MEMORIAL AND KATY SURGICAL SPECIALISTS
General, Breast and Laparoscopic Surgery

Kevin D. Wheeler, M.D., F.A.C.S.
Cameron R. Ruttman, M.D.
Enrique M. Sta.Ana, V, MD, FACS

We appreciate your confidence in selecting our office for your medical needs. Enclosed are the registration forms needed to establish you as a patient in our office. Please complete these forms and bring them with you to the appointment.

Also, please bring your insurance card and photo identification card so that we may copy it for your chart. **If you have had any diagnostic testing done, please bring copies of the reports, films and/or discs with you. This also includes any lab work or reports from your referring physician. It is very important that the doctor have these available at the time of your visit.**

Please feel free to contact this office if you have any questions or concerns. We look forward to welcoming you as a patient to our office.

Sincerely,

Memorial and Katy Surgical Specialists

1140 Business Center Drive, Suite 400 Houston, TX 77043
18400 Katy Freeway, Suite 420 Houston, TX 77094
Tel: 713-464-1981 Fax: 713-464-1131
www.mksurgery.com

Memorial And Katy Surgical Specialists
New Patient Registration Form

Financial Policy

Thank you for selecting our practice for your surgical care. We are committed to providing you with the best medical care and expertise. Your understanding of our financial policy is an essential element of your care and service. If you have questions regarding any aspect of our policy, please feel free to consult with our staff.

Insurance
We will verify your insurance prior to your appointment. All co-pays, coinsurance, or deductibles will be explained to you prior to your visit and are due at the time of service.

Referrals and pre-certification
If your insurance requires a referral from your primary care physician, it is your responsibility to obtain the referral. If surgery is indicated and your insurance requires pre-certification, we will initiate the request for pre-certification; however, it is your responsibility as well to confirm with our office prior to the surgery that the pre-certification has been authorized.

Surgical Procedures
If surgery is required, you will be contacted by our business office to discuss the insurance benefits and financial responsibility. Your estimated financial obligation will be required as a surgical deposit prior to the procedure. After the insurance has processed your claim, any balance remaining is due upon notice.

The surgery scheduler will contact you within 3-4 days after your office visit to discuss available dates, time and facility options. Some surgical cases require an assistant surgeon and/or surgical assistant. Such assistants are contracted by the surgical facility and bill independently under their group name. Questions regarding fees for the surgical assistant should be directed to the billing office of that group. Some ancillary groups providing services may not be contracted with all insurance. It is your responsibility to verify with your insurance carrier any services provided other than those services performed by Memorial and Katy Surgical Associates. Examples: pathology, laboratory, radiology, anesthesiology, and surgical assistants.

Medical Records
Medical records requests will be released when accompanied with a signed HIPAA compliant medical record release. Fees for copies of medical records are in accordance with the rules of the Texas Medical Board.

Disability Forms
A $25.00 fee is required for completion of disability forms. This fee must be paid prior to completing the form.

Office Visit Cancellation/No Show Fee
A $25.00 fee is required if you fail to notify our office to cancel your scheduled appointment. A 24 hour notice is required to avoid any fee.

Payment Options
We accept cash, check, money order, Mastercard, Visa, Discover, and American Express. There is a $25.00 returned check fee.

ACKNOWLEDGEMENT OF FINANCIAL POLICY RECEIPT

A copy of the Memorial and Katy Surgical Specialists financial policy has been provided to me.

_____
Patient/guardian signature

_____
Print patient name and Date

Memorial And Katy Surgical Specialists
New Patient Registration Form

AUTHORIZATIONS

Release of information:

I hereby authorize the release of medical or any other information to my insurance carrier(s), including Medicare, to determine benefits payable for related medical services. A copy of this authorization may be provided to the insurance carrier if requested. The original authorization will be kept on file by Memorial and Katy Surgical Specialists.

Benefits to physician:

I authorize direct payment of all insurance benefits, including Medicare, to Memorial City Surgical Associates, dba Memorial and Katy Surgical Specialists, for all medical services rendered to me during the course of treatment provided by Memorial and Katy Surgical Specialists. I understand and agree this assignment of benefits will have continuing effect for so long as I am being treated or cared for by Memorial and Katy Surgical Specialists.

I also understand that I am responsible for any portion of my bill not covered by my insurance company.

Patient name (printed) _____ Date of birth _____

Insured name (printed) _____ Insured signature _____ Date _____

Consent for medical treatment:

I hereby authorize Memorial and Katy Surgical Specialists to render the treatment necessary in evaluating, diagnosing, and treating my medical condition or the treatment of my dependent named below.

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

Print name of patient/parent/guardian _____ Relationship _____

Signature _____ Date _____

Memorial And Katy Surgical Specialists
New Patient Registration Form

HIPAA PRIVACY RULE

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's **Notice of Privacy Practices** provides a complete description *of* the uses and disclosures of my health information. I understand that:

I have the right to review this facility 's Notice of Privacy Practices prior to signing this acknowledgement;

This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

_____ _____

Signature of individual or legal representative Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barrier prohibited obtaining the acknowledgement
- ❑ An emergency prevented us from obtaining acknowledgement
- ❑ Other (please specify)

_____

_____ _____

HIPAA officer Date

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

Memorial And Katy Surgical Specialists
New Patient Registration Form

Patient Information (please use full legal name)

Last _____ First _____ Middle_____

Address _____

City _____ State _____ Zip_____

Home Phone _____ Alternative Phone _____

Date of Birth_____ Age _____ Sex _____ Marital Status_____

Driver License _____ State _____ Social Security # _____

Email Address _____

Race (please circle) American Indian Asian Black Native Hawaiian Pacific Islander White

Ethnicity (please circle) Hispanic/Latino Other _____Preferred Language_____

Patient Employer Information

Employer Name _____ Employer Phone _____

Employer Address _____

Provider Information

Primary Care Physician _____ Phone _____

Referring Provider _____ Phone _____

Emergency Contact

Contact Name _____ Relationship _____

Phone _____

Primary Insurance

Insurance Company _____ Policy ID # _____ Group _____

Insured Name _____ Insured DOB _____

Relationship to insured: Self _____ Spouse _____ Child _____ Other _____

Secondary Insurance

Insurance Company _____ Policy ID # _____ Group _____

Insured Name _____ Insured DOB _____

Relationship to insured: Self _____ Spouse _____ Child _____ Other _____

Memorial And Katy Surgical Specialists
New Patient Registration Form

Preferred Pharmacy

Pharmacy Name _____

Pharmacy Address _____

Pharmacy Phone _____

HIPAA Medical Release

I hereby authorize the release of information to the following persons.

Please place a check in the box (s)in which you are giving consent to release information.

Name	Appointment	Financial Information	Medication	Lab Results	Radiology Results

_____ _____ _____

Patient/ Guardian Signature Printed Name Date

Memorial and Katy Surgical Specialist
Medical Questionnaire

DATE:_____

Last Name:	**First Name:**	**MI**	**Date of birth:**	**Age:**
Referring Doctor:			**Height**	**Weight**

Please indicate reason for today's visit.
Please list any other doctors you see. If you see a Cardiologist, please list date of last visit.

Past Medical History (check what applies)

Condition	Yes	No
Angina/chest pain		
AFIB		
AIDS		
Asthma		
Arthritis		
Bleeding problems		
Cancer (what kind)		
Colitis		
Diabetes		
Emphysema		
Glaucoma		
Heart Attack		
Heart Failure		
Hepatitis		
High Blood Pressure		
High Cholesterol		
HIV Infection		
Jaundice (yellow skin)		
Kidney Failure		
Reflux		
Stroke		
Thyroid Disease		
Ulcers		

Memorial and Katy Surgical Specialist
Medical Questionnaire

Family Medical History

Condition	Father	Mother	Brother	Sister	Other
Anesthesia Problems					
Bleeding Problems					
Breast Cancer					
Colon Cancer					
Diabetes					
Heart attack					
Lung Cancer					
Ovarian Cancer					
Other					

Are both parents living and well _____
One parent deceased, cause of death _____
Both parent deceased, cause of death
Mother_____
Father _____

Previous Surgeries/Year	Provider Comments
Problems with anesthesia. If yes, please explain.	

Social History

Tobacco Use	Alcohol Consumption	Substance Abuse
No	No	No
Yes Cigarettes/Packs per day	Yes, Number of drinks per week	Yes. Select which applies
Smokeless tobacco		Cocaine
		Heroin
		Marijuana
		Other

Please list all medications you are currently. If you are taking blood thinner medications, please indicate what medication you are taking.

Medication Name	Strength	Directions for use	Prescriber	Taking as prescribed

Please list all allergies

Medication/Food	Reaction	Mild/Moderate/Severe