Med Center Health®

General Surgery

a department of The Medical Center

in partnership with GRAVES GILBERT CLINIC

NEW PATIENT LETTER

Dear New Patient:

Welcome to Med Center Health General Surgery. Your health and well-being are very important to us, and we are proud to be a part of your healthcare team.

At your appointment, we set aside time to devote our attention totally to you and to understanding your healthcare needs. We view good health as a partnership, which requires close involvement between you and your provider.

Early detection of any disease or illness usually means early treatment and a higher success rate. Thus, appointments that are not kept pose an increased risk to your health. If you are unable to keep an appointment, please notify us as soon as possible.

It is important you arrive on time for your scheduled appointment(s). Arriving late causes us to get behind schedule, which in turn makes all other patients' appointments run late. Therefore, **if you are late, we will require you to reschedule your appointment.**

Because of our concern with closely monitoring the health of all our patients, patients who fail to show up for an appointment or fail to call and reschedule more than two times may be discharged from the practice.

All co-pays and deductibles will be collected at the time of service.

Please complete the attached paperwork and bring it with you to your appointment along with your Insurance Card(s), a Picture ID, and a complete list of medications. Completing all paperwork will expedite your appointment. If you are unable to complete the enclosed paperwork, please arrive earlier than requested to receive assistance in completion / processing. If you have any questions or concerns, always feel free to contact our office.

It is a pleasure to serve you, and we look forward to seeing you in our office soon!

Appointment Date: _____

Time: _____

Provider: _____

Office Location: _____

Please plan to arrive 15 minutes early for processing of all paperwork!

Thank You

Riverside Professional Center • 825 E 2nd Avenue, Suite C1 • Bowling Green, KY 42101
270.780.2690 • MedCenterHealth.org

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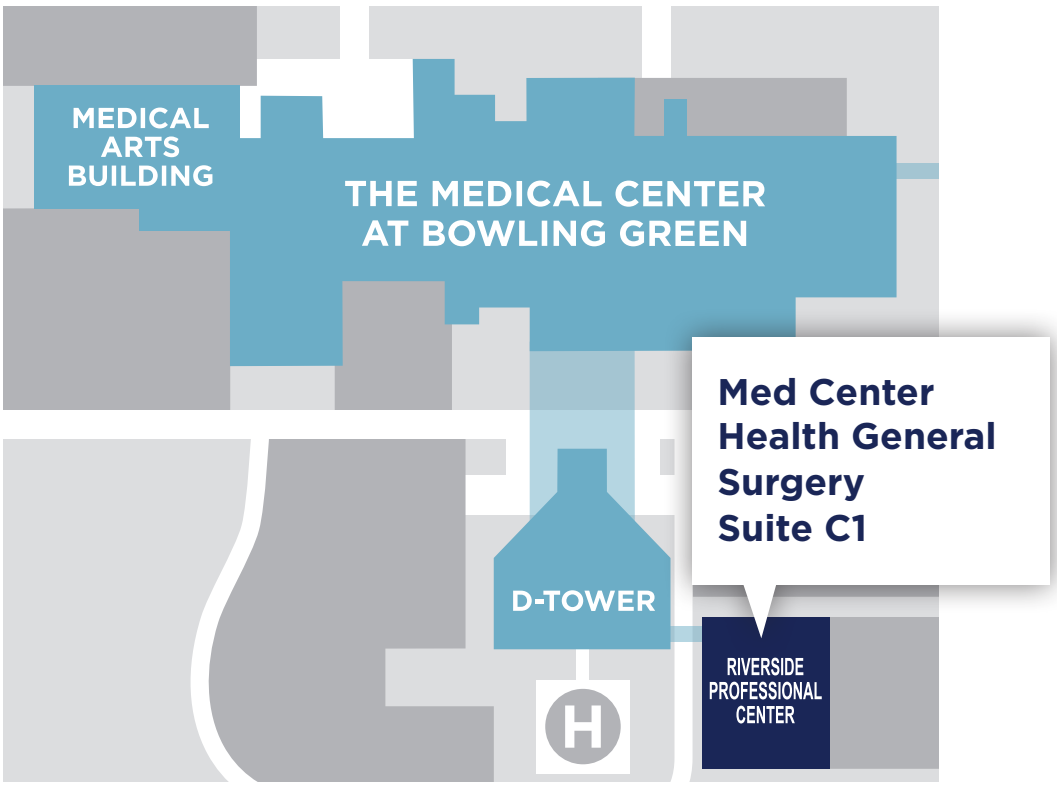
LOCATIONS

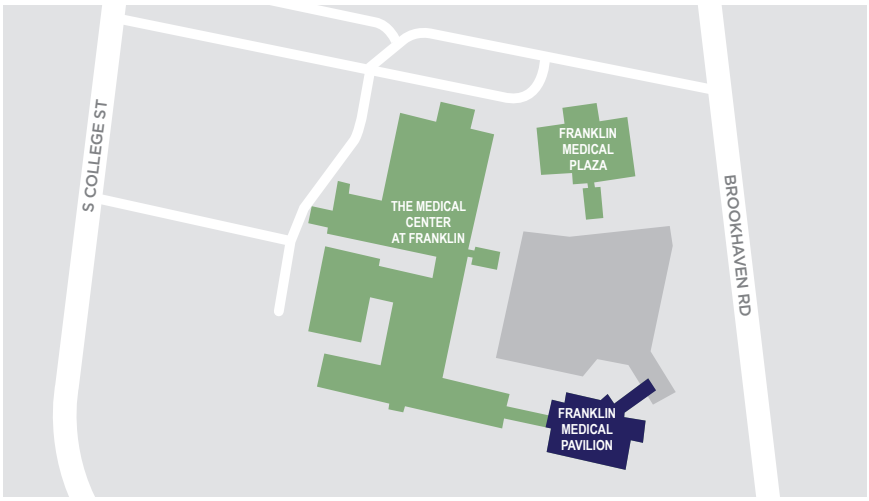
Med Center Health General Surgery has three locations for your convenience: Bowling Green, Franklin and Scottsville. If you have problems locating us, please feel free to call our office for directions at 270-780-2690.

Bowling Green



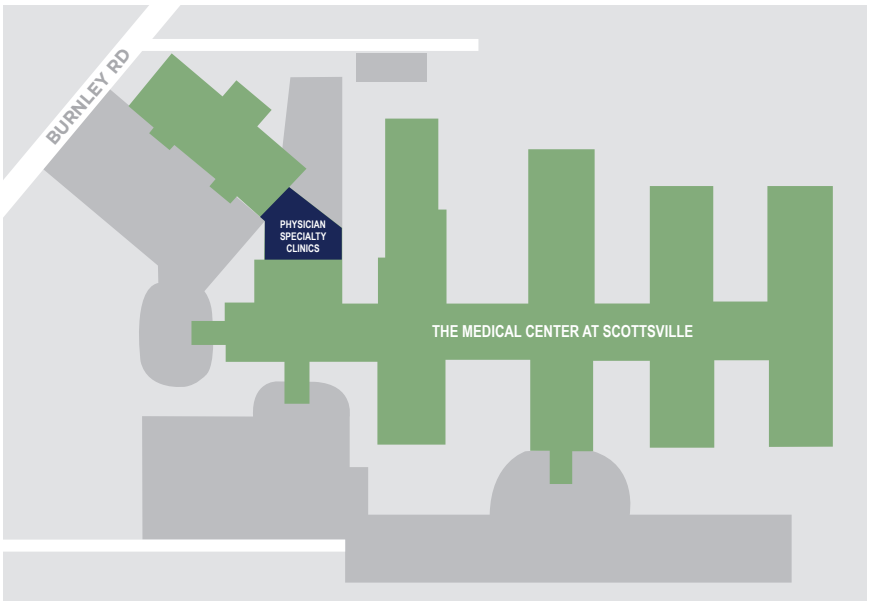
The main office of Med Center Health General Surgery is located in Bowling Green at 825 Second Avenue East, Suite C1.

Franklin



The Medical Center at Franklin
1100 Brookhaven Rd, Franklin, KY 42134

Scottsville



The Medical Center at Scottsville
456 Burnley Rd, Scottsville, KY 42164

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MEET OUR PROVIDERS

Amber H. Chambers, MD, FACS

Medical School:	University of Louisville School of Medicine, Louisville, Kentucky
Residency:	Good Samaritan Hospital - TriHealth, Cincinnati, Ohio
Board Certification:	American Board of Surgery, General Surgery
Locations:	Bowling Green

Dan L. Davis, MD, FACS

Medical School:	University of Kansas School of Medicine, Kansas City, Kansas
Residency:	Rosalind Franklin University of Medicine and Science, Chicago, Illinois
Board Certification:	American Board of Surgery, General Surgery
Locations:	Bowling Green, Franklin

Tage F. Haase, MD

Medical School:	University of Cincinnati, Cincinnati, Ohio
Residency:	Allegheny General Hospital, Pittsburgh, Pennsylvania
Board Certification:	American Board of Surgery, General Surgery
Locations:	Bowling Green

Darin L. Passer, MD, FACS

Medical School:	University of South Carolina School of Medicine, Columbia, South Carolina
Residency:	USC/Palmetto Health, Columbia, South Carolina
Board Certification:	American Board of Surgery, General Surgery
Locations:	Bowling Green, Scottsville

Timothy A. Wierson, MD, FACS

Medical School:	University of Iowa College of Medicine, Iowa City, Iowa
Residency:	University of Louisville Affiliated Hospitals, Louisville, Kentucky
Board Certification:	American Board of Surgery, General Surgery
Locations:	Bowling Green

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NEW PATIENT FORMS

PATIENT INFORMATION (Please Print)

Patient Name _____
(Last, First, Middle Initial)

Preferred Name (Nickname) _____ Name Suffix Jr. Sr. I II III IV V Age _____

Date of Birth _____ Male/Female _____ SS# _____

Ethnicity/Race _____ Preferred Language _____ Marital Status _____

Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

E-mail Address: _____ Have you registered for our patient portal? Y/N

How would you like to be contacted Home Phone Cell Phone Email Text Patient Portal

Employer _____ Occupation _____

PHARMACY INFORMATION

Pharmacy Name _____ Pharmacy Location _____

PHYSICIAN INFORMATION

Primary Care Physician _____ Office Phone _____ City_____ State ___

Referring Physician _____ Office Phone _____ City_____ State ___

EMERGENCY CONTACTS

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

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SYMPTOMS: Please circle any you have been recently experiencing.

CONSTITUTIONAL: weight loss weight gain night sweats fever fatigue none

SKIN: change in size/color of mole rash cyst/lump wound itching none

EYES: poor vision double vision blurred vision glasses contacts none

ENT: sinus pain deafness/ringing in ears hoarseness nose bleed runny nose sore throat none

CARDIOVASCULAR: palpitations chest pain shortness of breath difficulty breathing lying down swelling of feet/legs leg pain with exercise none

RESPIRATORY: chronic cough coughing up sputum coughing up blood pain with breathing wheezing shortness of breath none

GI/ABDOMEN: abdominal pain loss of appetite difficulty swallowing nausea vomiting hernia diarrhea constipation tarry/bloody stools change in stools painful stools jaundice none

MUSCULOSKELETAL: muscle weakness muscle cramps stiffness bone/joint deformity one joint pain diffuse joint pain none

KIDNEY/BLADDER: pain with urination decreased urine stream blood in urine unable to urinate urinary frequency kidney failure none

NEURO: weakness seizures migraines/headaches incoordination dizziness lightheadness chronic neck/back pain tremor numbness/tingling in extremities none

PSYCH: anxiety depression hallucinations confusion sleep disturbances none

ENDOCRINE: heat intolerance cold intolerance excessive sweating excessive thirst goiter none

BLOOD AND IMMUNE: swollen lymph node easy bruising/bleeding frequent infections none

REPRODUCTIVE (MALE): groin bulge testicular pain groin pain penile discharge none

REPRODUCTIVE (FEMALE): groin bulge heavy periods irregular periods vaginal discharge none

BREAST: breast lump breast pain nipple inversion nipple discharge none

MEDICATIONS/ALLERGIES:
Please list ALL medications you take, and ALL medication allergies.

ALLERGIES:

_____

_____

_____

_____

MEDICATIONS:

_____

_____

_____

_____

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MEDICAL HISTORY: Please circle any you have/have had.

EYES: glaucoma macular degeneration other eye disease none

CARDIOVASCULAR: heart attack coronary artery disease heart failure atrial fibrillation high blood pressure high cholesterol none

RESPIRATORY: asthma smoking COPD sleep apnea lung cancer other lung disease none

GI/ABDOMEN: GERD ulcer liver disease Hepatitis B or C colon polyps colon cancer none

MUSCULOSKELETAL: arthritis fibromyalgia other MSK disease none

KIDNEY/BLADDER: kidney stones freq. urinary infections kidney failure other renal disease none

NEURO: stroke/TIA memory issues seizures chronic neck/back pain other neuro disease none

PSYCH: anxiety depression bipolar disorder other psych disease none

ENDOCRINE: diabetes thyroid disease other endocrine disease none

BLOOD AND IMMUNE: autoimmune disease bleeding disorder clotting disorder HIV tuberculosis

DVT/PE (blood clots): use of blood thinner blood transfusions blood cancer none

REPRODUCTIVE: uterine/cervical/ovarian cancer prostate cancer BPH none

BREAST: benign breast masses breast cancer mastitis/abscess none

CANCER: other cancer not mentioned above none

SURGICAL HISTORY: Please list ALL surgeries you have had.

_____ _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY: Please circle/fill out all which apply.

TOBACCO USE: smoke chew e-cigs never used HOW MUCH? _____ QUIT? _____

ALCOHOL USE: daily moderately rarely never used HOW MUCH? _____ QUIT? _____

DRUG USE: marijuana heroin opiates meth cocaine other never used QUIT? _____

EDUCATION LEVEL (or highest grade completed in school): _____

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FAMILY HISTORY: Please circle all which apply.

FATHER:	heart attack	high blood pressure	diabetes	lung disease	mental illness	other
MOTHER:	heart attack	high blood pressure	diabetes	lung disease	mental illness	other
SIBLING(S):	heart attack	high blood pressure	diabetes	lung disease	mental illness	other
GRANDPARENTS:	heart attack	high blood pressure	diabetes	lung disease	mental illness	other
CHILDREN:	heart attack	high blood pressure	diabetes	lung disease	mental illness	other

HISTORY OF BREAST CANCER: Y/N If yes, who? _____

HISTORY OF COLON CANCER: Y/N If yes, who? _____

HISTORY OF OTHER CANCER: Y/N If yes, who? _____

_____ _____

Signature of Patient or Responsible Party Date

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TREATMENT WITH CONTROLLED SUBSTANCES

Name _____ Date of Birth _____

The physician/practitioner has discussed with me the option of treating my condition with a controlled substance. By accepting the prescription for the controlled substance(s) that was prescribed to me, I acknowledge I understand there are inherent risks and benefits associated with treating my condition/pain with a controlled substance. These risks include developing drug tolerance and dependence.

It is my responsibility to take the medicine as prescribed, and not more frequently than prescribed. I am not to share this medication with anyone else, including family members. The use of narcotics can depress my senses and impact driving and work safety. It is discouraged during pregnancy. There is a potential for overdose, and if I suspect I have overdosed, I should call 911 or go to the nearest emergency room as soon as possible.

The medication should be stored in a safe place out of the reach of children and should be properly disposed of after expiration. Any request for refills must be made during weekday hours before the prescription has expired.

Concerns of selling narcotics will be reported to the authorities.

Witness _____ Patient Signature or Person Authorized _____

Date _____ Relationship to Patient _____

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NO SHOW POLICY

It is the policy of Med Center Health Physician Practices to monitor and manage appointment no-shows. This is necessary to ensure we are able to provide timely access for all patients. High numbers of vacant appointments delay care to all patients.

We understand that it is sometimes necessary to cancel and reschedule, and that emergencies occur. If you have an appointment with one of our providers, your appointment must be canceled or rescheduled at least 24 hours prior to the scheduled appointment time. Any patient who fails to arrive for a scheduled appointment without canceling or rescheduling that appointment at least 24 hours in advance will be considered a "no-show."

As a courtesy, an appointment email is sent out five (5) days prior to your visit; a phone call goes out two (2) days prior; and a text is sent the day of the appointment.

Our policy is that at two (2) "no-shows," the patient is sent a warning letter with the dates of their missed appointments. At three (3) "no-shows," the patient is sent a discharge letter from the practice, and must seek care at another location thereafter.

Thank you,

Med Center Health Physician Practices

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Consent, Assignment of Benefits & Financial Agreement

Name: _____ DOB: _____

Consent to Diagnostic Tests, Medical Treatment and Procedures:
I do voluntarily consent to care involving diagnostic tests, medical treatment and procedures by the physicians/practitioners of Commonwealth Health Corporation, d/b/a Med Center Health General Surgery, their assistants and designees, and other employees of Med Center Health General Surgery as is necessary or advisable in their judgment. This consent includes testing for communicable diseases, including but not limited to Human Immunodeficiency Virus (HIV), hepatitis or any other blood-borne infectious disease if ordered for a diagnostic purpose or due to occupational exposure of a health care worker. I acknowledge no guarantee has been made to me as to the results of examination and treatment.

Assignment of Benefits and Financial Agreement:
I certify all information given by me is correct and I accept responsibility for the charges for the care provided. I agree to the assignment of all third-party benefits to Med Center Health General Surgery and to any physician, practitioner, organization or independent contractor who provided products or services, and agree to pay all charges not covered by third-party payers. If I am covered by an ERISA plan, with this assignment I specifically authorize my providers to receive copies of all notifications and information that I am legally entitled to receive under the terms of my insurance/health plan and to act on my behalf to appeal benefit determinations. I acknowledge any claim for benefits from a third party payer may be filed by Med Center Health General Surgery as a courtesy to me. However, I am primarily responsible for monitoring the filing process and making certain the claim is filed in compliance with the provisions specified by the applicable third party payer. The filing of the claim by Med Center Health General Surgery in no way releases me from liability for any portion of the bill not paid by a third party payer for any reason.

Unless other payment arrangements are approved by Med Center Health General Surgery, the account balance is due upon demand. Failure to pay for the services may result in the placement of an account with a collection agency or attorney for collection. All amounts due, as shown in the final statement and/or amended final statement, shall bear interest from the due date until paid at a per annum rate of eight percent (8%). In the event there is a judgment, the amount due shall accrue interest at the judgment rate of six percent (6%) until paid in full. Further, I agree to pay all costs of collection including court costs, interest, attorney fees and collection agency.

Contact Information:
I agree Med Center Health General Surgery, Commonwealth Health Corporation and their agents, attorneys or collection agencies may contact me regarding medical information or information about my account or for the purposes of collection by telephone at any number provided by me including wireless telephone numbers, and via text messaging or e-mail to any e-mail address provided. Methods of contact may include the use of pre-recorded or artificial voice messages and/or automated dialing.

Release of Information:
I authorize the release of all or part of my records, including information stored in Med Center Health General Surgery corporate-wide database, to my physician(s), whose name I provided at the time of registration, and to any physician or practitioner who has or will provide services to me. I authorize the release of statistical information as required by any local, state or federal agency or managed care program. I authorize the release of my HIV and hepatitis test results to health care personnel in the event of an occupational exposure.

I authorize Med Center Health General Surgery and any other holder of medical or other information to release information about me (including medical information concerning psychological or psychiatric conditions, alcoholism and/or drug related conditions and HIV or other blood-borne infectious diseases) as required to complete any claim for benefits due to services rendered to me to any person or corporation which is or may be responsible for all or part of the total charge incurred. The persons or corporations to which this information may be released includes, but is not limited to insurance companies, the Social Security Administration, its intermediaries and carriers, state agencies and workers' compensation carriers, as well as the review organization employed by my employer or the employer of the insured member of my family and any corporation engaged by Med Center Health General Surgery to make collection of any unpaid charges. I further authorize my employer to release to Med Center Health General Surgery or any agency engaged for the purpose of collecting any unpaid charges, verification of my employment status, including the amount of salary or wages and the number of hours worked.

Information Received:

_____ (initial) I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES.

_____ (initial) This authorization is valid until revoked in writing.

_____ (initial) My medical/financial information may also be released to the following person(s) _____

_____

_____

_____ _____ _____ _____

Signature Date Time Relationship (if not patient)

_____

Witness

MCH General Surgery
GENERAL CONDITIONS OF ADMISSION
7/17