

# ROCKWALL SURGICAL SPECIALISTS

Dr. David W. Ritter Dr. Jake K. Abbott Dr. Ashley L. Egan Dr. Jon W. 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

\_\_\_\_\_  
Marital Status

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Driver's License Number

\_\_\_\_\_  
Race

\_\_\_\_\_  
Ethnicity

\_\_\_\_\_  
Preferred Language Spoken

\_\_\_\_\_  
Emergency Contact Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone number

\_\_\_\_\_  
Primary Care Physician or Referring Physician

Is this Worker's Comp?

YES

NO

\_\_\_\_\_  
Employer's Name

\_\_\_\_\_  
Employer's Phone Number

\_\_\_\_\_  
Employer's Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Name of Insurance Company (Please put secondary on the next page)

\_\_\_\_\_  
ID Number

\_\_\_\_\_  
Policy Holder's Name

\_\_\_\_\_  
DOB for Policy Holder

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Policy Holder's Employer

\_\_\_\_\_  
Phone Number

I AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITIES SHOWN ON THE NEXT PAGE. PLEASE READ THOSE FORMS CAREFULLY.

X \_\_\_\_\_

DATE: \_\_\_\_\_

\_\_\_\_\_  
Name of Secondary Insurance Company

\_\_\_\_\_  
ID Number

\_\_\_\_\_  
Policy Holder's Name

\_\_\_\_\_  
DOB for Policy Holder

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Policy Holder's Employer

\_\_\_\_\_  
Phone Number

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.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

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.

THANK YOU FOR YOUR COOPERATION

Where would you like your prescriptions sent?

Pharmacy Preference: \_\_\_\_\_

Location: \_\_\_\_\_

Phone number: \_\_\_\_\_

**PATIENT INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Who referred you?: \_\_\_\_\_

What is your current chief complaint: \_\_\_\_\_

Do you have a history of:

- High Blood Pressure                       Heart disease                       Hepatitis
- Cancer     Breast Disease                       HIV
- Diabetes     Bleeding Problems                       Blood transfusion
- Other: Please specify \_\_\_\_\_

Family History (Please list): \_\_\_\_\_

Please List ALL of your previous surgeries:                      Last colonoscopy? \_\_\_\_\_ Last EGD? \_\_\_\_\_

<u>SURGERY</u>	<u>YEAR</u>	<u>SURGERY</u>	<u>YEAR</u>
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Please list ALL current medications:

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

Please list your drug allergies: \_\_\_\_\_

What is your occupation? \_\_\_\_\_ How long? \_\_\_\_\_

Do you:

- Smoke? How long? \_\_\_\_\_                       Have you ever smoked? How long? \_\_\_\_\_
- Drink alcohol? How much? \_\_\_\_\_                       Do drugs? What? \_\_\_\_\_
- Diet pills? What kind? \_\_\_\_\_

Have you recently had any of the following?

- |  |   |  |   |  |
|--|---|--|---|--|
| <input type="checkbox"/> Weight loss         | <input type="checkbox"/> Nausea             | <input type="checkbox"/> Rash            | <input type="checkbox"/> Weight gain        | <input type="checkbox"/> Vomiting              |
| <input type="checkbox"/> Weakness            | <input type="checkbox"/> Fever              | <input type="checkbox"/> Abdominal pain  | <input type="checkbox"/> Headache           | <input type="checkbox"/> Chills                |
| <input type="checkbox"/> Abdominal mass      | <input type="checkbox"/> Seizure            | <input type="checkbox"/> Bleeding issues | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Depression            |
| <input type="checkbox"/> Vision changes      | <input type="checkbox"/> Constipation       | <input type="checkbox"/> Delusions       | <input type="checkbox"/> Double vision      | <input type="checkbox"/> Hemorrhoids           |
| <input type="checkbox"/> Drug addiction      | <input type="checkbox"/> Hearing loss       | <input type="checkbox"/> Blood in stool  | <input type="checkbox"/> Penis discharge    | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Blood in urine      | <input type="checkbox"/> Testicular lumps   | <input type="checkbox"/> Ear ache        | <input type="checkbox"/> Painful urination  | <input type="checkbox"/> Vaginal discharge     |
| <input type="checkbox"/> Nose bleeds         | <input type="checkbox"/> Neck pain          | <input type="checkbox"/> Menstrual pain  | <input type="checkbox"/> Heart murmur       | <input type="checkbox"/> Painful joints        |
| <input type="checkbox"/> Venereal disease    | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Leg swelling    | <input type="checkbox"/> Swollen glands     | <input type="checkbox"/> Chest pain            |
| <input type="checkbox"/> Nipple discharge    | <input type="checkbox"/> Edema              | <input type="checkbox"/> Asthma          | <input type="checkbox"/> Breast lump        | <input type="checkbox"/> Jaundice              |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Itching            | <input type="checkbox"/> Hay fever       | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Change in mole        |
| <input type="checkbox"/> Allergy to food     | <input type="checkbox"/> Allergy to iodine  | <input type="checkbox"/> Immune problem  |   |  |

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 PMI 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: \_\_\_\_\_

## Contact Information:

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

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_

May we leave a detailed message on your answering machine or voicemail?

Yes  No (Failure to check one of these boxes may delay results)

Patient name: (Print and Sign) \_\_\_\_\_

Date: \_\_\_\_\_

Patient representative: (Print name, sign and describe authority)

\_\_\_\_\_

Date: \_\_\_\_\_

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## ASSIGNMENT OF BENEFITS

I consent for Dr. David Ritter, Dr. Jake Abbott, 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 or not paid by insurance.

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.

PRINTED PATIENT NAME: \_\_\_\_\_

RESPONSIBLE PARTY SIGNATURE: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

DATE: \_\_\_\_\_

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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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In the course of your treatment from Dr. David Ritter, Dr. Jake Abbott, or Dr. Ashley Egan, 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.

I have read and understand the above disclosure.

Patient name: \_\_\_\_\_

Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_

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We would like to inform you that if you are required to have a surgical procedure or medical treatment by Dr. David Ritter, Dr. Jake Abbott, 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.

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Patient name printed

---

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

# 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**

4400 W. I-30  
Suite 300  
Greenville, Texas 75402