



Somerset Surgical Specialists

PATIENT INFORMATION

Patient Name _____ Sex: M F Today's Date _____
Preferred Name _____ Preferred Pronoun He She Other _____
Marital Status _____ Name of Spouse (if applicable) _____
Social Security Number _____ Date of Birth _____ Age _____
Preferred Language: English Spanish Other Ethnicity: Hispanic Non-Hispanic Refuse to report
Street Address _____ City _____ State _____ Zip _____
Home Phone # _____ Cell Phone # _____
Student Yes No School _____
Employer _____ Length of Employment _____
Email Address _____
By providing your email, you will be invited to register in our patient portal.

EMERGENCY CONTACT

Name/Relationship _____ Contact # _____

REFERRING PHYSICIAN INFORMATION

Referring Physician _____
Phone # _____ Fax # _____
Street Address _____ City _____ State _____ Zip _____
Primary Physician _____
Phone # _____ Fax # _____
Street Address _____ City _____ State _____ Zip _____

PHARMACY

Name of Pharmacy _____ City _____
Phone # _____ Fax # _____

CONSENT FOR RXHUB INQUIRY

I hereby provide my consent for Somerset Surgical Specialists to obtain my Rx history using the Surescripts RxHub Network. I understand this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Management (PBM) and retail pharmacies. I also understand that Surescripts RxHub follows strict security protocols to align with HIPPA requirements and respects patient privacy. All queries and responses are made automatically through secure system to system communications.

Your Name: _____ Signature: _____



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ALLERGIES:

Yes No

If yes, please list: _____

Reaction to allergy: _____

Your past surgical history: (Check all that apply & indicate year)

- appendectomy gallbladder hysterectomy hernia repair
- breast surgery colon surgery peripheral vascular surgery
- heart: type _____ orthopedic: type _____ transplant type: _____
- cancer: type _____ cosmetic: type _____

Detailed explanation or other surgery: _____

Your past hospitalization:

If any, please list the date and reason

Date: _____ Reason: _____

Date: _____ Reason: _____

Date: _____ Reason: _____

Family History: (Check all that apply)

	Diabetes	High BP	Heart Problems	Stroke	Mental Illness	Cancer	Other
Grandfather Maternal							
Grandfather Paternal							
Grandmother Maternal							
Grandmother Paternal							
Father							
Mother							
Siblings							
Children							



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Name: _____

Your social history:

Do you presently smoke tobacco? yes no former thinking of quitting

How many per day? _____

Do you use a ecigarette or vape? yes no former thinking of quitting

Do you drink alcohol? yes no How many drinks per week? _____

Do you smoke marijuana? yes no Frequency _____

Use cocaine and/or heroin? yes no Frequency _____

Other illicit drugs? yes no Frequency _____

Current Symptoms: (Check all that apply)

General: weakness chills fever night sweats sleep disturbance

Allergy Immunology: current infection chornic steriod use

Eyes: double vision temporary loss of vision blurred vision

Endocrine: hot flashes cold intolerance excessive thirst

Respiratory: chronic cough shortness of breath at rest wheezing

Cardiovascular: chest pain with exertion palpitations shortness of breath

Gastrointestinal: constipation diarrhea exposure to hepatitis vomitting
 unexplained weight gain/loss

Hematology: anemia blood clot/deep vein thrombosis prolonged bleeding

Genitourinary: blood in urine frequent urination painful urination

Musculoskeletal: arthritis muscle aches painful joints

Skin: ulcers eczema keloid formation

Neurologic: dizziness fainting seizures

Phychiatric: anxiety depressed mood difficulty sleeping

Detailed explanation: _____



Authorization to Use and Disclose Health Information

I give the following individuals permission to discuss or to receive any medical documentation from this office.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

I give permission to have messages left on my voicemail at the following telephone number (s):

Home: _____

Cellular: _____

Business: _____

**SIGN BELOW IF YOU DECLINE TO SHARE YOUR MEDICAL
DOCUMENTATION FROM THIS OFFICE WITH ANYONE OTHER THAN
YOUR MEDICAL PHYSICIANS**

Patient Signature: _____ Date: _____



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Payment Policy

To patients who have insurance policy with which Somerset Surgical Specialists participates:

All copayments, coinsurances, and deductibles are the insured/patient's financial responsibility. Copayments are due at the time of check-in. Any deductibles and/or co-insurance are to be collected prior to surgical procedures as determined by your insurance contract. Remaining balances not covered by the insured/patient's insurance company are due within 30 days from the time of service. For emergent procedures that took place prior to today, a minimum payment of \$300 towards the balance and a payment agreement must be signed for the remaining balance.

To patients who have an insurance policy with out-of-network (OON) benefits with which Somerset Surgical Specialists does not participate:

You will not receive any surprise medical bills and you will NOT be balance billed. Our surgeons, although out-of-network for your insurance, will be providing services at an in-network hospital or surgery center, therefore you are protected under the No Surprises Act of 2022.

When you get services at an in-network hospital or ambulatory surgical center, out-of-network (OON) providers may ONLY bill you based on your plan's in-network cost-sharing amount. This applies to emergency medicine, surgeon, assistant surgeon, anesthesia, pathology, radiology, laboratory, neonatology, hospitalist, or intensivist services. These providers **cannot** balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, OON providers cannot balance bill you, unless you give written consent and give up your protections. **You are never required to give up your protections from balance billing. You also are not required to get care OON. You can choose a provider or facility in your plan's network.**

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay OON providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.



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- Base what you owe the provider or facility (cost-sharing) on what you would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and in-network out-of-pocket limit.

If you believe you've been wrongly billed, please visit www.cms.gov/nosurprises or call 1-800-985-3059.

To patients who are have an insurance policy with NO out-of-network benefits with which Somerset Surgical Specialists does not participate:

You will be charged your regular in-network copayment or deductible for your office consultation. If your case meets special criteria, we will try to apply for an exception for your insurance to cover surgery with one of our surgeons, even though you have no out-of-network benefits. This can be successful if: you have a complicated problem that is best cared for by one of our highly trained surgeons, nobody else in the area is trained to take care of your surgical problem, you have a previous relationship with one of our surgeons, or your primary care physician (or specialist: urologist, gastroenterologist, oncologist) recommended surgery by one of our surgeons. Typically, these exceptions take 4-6 weeks. If you need surgery sooner, then you may have to find another surgeon, or go to the emergency department.

To patients who are uninsured:

All office visits must be paid in full at the time of service. Planned procedures must be paid in full 1 week prior to the surgery date. For emergent procedures that took place prior to today, a \$300 payment must be made towards the balance and a payment agreement must be signed for the remaining balance.

Applicable to all patients:

Any outstanding balances must be paid in full prior to any new appointments being made. Outstanding balances that are more than 60 days past due may be referred to an outside collection agency and will be subject to a collection fee of 25% of the outstanding balance, unless we receive a letter of financial hardship or request to set-up a payment plan. Patients who have been sent to collections will be discharged from the practice until the balance is paid in full.



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Missed or Cancelled Appointments:

The office requires a 24-hour notice if an appointment needs to be canceled or rescheduled. Failure to provide notice will result in a **\$75 no-show** fee. For any returned check, there will be a fee of **\$30** applied to the account. You may request a copy of your operative report, consultation, and pathology report at no charge one time. Any additional requests for records will be a fee of **\$10**. There is no fee for disability paperwork to be filled out after surgery (one time). If you require disability or leave of absence paperwork to be filled out prior to surgery, or request an extension on disability, then there will be a fee of **\$10**.

By signing below, I acknowledge that I have read the payment policy. I understand that I **will NOT** be balance billed for out-of-network surgery performed at an in-network facility (hospital or surgery center) because I am protected according to the law. I **do NOT** waive my protections set forth by the No Surprises Act of 2022. I will only be responsible for in-network copayment, deductible, and out-of-pocket costs.

Print Name:

Signature:

Date: