DUCHARME
General Surgery PLLC

DUCHARME GENERAL SURGERY COPAY POLICY

Thank you for choosing Ducharme General Surgery PLLC for your surgical needs; our physician(s) and staff are committed to providing you with the highest quality of care. In order to serve you today, your insurance policy requires our office to collect your assigned copay at the time of your appointment. As your condition requires continued medical attention, our office will assist as best we can to accommodate your needs and ensure your health care requirements are met. If you do not have or are unable to pay your copay at the time of your appointment, please work with our staff in rescheduling your appointment at a time that is convenient for you. As our office will no longer provide statements for assigned copays; we request your assistance in following the compliance measures mandated by your health insurance policy. For patients with a high deductible health insurance policy, this amount will be collected at the time your surgery is scheduled. In consideration of your time and your physician's, our office requests 24-hour notice to cancel or reschedule your scheduled appointment. Any cancelations or rescheduled appointments that do not provide 24-hour notice will be assessed a $25.00 fee. We appreciate your consideration and are available to answer any questions.

Patient Signature_____**Date** _____

1200 N El Dorado Pl, STE E-520. Tucson AZ 85715. Phone (520) 526-2325. Fax (520) 526 2837

Ducharme General Surgery, PLLC

PATIENT REGISTRATION FORM

Account #_____ Date _____

Patient Name:_____M_____F _____

Last First Legal Nickname MI

Is this your legal name? Yes_____No_____If no, what is your legal name? _____

Marital Status: Single_____Married_____Divorce_____Widow_____Spouse's Name: _____

Street Address:_____PO Box:_____Apt/Suite:_____

City:_____State:_____Zip Code:_____Phone # _____

Date of Birth:_____Age:_____Social Security #:_____Cell #: _____

Email:_____Race:_____Language:_____

Your Employer:_____Phone#_____Occupation:_____

Primary Care Physician:_____Phone #: _____

Referring Physician (if different)_____Phone #: _____

Pharmacy Name and Address:_____Phone #: _____

INSURANCE INFORMATION

Are you covered by health insurance? Yes_____No_____**If No, please make payment arrangements with our business office.**

Primary Insurance_____Policy #_____Group # _____

Policy Holder Name_____Policy Holder Date of Birth _____

Social Security Number_____Copay_____

Secondary Insurance_____Policy #_____Group # _____

Policy Holder Name_____Policy Holder Date of Birth _____

Social Security Number_____Copay_____

If this visit related to an at work injury? Yes_____No_____If yes, Employer at time of injury _____

Date of Injury_____Insurance Info_____Claim # _____

EMERGENCY CONTACT

Emergency Contact_____Relationship to Patient _____

Phone #_____Cell #_____Date of Birth _____

ALL PATIENTS

PLEASE COMPLETE AND SIGN THIS RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS

"I hereby authorize Ducharme General Surgery, PLLC to release to or to request from any insurance company, other physician or hospital, any information including the diagnosis and records of any treatment or examination rendered to me during surgical care, including any financial information. This information may be faxed or sent electronically. I also authorize and request my insurance companies to pay directly to the above named corporation the amount due on any pending insurance claim for medical and/or surgical treatment or service. I also understand that if it becomes necessary to refer my account to collections, I will be liable for the reasonable collection fees and court costs expended therein." I understand that there is a $35 pre-paid fee for all disability forms filled out by the physician. The organization reserves the right to charge interest on unpaid accounts.

PATIENT SIGNATURE:_____DATE: _____

(Or parent/guardian if patient is a minor)

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DUCHARME
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Name: _____ Age: _____ Sex: _____
Referring Physician: _____
Primary Care Physician: _____
Preferred Pharmacy Location: _____
Reason for today's visit: _____
Current Height_____Current Weight_____Weight one year ago _____

Current and Past Medical Problems: (please circle Yes or No)

Yes No * Diabetes – when were you diagnosed?
Yes No * Heart Disease – If Yes, What Type? _____
Yes No * Angina (chest pain)
Yes No * High Blood Pressure
Yes No * Stroke – when?_____Any paralysis or deficit? _____
Yes No * Epilepsy or Seizures
Yes No * Cancer (type/treatment): _____
Yes No * Lung Disease: Emphysema Asthma TB Valley Pneumonia
Yes No * Kidney Problems
Yes No * GI Disorders: Diverticulosis Stomach Ulcers Ulcerative Colitis Crohn's Disease Irritable Bowel Disorder
Yes No * Hepatitis – if Yes, What Type? _____
Yes No * Anemia or Blood Disorders
Yes No * Phlebitis or Blood Clots
Yes No * Thyroid Disease: Hyperthyroid Hypothyroid
Yes No * Arthritis
Yes No * Glaucoma: Macular Degeneration Legally Blind
Yes No * Mental Illness
Yes No * Do you have a Pace Maker?

Other:_____
Past Surgical History (please include dates): _____
_____
Have you ever had a blood transfusion? Yes No If Yes, Any Reactions? _____
Have you ever had general anesthesia? Yes No If Yes, Any Problems? _____
PLEASE LIST ALL MEDICATIONS AND DOSAGES: _____
_____
Please circle if you are taking any of the following: Coumadin Daily Aspirin Diabetes Medication
Are you allergic to any medications? Yes_____No_____If Yes, please list the medications and any type of reaction:
_____
Social History: Do you smoke? Yes_____No_____If Yes, packs per day_____How many years_____If quit, when _____
Alcohol Use: Yes_____No_____Drinks per_____day or week
Date of Last Chest X-Ray_____Date of last EKG_____Date of Last Mammogram _____

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REVIEW OF SYSTEMS

PATIENT NAME_____ DATE_____

GENERAL: DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS? **(PLEASE CIRCLE)**

Fever	Sweats	Chills	Headaches	Dizziness
Weight gain or loss	Fatigue	Skin rash	Lymph node swelling	

Other: _____

HEART, LUNGS, VASCULAR:

Coughing/wheezing Irregular heartbeat Chest tightness/pain Leg swelling
Coughing up blood Last Chest X-ray_____Last EKG_____Leg ulcers
Other: _____

STOMACH DIGESTION:

Changes in appetite Constipation/diarrhea Change in bowel habits Nausea/vomiting
Indigestion/heartburn Bloody/black stools Hemorrhoids Yellow color to skin/eyes Abdominal bloating/swelling Bulges visible on the abdominal wall

Stomach pain that occurs after eating? If yes, what food types? _____
Last rectal exam _____
Have you ever had a lower bowel exam with a scope? If yes, when? _____
Have you ever had an exam with a scope looking at the stomach? If yes, when? _____
Have you ever been to see a GI specialist? If yes, who? _____
Other: _____

KIDNEY, URINATION:

Frequent urination	Urination at night	Pain with urination	Blood in urine
Hard to start/stop flow	Enlarged prostate	Impotence	

Prostate cancer – if yes, what type of treatment? _____
Other: _____

FUNCTIONAL:

Depression Anxiety Difficulty sleeping Under Psychiatric care
Other: _____

FEMALE MEDICAL HISTORY:

Number of pregnancies_____Number of children_____Number of vaginal deliveries _____
C-sections YES/NO Are you currently pregnant? YES/NO Last menstrual period _____ Are your periods painful? YES/NO
Do you have abnormal vaginal bleeding or discharge? YES/NO Do you currently have any palpable breast lumps? YES/NO
Do you have painful breasts? YES/NO if YES, is the pain related to your menstrual cycle? YES/NO
Do you have nipple discharge? YES/NO if YES, what color is the discharge?_____ Do you have a family history of breast cancer? YES/NO

FAMILY HISTORY:

Mother _____
Father_____
Siblings_____

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DUCHARME GENERAL FINANCIAL POLICY

Thank you for choosing Ducharme General Surgery, PLLC for your surgical needs. The physicians and staff are committed to providing you with the highest quality of care. This following financial policy is in place to assist you with any questions you may have regarding your financial obligation to this practice. We ask that you please review and confirm with your signature below. All billing is completed as a courtesy to our patients on behalf of their health insurance provider. Patients are financial responsible for all medical services.

INSURANCE

Although we are participants of many insurance companies, it is ultimately your responsibility to confirm that Ducharme General Surgery, PLLC or your individual doctor, is in fact a provider for your particular insurance. We will submit a claim for payment for your services to your insurance as a courtesy, but you are responsible for any copays or deductibles not covered by your insurance. These are collected at time of service. If you are billed for any balance, payment is required within 30 days of receipt of a bill. Secondary insurance claims are filed as a courtesy, and become the responsibility of the patient if payment is not received within 60 days of filing a claim. It is your responsibility to be aware of your benefits with your insurance. If your insurance information, copay, or coverage has changed at any time during your treatment, it is your responsibility to notify the office with the most current and up-to-date information.

PATIENT RESPONSIBILITY

Copayments and deductibles are due prior to being seen. If you require a bill sent to you for your copay, a $10.00 processing fee will be added to your balance. It is your responsibility to provide us with any referral required from your insurance. Any service deemed "non-covered" by your insurance will be your responsibility. If you do not have insurance, or we are not contracted with your particular insurance, you will be required to pay for services prior to receiving them. "Self-pay" accounts are eligible for a discount, which is due prior to any services; NO payment arrangements are made when any discounts have been applied. If a circumstance arises where payment arrangements are approved, the discount will be taken after all payments are received. If you fail to adhere to your payment agreement, your full balance along with additional fees will be assigned to a collection agency. If your account is referred to a collection agency, you will be responsible for all costs. If you need to reschedule or cancel your office appointment please contact our office 24 hours prior to your appointment to avoid a $25.00 fee. All appointments that are rescheduled a third time will require a prepayment charge of $25.00 which, is not associated with your required copay.

PAYMENT METHODS

For your convenience, acceptable forms of payments are; cash, check, money order, VISA, MasterCard, American Express, or Debit cards. Please note: if a personal check is returned for insufficient funds, there will be a $25.00 fee added to your account.

BILLING INQUIRIES

If you have any questions regarding a bill you received from our office, please feel free to contact our Business Office at (520) 722-3777. Our office hours are 8:00am – 5:00pm.

Thank you for allowing Ducharme General Surgery, PLLC to be an important part of your medical care. For any further questions or concerns our staff is available to assist you.

ACKNOWLEDGEMENT AND AUTHORIZATION

I have read, and understand, and agree to the above financial policy. Regardless of my insurance status, I am ultimately responsible for payment for any professional services rendered. I authorize the release of any medical information necessary to process a claim for benefits under my policy and assign payment to Ducharme General Surgery, PLLC.

Signature_____**Date** _____

DUCHARME
General Surgery PLLC

Authorization for Use and Disclosure of Protected Health Information

Printed Name:_____Date of Birth: _____

Address:_____

Social Security #:_____Telephone:_____

Information To Be Released – Covering the Periods of Health Care

From (date)_____To (date) _____

Please check type of information to be released:

☐ Entire medical record	☐ Pathology report	☐ Discharge summary
☐ History and physical exam	☐ Consultation reports	☐ Progress notes
☐ Laboratory test results/reports	☐ X-ray reports	☐ X-ray films / images
☐ Operative report	☐ Emergency room record	☐ Itemized bill

Other (specify):_____

I authorize the individuals listed below to receive my medical information:

Name:_____

Address:_____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B & C testing, and/or other sensitive information, I agree to its release.

Check one and initial

☐ Yes	Initials
☐ No	

I understand that if my medical or billing record contains information in reference To HIV/AIDS (Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

Check one and initial

☐ Yes	Initials
☐ No	

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time, I can revoke this authorization by submitting a notice in writing to the Privacy Officer at Ducharme General Surgery, PLLC 1200 N. El Dorado Pl. Suite, E520– Tucson, AZ 85715. This authorization is valid for a period of six months from date of signature.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization. However, authorization to release my medical records will be denied if I do not sign this form as specified.

I authorize Ducharme General Surgery, PLLC to release the protected health information specified above.

Signature:_____Date:_____

Authority to Sign if not patient:_____Verified By: _____

Identity of Requestor Verified via: ☐ Photo ID ☐ Matching Signature ☐ Other (specify): _____

Ducharme General Surgery Pain Management Policy & Consent

1. Your physician will not prescribe any narcotics, pain pills, etc. other than over the counter medications prior to your scheduled operation.
2. After your operation, hospital inpatients will receive pain medications as determined by their daily inpatient assessment.
3. As a Ducharme General Surgery PLLC patient, one refill for pain medications may be prescribed upon your discharge from hospital.
4. At the physician's discretion, one refill for pain medication may be prescribed at your post-operative appointment.
5. In consideration of continued follow-up care, unless a surgical complication exists, there will be no further pain medications prescribed.
6. At their discretion, the covering physician may prescribe a small quantity of pain medication determined adequate until your surgeon returns.
7. There will be no pain medications prescribed after 12pm Friday, please contact the office after 8am Monday for any pain medication request.

I understand and agree to the following:

- I will candidly provide my physician with a complete and accurate treatment and medication history, including past medical records, past pain treatment, psychiatric history, and alcohol and other drug addiction history.
- I will take my medication as directed by my physician and will not horde, sell or share my medication.
- Because alcohol and other recreational drugs should not be mixed with narcotics, I will not take them while receiving treatment.
- I will inform my physician before taking naturopathic products or over-the-counter medications.
- I will **not** obtain narcotics from any other physician, including associates of my physician who may be taking his/her calls.
- I will obtain narcotics from one pharmacy and notify my physician of any changes in the pharmacy.
- I understand that if my narcotic medication should be lost, destroyed, stolen, etc., my physician will **not** refill it until time for the next regular refill.
- I understand that my physician may share information regarding my care and treatment with other providers as necessary for my continued care.
- I understand that no guarantee or assurance has been made as to the results of the treatment.
- **Female Patients:** I affirm that I am not pregnant and that I will immediately notify my physician if I plan to or do become pregnant.

I have read and fully understand this form. I understand I should not sign if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this form. I have no further questions.

Do not sign unless you have read and thoroughly understand this form.
By refusing to sign this consent, I understand no further prescriptions will be issued.

By signing this form, I am stating that I have read, understand, consent and agree to the above.

_____ _____

PATIENT | LEGAL REPRESENTATIVE DATE

_____ _____

WITNESS'S SIGNATURE DATE