian must be present at the time of consultation. I, the undersigned, certify that I or my dependent, have insurance coverage and that I have provided that information. I also understand that it is MY RESPONSIBILITY to keep the information updated. I understand there is the possibility that Out-of-Network Provider(s) may provide all or part of the Covered Services. You may contact your insurance company for more information. I assign directly to the above-mentioned physician all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize the physician to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for all procedures and others pay a percentage of the charges. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

If this account is assigned to an attorney for collections and/or suit, the practice shall be entitled to reasonable attorney fees and cost of collections. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to the practice named on this form. The assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

In the course of your treatment from Dr. David Ritter, Dr. Ashley Egan, or Dr. Jon Harris, you may be referred to, or certain procedures may be performed at a facility that the physician may have a financial interest in. By signing this disclosure, you acknowledge the physician's possible financial interest in this facility and your election to use such facility. You are not required to use any of these facilities and have the option to use an alternative health care facility. Please let us know if you have any concerns regarding the relationship between the physician and facilities.

We would like to inform you that if you are required to have a surgical procedure or medical treatment by Dr. David Ritter, Dr. Ashley Egan, or Dr. Jon Harris the fees that are quoted to you from this office are for the services rendered by our office only. You will need to discuss laboratory, pathology, anesthesiology, and facility charges with those individuals. They each have a separate billing office and have NO AFFILIATION with our office. The amount you are requested to pay at the time of scheduling is an estimated amount, due to your insurance benefits. After the surgical procedure or medical services are preformed, your insurance company will be billed. If there is any remaining balance that you are required to pay, you will receive a statement from our office with that amount on it. By signing this form, you acknowledge that you are responsible for any balances on your account and or any services not covered by your insurance company. I have read the above statement and agree that if my insurance company fails to pay, I accept responsibility for charges incurred.

I have read and understand the above disclosure.

PRINTED PATIENT NAME: _____

RESPONSIBLE PARTY SIGNATURE:_____

RELATIONSHIP TO PATIENT:_____ DATE: _____

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FMLA/Short Term Disability Release of Information Authorization

I, _____, here by authorize Rockwall Surgical Specialists (physicians and staff) to release any information requested from my employer, human resource department, insurance company, or disability company that is in regards to my time off work request, family leave forms (FMLA), disability payments, or time off compensation.

I also understand that at any time I can revoke this authorization by submitting a request in writing. If I need to re-instate this authorization I must sign a new form with a current date and this request must be presented in person (by the patient) for authenticity.

_____

Printed name

_____

Signature

_____

Date

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ROUTINE COLONOSCOPY SCREENING

The majority of insurance companies cover one Routine Colonoscopy Screening every 10 years after the age of 50 under your preventative benefits at 100%.

Rules differ depending on each insurance company and/or group insurance plan. However, it is important to note that, if while performing your Routine Colonoscopy, the physician finds and removes colon polyps, your insurance company has the right to apply this procedure to your surgical benefit versus routine benefit.

We do not change the procedure code or bill the insurance company any differently, however, by law, we have to report that polyps were removed. This may affect how your claim is paid by insurance. Again, all insurance companies and plans have different protocols and this may or may not apply to your particular plan. However, we do want to inform you of possible issues prior to your procedure.

As a courtesy to our patients, we will check your benefits and then forward the information to you as we have received it from the customer service representative at your insurance company.

I have read and understand the above information.

_____ _____

Patient name Date

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Colonoscopy INFORMATION

PRE OP: via phone

A NURSE will contact you from the facility no later than the day prior to surgery/procedure to review your personal healthy history, allergies and medications.

ROCKWALL SURGICAL CENTER	PRESBYTERIAN OF ROCKWALL
825 W YELLOWJACKET	3150 HORIZON RD
ROCKWALL, TX 75087	ROCKWALL, TX 75032
972-772-6166	469-698-1000

SURGERY DATE: _____

APPROX. CHECK IN: _____ **APPROX. PROCEDURE TIME**: _____

Due to unexpected emergencies, your arrival/procedure time may change. We will make every attempt to contact you; however, it is recommended that you confirm your times with the facility the day prior to your surgery/procedure.

- **5-7 DAYS PRIOR TO SURGERY:** NO ANTI-INFLAMMATORIES OR BLOOD THINNERS (Aspirin, Plavix, Coumadin, etc.) Tylenol is okay to take for general pain. See the attached list and check with your prescribing provider.
- **You *WILL NOT* be allowed to drive home following your surgery.** Please make arrangements for a ride home. Taxi's or any other form of public transportation will not be sufficient unless it is a licensed medical transport.
- **NOTHING TO EAT OR DRINK AFTER MIDNIGHT THE NIGHT PRIOR TO SURGERY.** If you take blood pressure medications, it is OK with a small sip of water ONLY. Not adhering to this may cause complications with your procedure.
- **CLEAR LIQUID DIET THE DAY PRIOR AND TAKE THE SUPREP KIT DOSES AT 5:00PM AND 10:00PM.**

Based on the info we received from your insurance or if you are self-pay, we may collect a down payment prior to surgery. We will bill you if there is any remaining balance after your insurance has processed the claim. An insurance specialist from the facility will check your benefits and contact you regarding out of pocket expenses for their facility prior to your surgery/procedure. ***THE FACILITY, ANESTHESIOLOGY, PATHOLOGY AND ALL OTHER PARTIES INVOLVED WILL BILL SEPERATELY AND ARE NOT AFFILIATED WITH ROCKWALL SURGICAL SPECIALISTS. PLEASE CONTACT THEIR COMPANIES REGARDING THEIR SERVICES AND STATEMENTS.***

SUPREP BOWEL PREP

INSTRUCTIONS FOR THE DAY PRIOR TO YOUR COLONOSCOPY

Stay on a CLEAR LIQUID DIET ALL DAY.

Clear liquids include:

Water, chicken broth, Gatorade, coffee (no creamer), tea, lemonade, limeade, apple juice, WHITE grape juice, clear soft drinks, Jell-O, popsicles.

DO NOT HAVE MILK PRODUCTS, ANYTHING COLORED RED OR PURPLE.

THE EVENING PRIOR @ 5:00PM

Complete steps 1 through 4 using one bottle in your SUPREP kit.

1. Pour One (1) 6-ounce bottle of SUPREP liquid into the cup provided.
2. Add cool drinking water to the 16-ounce line on the cup and mix well.
3. Drink ALL the liquid in the cup.
4. You MUST drink two (2) more 16-ounce cups of water over the next hour.

REPEAT ABOVE STEPS @ 10:00PM

Repeat steps 1 through 4 using the other 6-ounce bottle of SUPREP.

Be sure to finish ALL of the solution and water.

Both 6-ounce bottles are required for a complete prep.

STOP!!!!!

All blood thinners **5 (five) days** prior to your surgery. Blood thinners may include:

Aggrenox
Aleve
Arixtra
Aspirin
Brilinta
Celebrex
Cilostazol
Clopidogrel
Coumadin
Dipyridamole
Effient
Eliquis
Excedrin
Fish Oil
Fragmin
Ibuprofen
Naproxen
Mobic
Motrin
Plavix
Pradaxa
Prasugrel
Vitamin E
Xarelto
Warfarin

Tylenol is OK to use if needed

OFFICE LOCATIONS

PLEASE NOTE WE HAVE OFFICES IN 4 DIFFERENT LOCATIONS FOR YOUR CONVENIENCE. IF YOU HAVE QUESTIONS REGARDING WHERE YOUR OFFICE APPOINTMENT IS LOCATED PLEASE DON'T HESITATE TO CALL AND CONFIRM (972) 412-7700.

Rockwall

1005 W. Ralph Hall Pkwy
Suite 211
Rockwall, Texas 75032

Rowlett

7501 Lakeview Pkwy
Suite 270
Rowlett, Texas 75088

Forney

763 Highway 80
Suite 130
Forney, Texas 75126

Greenville

4004 Medical Pkwy
Greenville, Texas 75402