CPM Cranford Powell Morris
Advanced Surgical Specialists

NEWNAN BREAST CENTER
Delivering hope one patient at a time.

775 Poplar Road, Suite 350, Newnan, Georgia 30265
Phone: 770-502-2150 Fax: 770-502-2103

PATIENT REGISTRATION FORM

(Please Fill Out Completely and Clearly)

Date: _____ SS# _____

Name: _____ Preferred Name: _____

(Last Name) (First Name) (Middle Initial)

Address: _____

City: _____ State: _____ Zip Code: _____

Sex: ☐ M ☐ F Date of Birth: _____ Age: _____ ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Preferred Contact Number: ☐ Home ☐ Mobile ☐ Work / Time of Day: ☐ Morning ☐ Afternoon ☐ Evening

Email Address: _____ Preferred Method of Confirming Appointments: _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ White/Caucasian ☐ Nat Hawaiian/Pacific Islander

☐ Other Race: _____ ☐ Unknown ☐ Decline to Answer Primary Language: _____

Patient Employed By: _____ Occupation: _____

Business Address: _____ City/State/Zip: _____

If married, spouse's name: _____ Date of Birth: _____ SS# _____

Emergency Contact NOT living with you: _____ Phone Number: _____

Is this visit work related? ☐ Yes ☐ No If yes, date of injury? _____ Claim # _____

How did this injury happen? _____

Referring Physician's Name: _____ Phone Number: _____

Preferred Pharmacy: _____ Phone Number: _____

How did you hear about our practice? _____

Who is responsible for this account? _____ Relationship: ☐ Self ☐ Spouse ☐ Parent

******PLEASE PRESENT YOUR INSURANCE CARD(S) & PHOTO ID FOR TO COPY FOR OUR RECORDS******

Primary Insurance Information

☐ **No Medical Insurance *If you do not have insurance, have you applied for Medicaid? ☐ Yes ☐ No**
*** If yes, what is the name of the case worker you were working with?** _____
☐ **Medicare ☐ Medicaid / Claim ID #** _____

Policy Holder (if different from above): _____ Date of Birth: _____

SS# _____ Relationship: _____ Phone Number: _____

Employers Name: _____ Occupation: _____

Employers Address: _____ City, State, Zip: _____

Primary Medical Insurance Company: _____ Phone Number: _____

Address: _____ City/State/Zip: _____

Policy ID# _____ Group Name: _____ Group # _____

Secondary Insurance Information

Policy Holder (if different from above): _____ Date of Birth: _____

SS# _____ Relationship: _____ Phone Number: _____

Employers Name: _____ Occupation: _____

Employers Address: _____ City, State, Zip: _____

Primary Medical Insurance Company: _____ Phone Number: _____

Address: _____ City/State/Zip: _____

Policy ID# _____ Group Name: _____ Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned, authorize and assign the payment of my medical payments and benefits to CPM Advanced Surgical Specialists otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by insurance for services rendered on my behalf or my dependents. I authorize CPM Advanced Surgical Associates to release any information to complete and process my insurance claims and to secure payment of benefits. I further agree to pay all collection costs, attorney fees, and other collection costs that may be incurred to enforce the collection of any amounts that are outstanding and unpaid. I authorize the use of this signature on all insurance submissions.

*(If Patient is a minor, Signature must be the Responsible Party Signature)

*Signature _____ Date: _____

MEDICARE AUTHORIZATION

I, the undersigned, request that payment of authorized Medicare benefits be made to CPM Advanced Surgical Specialists for any services rendered. I authorize the holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "the other health insurance" is indicated in box 9 of the HCFA-1500 form, or elsewhere on the approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

*(If Patient is a minor, Signature must be the Responsible Party Signature)

*Signature _____ Date: _____

BILLING AND FINANCIAL POLICY

The following sets forth the general Billing and Financial Policy of CPM Advanced Surgical Associates. Please review and sign below where indicated:

- I understand that it is my responsibility to provide the office of CPM Advanced Surgical Associates with current, accurate billing information at the time of check in.

- I understand that my account balance should be paid, including my Primary Care co-pay amount prior to services being rendered.

- I understand that this is a contractual agreement that I have with my health plan and that the practice rendering services also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to make co-pay.

- I understand that if I present an insufficient check (NSF) for payment associated with my care, I will be charged a $35.00 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashiers check or credit card.

- I understand that there is a $30.00 fee to complete disability paperwork associated with my care. I will be provided a standard form free of charge; however if additional disability forms (such as FMLA) requires completion, I understand that the $30.00 fee (payable prior to completion) is required.

- I understand that the clinic will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any elective surgery that I may have. I further understand that it is the policy to collect the deductible and/or coinsurance prior to scheduling my elective surgery. I further understand that the FEE that I am QUOTED is only and ESTIMATE that is based on: First, the anticipated surgery to be performed and second, the current information provided to clinic by my insurance carrier.

- I understand that I will be billed for any amounts due by me and that I have a financial responsibility to pay these amounts in FULL. I understand that I will be provided with two statements for any balance due after the insurance payment is received. I further understand that if I have not made payment prior to the second statement is mailed, that the next statement will be marked FINAL NOTICE and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with collection efforts.

- I understand that the practice will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is NOT a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.

- I understand that the practice may also take a verbal request to use my listed credit card for payment on my account or they may also use the same listed credit card on my account should my account become delinquent or to cover an NSF check and the fee.

  My signature below confirms that I have read these billing policies and my obligation as pertains to the physicians of CPM Advanced Surgical Specialists, LLC.

*(If Patient is a minor, Signature must be the Responsible Party Signature)

*Signature _____ Date: _____

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Privacy Consent – For the Use and Disclosure of Protected Health Information

This consent is required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to CPM Advance Surgical Specialists to use and disclose my protected health information for the purpose of treatment, payment and operations of my healthcare and this practice.

Consent for treatment: I, with my signature, authorize CPM Advance Surgical Specialists and any employee working under the direction of the physician, for the purpose of evaluating my health, diagnosing medical condition, and providing treatment.

Authorization to Pay Benefits to Physician: I hereby authorize payment of medical benefits directly to CPM Advance Surgical Specialists. I understand that co-payments, deductibles, out of pocket expenses and non-covered services are due at the time of service, unless prior arrangements have been made with the office administrator. CPM Advance Surgical Specialists will bill my insurance for services rendered. If my insurance does not pay within 30 days, I understand I am responsible for payment of the bill and/or contacting insurance company to secure payment.

Authorization to Release Information: I hereby authorize CPM Advance Surgical Specialists to release any medical information necessary to process any insurance claim. This may be in the form of copy or medical records or information conveyed via telephone or fax to my insurance and/or any/or any other necessary third party and/or its agents (collectively referred to as "the Plan") I also authorize this facility to disclose any medical information necessary to the Plan to verify services, conduct quality, chart site, or utilization reviews, investigate grievances. The Plan may review my medical chart in your office for proper documentation or for their studies as a measure of quality. My referring physician will receive a copy of your chart notes regarding my visit. This authorization also releases to the Health Care Financing Administration (HCFA) or its medical claims agencies any information referred to as "the Plan." I hereby authorize CPM Advance Surgical Specialists to release any medical information needed to administer Title XVII (the Medicare Program) of the Social Security Act. This authorization is valid until revoked by me in writing.

Consent related to the Privacy Notice: I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand the terms of the Practice Notice may change and I may obtain these revised notes by contacting the Practice Privacy Officer by phone or writing. I understand I have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions.

Patient Name Printed: _____ DOB: _____

Guardian Name Printed: _____

Patient/ Guardian Signature: _____ Date: _____

If not Patient, Relationship: _____

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HIPPA Privacy Act Patient Consent Form

The Health Insurance Portability and Protection Act, H.I.P.P.A requires that all medical providers, insurance companies and others, put in place controls to ensure that your personal medical information is safe.

Our office requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Name of Patient: _____ **Patient Date of Birth** _____

Signature of Patient or Guardian: _____ **Date** _____

Authorization to Release Information to Family Members and/or Friends

Many of our patients allow family members such as their spouse, parents or others such as friends to call and request appointment times, rescheduling of appointment times for the patient, to go over insurance benefits, and/or the request results of tests and procedures. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have this information released to family members and/or friends you must sign this form. Signing this form will only give consent to release appointment times, rescheduling of patient appointment times, to go over insurance benefits, and/or the results of tests and procedure to the family members and/or friends indicated below. This consent form will not allow our office to release any other information about you. This H.I.P.P.A consent is **valid up to one year**. However, you have the right to revoke this consent, in writing prior to expiration of that one year, except where we have already made disclosures in reliance on your prior consent.

I authorize this office to speak with the below listed individuals regarding my appointment times, rescheduling of appointment times, to go over insurance benefits, and/or the results of tests and procedures.

1. Individual Name_____ Relation to Patient: _____

2. Individual Name_____ Relation to Patient: _____

Signature of Patient or Guardian: _____ **Date** _____

Leaving Messages with Household Members/Answering Machine

From time to time it is necessary for our office to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to go over insurance benefits, to notify the patient that we would like to discuss lab or procedure results, or to ask a patient to call us regarding an issue or concern. At no time will our office discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

To serve you better, please complete this entire form.

For Office Use Only:
Height: _____ Weight: _____
BP: _____ Pulse: _____
Temp: _____ O2: _____

Today's Date: _____

Name: _____

Date of Birth: _____

What are you here to be seen for today?

_____

_____

Primary Care Doctor: _____

Do You:

Smoke tobacco? _____Yes _____No
How much? _____
How long? _____

Drink Alcohol? _____Yes _____No
How much? _____
How long? _____

Use drugs? _____Yes _____No
How much? _____
How long? _____

Do you have any medical problems? ____Yes ____No
(i.e.: heart disease, diabetes, high blood pressure)
If yes, please list your medical problems:

_____

_____

_____

List any surgeries, including dates that you have had:

_____

_____

_____

List any medications that you are currently taking:

_____

_____

_____

_____

Are you allergic to anything? ____Yes ____No (If yes, what?)

_____

_____

_____

Please provide the following information about your family:

Father: ____ Alive ____ Passed away
Medical problems:

_____

_____

Mother: ____ Alive ____ Passed away
Medical problems:

_____

_____

Brothers and/or Sister ____ Alive ____ Passed away
Medical problems:

_____

_____

Additional Notes: *(for office use only)*

Please circle any symptoms you may have:

General	Ear, Nose, Throat	Lungs
Fever	Earache	Shortness of Breath
Weight Gain	Change in hearing	Cough
Weight Loss	Nasal Discharge	Wheezing
Chills	Sore Throat	TB/TB exposure
Fatigue		
Head	**Eyes**	**Breasts**
Headaches	Pain	Lumps
Dizziness	Change in Vision	Tenderness
Vertigo		Discharge
Skin	**Neck**	**Lymph Nodes**
Rash	Stiffness	Enlargement
Itching	Mass	Tenderness
Heart	**Genitourinary**	**Musculoskeletal**
Chest pain	Pain with urination	Pain (location?)
Palpitation	Incontinence	_____
Swelling	Urgency	Muscle Weakness
GI		
Nausea	Change in appetite	Stomach pain
Vomiting	Blood in stool	Constipation
Diarrhea		
Hematological	**Metabolic**	**Physiological**
Anemia	Excessive thirst	Depression
Bleeding tendency	Heat or Cold tolerance	Anxiety
Neurological		
Numbness	Location:_____	
Weakness		

Other:

_____

_____