

Complete all forms and bring
them with you on your scheduled
appointment date.

Thank you!

University Surgical Associates, PSC

General Surgery

Robert N. Cacchione, M.D.
William G. Cheadle, M.D.
Eric G. Davis, M.D.
Glen A. Franklin, M.D.
Richard N. Garrison, M.D.
Brian G. Harbrecht, M.D.
Farid J. Kehdy, M.D.
Gerald M. Larson, M.D.
Frank B. Miller, M.D.
J. David Richardson, M.D.
Jorge L. Rodriguez, M.D.
Jason W. Smith, M.D.
Benjamin D. Tanner, M.D.
Gary C. Vitale, M.D.

Colorectal Surgery

Susan Galandiuk, M.D.
Jeffrey R. Jorden, M.D.
Michael H. McCafferty, M.D.

Surgical Oncology

Anees B. Chagpar, M.D.
Michael B. Flynn, M.D.
Richard E. Goldstein, M.D., Ph.D.
Robert C. G. Martin, M.D.
Kelly M. McMasters, M.D., Ph.D.
Hiram C. Polk, Jr., M.D.
Charles R. Scoggins, M.D.

Transplant

Joseph F. Buell, M.D.
Mary Eng, M.D.
Michael R. Marvin, M.D.
Kadiyala V. Ravindra, M.D.

Vascular Surgery

Amit J. Dwivedi, M.D.
Charles B. Ross, M.D.
Andrea E. Yancey, M.D.

Plastic and Reconstructive

Larry D. Florman, M.D.
Jarrod A. Little, M.D.
Terry M. McCurry, M.D.
Pradeep S. Mohan, M.D.
Gordon R. Tobin, M.D.
Bradon J. Wilhelmi, M.D.

**Otolaryngology,
Head and Neck Surgery**

Jeffrey M. Bumpous, M.D.
Swapna K. Chandran, M.D.
Arun K. Gadre, M.D.
Toni M. Ganzel, M.D.
Kevin L. Potts, M.D.
Welby Winstead, M.D.



Welcome to our practice.

It is very important that you fill out the enclosed patient registration form, medical history form, and financial policy form completely, prior to your appointment. Please be sure to bring these forms and your current insurance card or cards with you to your appointment. We **must** get copies of your insurance cards to enable us to bill claims properly. ***Please do not mail paperwork to our office, bring it with you!***

The anticipated cost of your initial visit can range in cost. It is difficult for us to provide you with a precise cost estimate for your visit, however, you must pay your copay prior to being seen by the doctor.

Some insurance plans require that you obtain a referral from your Primary Care Physician in order to see a Specialist. Please remember it is the **patient's responsibility** to know their individual insurance plans, each plan has different coverages and networks. If your insurance company requires you obtain a referral we **must have this prior to your appointment or you may bring it with you to your appointment. If you do not have your referral we cannot see you and your appointment will be rescheduled to our next available appointment date. There will be no exceptions!**

Insurance plans that may require a referral include:

**Aetna HMO/Aetna MC/Aetna QPOS
Cigna HMO/Cigna MC
Humana HMO/Humana HMO-MBP
Indiana Medicaid/Hoosier Healthwise
Kentucky Medicaid/KENPAC
Passport
Tricare**

This is not an inclusive list; please check with your benefits administrator if you have any questions concerning referrals.

Thank you for choosing our practice! We are here to help you in any way possible. Our office hours are Monday – Friday; 8:30 am to 5:00 pm. The clinical and business staff will be happy to help you with any appointment, please call to cancel well in advance so that we may offer this appointment space to someone else in need.



How did you hear about University Surgical Associates and/or your doctor?

- Internet
 Radio
 Direct Mail
 Today's Woman
 Louisville Magazine
 Newspaper
 Audience Playbill
 Your physician
 TV
 Friend or word of mouth
 Other _____

Referring Doctor: _____ Family Doctor / PCP: _____

Address _____ Address: _____

Phone: _____ Phone: _____

Patient Information

Patient's Last Name:		First Name:		M.I.	Patient's Social Security #:	
Street Address:					Age:	Date of Birth:
City:		State:	Zip:	Email Address:		Patient's Home Phone:
Employment or Student Status (if not a minor): Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Active Military <input type="checkbox"/> Name of School: _____				Gender: (circle one) Male Female		Patient's Cell Phone:
Marital Status: S M D W		Patient's Employer:			Patient's Occupation:	
Patient's Work Phone & Ext#:		Employer's Address:			Date Employment Started:	
Spouse's Date of Birth:		Spouse's Name:			Spouse's Social Security #:	
Spouse's Work Phone:		Spouse's Employer:			Spouse's Occupation:	

NOT NEEDED IF A

Responsible Party / Child's Parent Information

Responsible Party or Father's Name:			Responsible Party or Mother's Name:		
Social Security #:	Date of Birth:	Relationship to Patient:	Social Security #:	Date of Birth:	Relationship to Patient:
Employer:		Work Phone & Ext:	Employer:		Work Phone & Ext:
Home Address if different from Patient's:			Home Address if different from Patient's:		
City, State & Zip:		Phone:	City, State & Zip:		Phone:

Primary Insurance

PLEASE NOTE: We MUST Make A Copy of Your Insurance Card.

Insurance Company Name:		Effective Date:	Subscriber's Date of Birth
Subscriber's Full Name:		Subscriber's Social Sec #:	Relationship to Patient:

Secondary Insurance

PLEASE NOTE: We MUST Make A Copy of Your Insurance Card.

Insurance Company Name:		Effective Date:	Subscriber's Date of Birth:
Subscriber's Full Name:		Subscriber's Social Sec #:	Relationship to Patient:

Emergency Contact

SOMEONE WITH A DIFFERENT PHONE NUMBER

Name:	Phone Number:	Relationship to Patient:
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RELEASE OF INFORMATION: I hereby authorize the release of medical information or other information acquired during the course of examination and treatment to insurance carriers, physicians, or my legal representatives. I hereby request payment of benefits from all insurance carriers to University Surgical Associates P.S.C. I understand I am responsible for and will pay any amount not covered by insurance including collection costs and reasonable attorney fees if referred for collection.

Signature – Responsible Party _____

Date _____

USA Doctor _____

Registrar _____

UNIVERSITY SURGICAL ASSOCIATES, PSC PATIENT HISTORY FORM
(see also dictated note/letter from today's date)

Patient's Name: _____ **Today's Date** _____

Age: ____ **Birth Date:** _____ **Race:** _____ **SSN:** _____

Family Physician: Dr. _____ **Referred by: Dr.** _____

Other Physicians you see: _____

Reason for Visit: _____

THIS BOX FOR MD USE ONLY

Location
Quality
Severity
Duration
Timing
Context
Modifying Factors
Associated Signs and Symptoms

Past Medical Problems: (check boxes that apply, describe below and list dates if possible)

High Blood Pressure Diabetes Heart Disease/Heart Attack Kidney Disease Lung Disease/COPD Seizures Stroke Cancer Emotional/Psychiatric Problems Hepatitis

List all Previous Operations/Procedures (for example, colonoscopy, cardiac stent, etc.) List reason, date, & MD

Cancer Treatments: Have you ever had Chemotherapy or Radiation Therapy? If so when and by whom:

Medications: (List name, dose, & how often taken)

Do you take aspirin/ aspirin-containing products / any blood thinners? YES NO (if yes, please list)

Are you allergic to any medications? YES NO (if yes, please list) **ALLERGIC to LATEX?** YES NO

Social History

Single Married Separated Divorced Widowed Occupation _____
 Do you use alcohol? YES NO How much and how often? _____
 Do you use tobacco now? YES NO Did you ever use tobacco? YES NO
 Describe tobacco use (for example, packs per day) _____
 Heavy Sun Exposure in past? YES NO Blistering Sunburns in past? YES NO
 Tanning Bed Use? YES NO

Family History List diseases (including specific types of cancer) that run in the family, which relative was affected, and at what approximate age.

ROS: List all symptoms that you are experiencing currently

<u>General</u>	<u>Yes</u>	<u>No</u>	<u>Heart</u>	<u>Yes</u>	<u>No</u>	<u>Reproductive History</u>	<u>Yes</u>	<u>No</u>
Weakness	_____	_____	Chest Pain	_____	_____	Age at 1 st period	_____	_____ yrs
Weight loss	_____	_____	Heart Attack	_____	_____	Age at menopause	_____	_____ yrs
Fever/chills	_____	_____	Irregular Heart Beat	_____	_____	# Pregnancies	_____	_____
Night sweats	_____	_____	Heart Failure	_____	_____	# Live births	_____	_____
<u>Eyes</u>	<u>Yes</u>	<u>No</u>	Swelling in Ankles	_____	_____	Age at 1 st pregnancy	_____	_____ yrs
Vision changes	_____	_____	Palpitations	_____	_____	Breast Fed	_____	_____
Double vision	_____	_____	<u>Gastrointestinal</u>	<u>Yes</u>	<u>No</u>	If yes, your age at the time	_____	_____ yrs
<u>Head/Neck</u>	<u>Yes</u>	<u>No</u>	Abdominal pain	_____	_____	Last Menstrual period	_____	_____
Headache	_____	_____	Nausea/Vomiting	_____	_____	Last Pap Smear	_____	_____
Blackout spells	_____	_____	Vomit Blood	_____	_____	Currently use Hormone	_____	_____
Changes in hearing	_____	_____	Difficulty Swallowing	_____	_____	Replacement Therapy	_____	_____
Changes in taste/smell	_____	_____	Heartburn /Indigestion	_____	_____	If yes, how long	_____	_____
Thyroid Problems	_____	_____	Blood in Stool	_____	_____	Previously used Hormone	_____	_____
Neck lumps	_____	_____	Black/Tarry Stool	_____	_____	Replacement Therapy	_____	_____
Ear pain	_____	_____	Change in stool size/color	_____	_____	If yes, when stopped	_____	_____
<u>Hematologic</u>	<u>Yes</u>	<u>No</u>	Constipation	_____	_____	<u>Neurologic</u>	<u>Yes</u>	<u>No</u>
Anemia	_____	_____	Yellow Jaundice	_____	_____	Tingling	_____	_____
Easy Bruising	_____	_____	<u>Kidney</u>	<u>Yes</u>	<u>No</u>	Numbness	_____	_____
Clotting Problem	_____	_____	Blood in Urine	_____	_____	Weakness	_____	_____
<u>Lung</u>	<u>Yes</u>	<u>No</u>	Kidney/bladder infection	_____	_____	<u>Psychiatric</u>	<u>Yes</u>	<u>No</u>
Lung problems	_____	_____	Kidney stones	_____	_____	Depression	_____	_____
Shortness of breath	_____	_____	Painful urination	_____	_____	Anxiety	_____	_____
Cough up blood	_____	_____	Difficulty urinating	_____	_____	Mood swings	_____	_____
Wheezing/Asthma	_____	_____	<u>Breast</u>	<u>Yes</u>	<u>No</u>	<u>Skin</u>	<u>Yes</u>	<u>No</u>
Pneumonia	_____	_____	Lump	_____	_____	Rash	_____	_____
Tuberculosis	_____	_____	Nipple discharge	_____	_____	Skin cancer	_____	_____
<u>Musculoskeletal</u>	<u>Yes</u>	<u>No</u>	Pain	_____	_____	Change in mole	_____	_____
New aches/pains in	_____	_____	Date Last Mammogram	_____	_____			
Bones/joints	_____	_____						
Arthritis	_____	_____						

FOR BARIATRIC PATIENTS ONLY:

Diets used and weight lost: _____
 Sustained weight loss: _____ How long was weight lost? _____
 How long over 100 lbs. overweight? _____ How many times have you lost over 25 lbs? _____
 How long have you been overweight? _____ years.
 Are you currently under a physician's care for weight loss? YES NO Physician's Name: _____

PHYSICIAN COMMENTS:

Physician Signature: _____ **Date** _____

(History Form Reviewed with Patient)

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. Please read the following policy. If you have any questions, please feel free to discuss them with our staff.

YOUR INSURANCE

We have made prior arrangements with many insurers and other health plans. We will bill those plans with whom we have an agreement and will collect any required copayment at the time of service. The copayment will be collected when you arrive for your appointment. For elective surgery you will be contacted to arrange for payment of the coinsurance and deductible. In the event your health plan determines a service to be “not covered” or you have “no insurance coverage”, you will be responsible for the complete charge. We will also bill your health plan for all services we provide in the hospital. We will be glad to establish a payment plan to meet your needs.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

CANCELLATION/NO SHOW POLICY

An appointment must be cancelled 24 hours in advance. A patient that does not cancel their appointment at least 24 hours in advance or is a NO SHOW will be charged \$25.00.

SUPPLIES POLICY

If we know there are supplies involved we will try to alert you of our charges before you come for your scheduled appointment. Your insurance may deny payment for this _____ service/supply. The patient/responsible party understand that this charge may be non covered and will be responsible for these charges at the time of service.

MEDICAL RECORD POLICY

When requesting disability forms to be completed we will require a \$25.00 payment for the initial form and a \$10.00 payment for follow-up forms in advance of their completion.

PRESCRIPTION POLICY

We ask that you call in your refill request for prescriptions during the hours of 9:00 am – 3:00 pm Monday thru Friday only. Prescription refills from 3:00 pm Friday – 9:00 am Monday are not available.

I have read and understand the financial policies of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Signature of Patient or Responsible Party if a Minor

Date

Signature of Co-responsible Party

Please Print the Name of the Patient

University Surgical Associates

401 East Chestnut St. Suite 710
Louisville, KY 40202

**AUTHORIZATION TO OBTAIN RECORDS FROM ANOTHER DOCTOR
(DISCLOSURE OF PROTECTED HEALTH INFORMATION)**

This authorization, if signed, will authorize University Surgical Associates to obtain certain protected health information that is in the below mentioned entity's possession for the patient named below.

Patient Name: _____ Date of Birth: _____

Patient Address: _____ City, State & Zip _____

I, _____ (patient's name) hereby authorize the following entity _____ (practice or doctor records to be acquired FROM) located at _____

to release or disclose my protected health information described below to Dr. _____ with **University Surgical Associates, PSC** located at **401 East Chestnut St., Suite 710, Louisville, Kentucky 40202.**

_____ Entire Medical Record

Or the specified records as indicated:

	Date(s) of service
_____ History and physical examination	_____
_____ Consultation reports	_____
_____ X-ray reports	_____
_____ Laboratory tests	_____
_____ Operative report	_____
_____ Discharge summary	_____
_____ Progress notes	_____
_____ Photos, videotapes, or digital or other images	_____
_____ Other (please list)	_____

I understand that this information may include information relating to Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, or mental or behavioral health or psychiatric care.

Signature (Patient or Patient's Representative)

Date

Printed Name of Patient's Representative given authority to act for patient

Phone Number

Relationship to Patient

Did you know that your surgeon not only takes care of patients, but:

- Is a Professor of Surgery at the University of Louisville School of Medicine?
- Performs basic, translational, and clinical research to improve patient care?
- Teaches students, residents and fellows who come from around the world to learn the latest surgical procedures and participate in groundbreaking research?

We want to tell you about some of the exciting research and educational programs that are underway in the Department of Surgery at the University of Louisville School of Medicine. We are proud to be nationally recognized for groundbreaking advances in: **Cancer Detection and Treatment, Trauma and Critical Care, Minimally Invasive Surgery, Bariatric Surgery, Digestive Diseases, Endocrine Surgery, Vascular Surgery, Head and Neck Surgery, Plastic and Reconstructive Surgery, Hearing and Speech Disorders, Organ Transplantation, and Surgical Infections.**

A small sampling of our research includes:

1. The Sunbelt Melanoma Trial, a multicenter study that is the largest ever conducted in melanoma with more than 3,600 patients registered. It was conceived, written and directed from the Department of Surgery.
2. Genetic research relating to colorectal cancer and inflammatory bowel disease, which together affect hundreds of thousands of Americans every year. We have been using the latest technology such as gene chips to try to identify the cause of these disorders.
3. Minimally Invasive Parathyroid and Thyroid Surgery. We are one of the first centers to develop and test the procedure of Minimally Invasive Radioguided Parathyroidectomy, which allows patients with parathyroid tumors to undergo a much less invasive yet curative procedure through a small incision. We have also developed techniques for minimally invasive endoscopic thyroid surgery.
4. Studies of sound perception and speech production in children and adults that have undergone cochlear implant surgery
5. The University of Louisville Breast Cancer Sentinel Lymph Node Study, which involves more than 4,000 patients from 79 institutions across the US and Canada. It is the largest study of its kind and is largely responsible for the acceptance of this minimally invasive procedure for patients with breast cancer around the world.

6. Basic research into the molecular basis for the response to trauma, shock, inflammation, and infection.
7. New technologies for the treatment of liver tumors. Over the past decade, we have helped develop and test new minimally invasive techniques for treatment of liver tumors. This allows many patients who previously were not candidates for surgery to eliminate cancer in the liver.
8. New gene therapy approaches to cancer as an alternative to chemotherapy. In the past decade, we have developed several new treatments of liver tumors, colon cancer, pancreatic and stomach cancer, melanoma, breast cancer, and cervical cancer.
9. Studies to evaluate rare endocrine tumors using artificial intelligence.
10. We were one of the first U.S. centers to pioneer the use of the Lap Band System™ and other minimally invasive surgical treatments for obesity. We were the first center in America to perform an intragastric balloon and this was done in the setting of a clinical trial.

This is where you can help.

Research is responsible for the development of new approaches to surgery and the treatment of a variety of conditions and diseases. We have made much progress, yet our work is far from done. With additional funding support, we feel confident we can bring some of these exciting results to our patients more quickly.

Your investment in our research will bear dividends for years to come, helping others facing a diagnosis such as yours. Any amount helps, and you can specify where you would like your money to be used.

If you are interested in investing in our research by making a donation or want to learn more, please contact Larissa Reece by email at lfreec01@gwise.louisville.edu or **502-852-8910** or **1-800-872-8033**. She also may contact you following your treatment to gauge your interest and to discuss your experience with our office. In addition, you can discuss your interest with your surgeon or our office staff any time. You can also visit our Web site at louisvillesurgery.com. Thank you again for your confidence in our program.

If you wish to have your name removed from the list to receive fundraising requests supporting the Department of Surgery, please make your wishes known in writing to: Department of Surgery, Development Office, 530 South Jackson Street; Louisville, KY 40202, and all reasonable efforts will be taken to ensure you will not receive any such communications from us in the future.