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

______________________ Is this Worker's Comp? YES NO
Primary Care Physician or Referring Physician

__________________________ ____________________________
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

AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITES 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? ___________

SURGERY	YEAR	SURGERY	YEAR
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?

___ Weight loss
___Nausea
___ Rash
___Weight gain
___ Vomiting
___Weakness
___Fever
___Abdominal pain
___Headache
___Chills
___Abdominal mass
___Seizure
___Bleeding issues
___Change in appetite
___Depression
___Vision changes
___Constipation
___Delusions
___Double vision
___Hemorrhoids
___Drug addiction
___Hearing loss
___Blood in stool
___Penis discharge
___Difficulty swallowing
___Blood in urine
___Testicular lumps
___Ear ache
___Painful urination
___Vaginal discharge
___Nose bleeds
___Neck pain
___Menstrual pain
___Heart murmur
___Painful joints
___Venereal disease
___Heart palpitations
___Leg swelling
___Swollen glands
___Chest pain
___Nipple discharge
___Edema
___Asthma
___Breast lump
___Jaundice
___Shortness of breath
___Itching
___Hay fever
___Pneumonia
___Change in mole
___Allergy to food
___Allergy to iodine
___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: ________________________________

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

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: ___________________________

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

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

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

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:____

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

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.

____
Patient name

____
Signature

____
Date

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