Independence Surgical Clinic
Division of Signature Medical Group
Pascal E. Spehar, MD, FACS • Jared B. Smith, MD FACS • Mindi S.T. Beahm, MD

PLEASE PRINT CLEARLY, COMPLETING EACH ITEM.	**DATE:**	
Name ***(First, M.I, Last.):***	❑ **M** ❑ **F**	**Date of Birth:**
Marital status: ❑ **Single** ❑ **Partnered** ❑ **Married** ❑ **Separated** ❑ **Divorced** ❑ **Widowed**		
Address:	**City, State, Zip:**	
Social Security No.:	**Home Phone:**	**Cell Phone:**
Occupation:	**Employer:**	**Employer Phone No.:**
Referring Physician:	**Primary Care Physician:**	**Email:**

IN CASE OF EMERGENCY

Emergency Contact:	**Relationship to Patient:**	
Home Phone No.:	**Cell Phone No.:**	**Work Phone No.:**

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate Primary insurance:		
Subscriber's Name:	**Subscriber's Date of Birth:**	**Subscriber's Social Security:**
Policy/ID No.:	**Group No.:**	**Specialty Co-payment:**
Patient's relationship to subscriber/self:		

Name of Secondary insurance (if applicable)		
Subscriber's Name:	**Subscriber's Date of Birth:**	**Subscriber's Social Security:**
Policy/ID No.:	**Group No.:**	**Patients relationship to subscriber/self:**

Is this visit related to a Workman's Compensation Insurance Claim?	**Date:**

RACE/ETHNICITY FORM

Independence Surgical Clinic, INC a division of Signature Medical Group is required by law to provide the Missouri State Agencies with information regarding the race and ethnicity of their patient population. Our mission is to plan for and support the development of a healthcare system that meets the current and future healthcare needs of their patients. In doing so, we ask that you assist us in providing this information by making the most appropriate selection regarding race and ethnicity from the choices listed below.

Ethnicity:	❑ **Hispanic**	❑ **Non-Hispanic**	❑ **Decline Response**
Preferred Language:	❑ **English**	❑ **Spanish**	❑ **Other**
Race:	❑ **American-Indian or Alaskan native**	❑ **Black/African American**	❑ **Hispanic**
	❑ **Native Hawaiian or other Pacific Islander**	❑ **White**	❑ **Other**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Independence Surgical Clinic, INC a division of Signature Medical Group or insurance company to release any information required to process claims.

Signature of Patient/Patient Representative Date

PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECK, MASTERCARD, VISA, AND DISCOVER.

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Patient Financial Policy Statement

The physicians and staff of Independence Surgical Clinic, INC a division of Signature Medical Group are here to serve your needs as our patient. Our PATIENT FINANCIAL POLICY is intended to describe our expectations regarding the payment for services we provide. Please note that payment is due at the time of service.

Our staff is prepared to provide patients with any assistance or resources in making arrangements for services. We can help patients contact the appropriate entities to obtain documents needed to ensure proper payment such as referrals and pre-authorizations for procedures. We ask that patients recognize their responsibility to understand what services their insurance covers as well as what documents are required to assure payment is made.

THE PATIENT FINANCIAL POLICY details the expectations of our medical group as they relate to patients making payments for services. Patients should acknowledge the following policy requirements:

1. The patient or their designated guarantor is responsible for payment of services.
2. All office charges, co-payments, co-insurance, and applicable deductible amounts are due at the time of service.
3. The provision of an insurance card for payment of services will be filed on behalf of the patient; however, the patient is still responsible for payment if their insurance coverage fails to adequately provide payment in a timely or appropriate manner. If you do not have your insurance card you are considered a self-pay patient.
4. It is the obligation of the patient to obtain and provide any referral notifications required by the patient's insurance carrier. Without the appropriate referral the patient's appointment may be rescheduled.
5. Arrangements for co-insurance payments must be made prior to the scheduled surgery date in order to prevent possible delays in surgery.
6. Patient account balances are due within 30 days of the receipt of the billing statement.
7. Account balances over 60 days old may be charged interest at the highest rate allowed by the law.
8. Patients may contact our patient accounts representative to make payment arrangements. After 90 days, if no arrangements have been made for payment, or if no payments have been received, then collection proceedings will begin.
9. Delinquent accounts may be assigned to a collection agency. All collection costs, including legal fees will be added to your outstanding account balance and will become an additional cost to you. We will not be held responsible for any collection agency or legal fees.
10. From time to time, various forms including to but not limited to disability and FMLA forms need to be filled out. There is a $25.00 fee to complete each form. There is a $35.00 fee to copy medical records.
11. We accept MasterCard, Visa and Discover Cards. Checks returned for closed accounts or non-sufficient funds will be charged a $30.00 service fee and sent to the respective state reporting agencies.

Signature of Patient/Patient Representative Date

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Acknowledgement of Receipt of Notice of Privacy Practices

I give Independence Surgical Clinic, INC a division of Signature Medical Group permission to disclose my protected health information to the following individuals involved in my health care and/or payment for health care goods and services. ***If you decline to give such permission, leave the following blank.***

Spouse:	Phone Number:
Children:	Phone Number:
Other:	Phone Number:

I give Independence Surgical Clinic, INC a division of Signature Medical permission to leave a message with the person who answers the telephone or voice-mail message at the most current telephone number on file concerning appointment reminders or requesting that I contact my health care provider. ***If you decline to give such permission, leave the following blank.***

Telephone Number(s):

I give Independence Surgical Clinic, INC a division of Signature Medical permission to contact me at the following telephone number or send a message to the most current e-mail on file to notify me of any breach of my protected health information. ***If you decline to give such permission, leave the following blank.***

Telephone Number(s):	❑ Same as above
Email Address:	❑ Same as above

TERMINATION, RELEASE, COPIES AND FACSIMILES

This release shall terminate on the first to occur of: (1) two years following my death, or (2) upon my written revocation actually received by the covered entity. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, electronic mail, or any other receipt evidencing actual receipt by the covered entity. This release shall not be affected by my subsequent disability or incapacity. There are no exceptions to my right to revoke this release. Each covered entity that acts in reliance on this release shall be released from liability which may result from disclosing my individually identifiable health information and other medical records. Copies or facsimiles of this release shall be as valid as the original release.

I acknowledge that I have received a copy of Independence Surgical Clinic, INC a division of Signature Medical Notice of Privacy Practices with the effective date of July 01, 2015.

_____ _____

Signature of Patient/Patient Representative (Expires one year from date signed) Date

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AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As set forth more fully in our "Notice of Privacy Practices," we are required by law to obtain your authorization for any use or disclosure of your health information for purposes other than treatment, payment or health care operations. In our "Notice of Privacy Practices," we provided you information about how Independence Surgical Clinic, INC a division of Signature Medical Group can use or disclose your health information. You have a right to review our "Notice of Privacy Practices" before signing the authorization.

Patient Name: DOB: SSN:

Address City, State, Zip Phone Number

I hereby authorize **Independence Surgical Clinic, INC a division of Signature Medical Group**

To release to_____
(Insert name and address who is authorized to receive the protected health information)

the following patient records including care and treatment relating to mental health conditions, drug or alcohol abuse, HIV testing, infection status, or care and treatment for AIDS:

- ❑ Medical Records
- ❑ Radiology Reports
- ❑ Laboratory Reports
- ❑ Other

for the following purposes: _____
(Describe the purpose of the requested use or disclosure)

RESTRICTIONS: Only medical records that have originated through this health care facility will be photocopied. This consent shall remain in effect for one (1) year from the date executed unless revoked earlier by me. If revoked earlier, it is understood by all parties that the information released prior to being notified of such revocation was made at my request with my consent Independence Surgical Clinic, INC a division of Signature Medical Group may not require that you sign this Authorization to receive treatment. Once release of this information is made to the above named person or persons, your information may be subject to re-disclosure by that person or persons. A photo static copy of this consent and authorization shall be considered as effective and valid as the original.

_____ _____
Signature of Patient/Patient Representative Date

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*	❑ M ❑ F	**DOB:**

PERSONAL HEALTH HISTORY		
Please list any current or past medical history and or treatment (Heart problems, Diabetes, Cholesterol, etc.)		
Surgeries		
Year	Reason	Hospital
Date of Last Physical Exam:		
Have you ever had a colonoscopy?	❑ Yes	❑ No

SOCIAL HISTORY

Do you smoke or use tobacco products? ❑ Yes ❑ No
Frequency _____

Have you ever smoked or used tobacco products? ❑ Yes ❑ No
When? _____

Do you drink? ❑ Yes ❑ No Frequency _____

Do you take drugs for any reasons that are not medical?

❑ Yes ❑ No If yes, please list _____

FAMILY HEALTH HISTORY

Under Siblings please write Brother or Sister
Under Grandmother & Grandfather please write Maternal (mother) or Paternal (father)

	MOTHER	FATHER	SIBLINGS	GRANDMOTHER	GRANDFATHER	CHILDREN	AUNT	UNCLE
Anesthetic Problems								
Cancer – Breast								
Cancer – Colon								
Cancer – Pancreatic								
Cancer – Prostate								
Cancer – Other **List type**								
Diabetes								
Heart Disease								
High Blood Pressure								
Stroke								

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Name *(Last, First, M.I.):*	❑ M ❑ F	**DOB:**

ALLERGIES TO MEDICATIONS (INCLUDE TYLENOL, ASPIRIN, VITAMINS, OVER THE COUNTER MEDS, HERBAL REMEDIES, SUPPLEMENTS, ETC…)	
Name the Drug	**Reaction you had**
Allergies to	**Reaction you had**
❑ Latex	
❑ Adhesive tapes	
❑ Betadine	
❑ Foods	

MEDICATIONS

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

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Name *(Last, First, M.I.):*	❑ M ❑ F	**DOB:**

MENTAL HEALTH		
Do you have anxiety?	❑ Yes	❑ No
Do you feel depressed?	❑ Yes	❑ No
Do you hallucinate?	❑ Yes	❑ No
Have you ever attempted suicide?	❑ Yes	❑ No
Have you ever seriously thought about hurting yourself?	❑ Yes	❑ No
Do you have trouble sleeping?	❑ Yes	❑ No
Have you ever been to a counselor?	❑ Yes	❑ No

WOMEN ONLY

Number of pregnancies:	Number of live births:	Are you pregnant or breastfeeding?	
When was your last Breast Exam/Mammogram?			
Experienced any recent breast tenderness, lumps, or nipple discharge?		❑ Yes	❑ No
Date of last pap and rectal exam?			
❑ Painful urination	❑ Irregular periods	❑ Discharge	
❑ Frequency	❑ Urgency	❑ No Problems	

MEN ONLY

Do you usually get up to urinate during the night?	❑ Yes	❑ No
If yes, # of times		
Do you feel pain or burning with urination?	❑ Yes	❑ No
Any blood in your urine?	❑ Yes	❑ No
Do you feel burning discharge from penis?	❑ Yes	❑ No
Has the force of your urination decreased?	❑ Yes	❑ No
Any testicle pain or swelling?	❑ Yes	❑ No
Date of last prostate and rectal exam?		
❑ Testicular mass	❑ No problems	

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SIGNATURE MEDICAL GROUP OF KC, P.A. ("SIGNATURE")

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND SHARED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes the privacy practices of Signature. It applies to the health services you receive at Signature, including all Divisions within Signature. Signature will be referred to herein as "we" or "us." We will share your health information among ourselves to carry out our treatment, payment, and health care operations.

1. Our Privacy Obligations. The law requires us to maintain the privacy of certain health information called "Protected Health Information" ("PHI"). Protected Health Information is the information that you provide us or that we create or receive about your health care. The law also requires us to provide you with this Notice of our legal duties and privacy practices. When we use or disclose (share) your Protected Health Information, we are required to follow the terms of this Notice or other notice in effect at the time we use or share the PHI. Finally, the law provides you with certain rights described in this Notice. Furthermore, we are required to notify you following a breach of unsecured PHI.

2. Ways We Can Use and Share Your PHI Without Your Written Permission (Authorization). In many situations, we can use and share your PHI for activities that are common in many hospitals and clinics. In certain other situations, which we will describe in Section 3 below, we must have your written permission (authorization) to use and/or share your PHI. We do not need any type of permission from you for the following uses and disclosures:

A. **Uses and Disclosures for Treatment, Payment and Health Care Operations.** We may use and share your PHI to provide "Treatment," obtain "Payment" for your Treatment, and perform our "Health Care Operations." These three terms are defined as:

i. **Treatment.** We use and share your PHI to provide care and other services to you--for example, to diagnose and treat your injury or illness. In addition, we may contact you to provide appointment reminders or information about treatment options. We may tell you about other health-related benefits and services that might interest you. We may also share PHI with other doctors, nurses, and others involved in your care.

ii. **Payment.** We may use and share your PHI to receive payment for services that we provide to you. For example, we may share your PHI to request payment and receive payment from Medicare, Medicaid, your health insurer, HMO, or other company or program that arranges or pays the cost of some or all of your health care ("Your Payor") and to confirm that Your Payor will pay for health care. As another example, we may share your PHI with the person who you told us is primarily responsible for paying for

your Treatment, such as your spouse or parent. However, if you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with Your Payor. We will follow your request unless a law requires us to share that information.

iii. **Health Care Operations.** We may use and share your PHI for our health care operations, which include management, planning, and activities that improve the quality and lower the cost of the care that we deliver. For example, we may use PHI to review the quality and skill of our physicians, nurses, and other health care providers.

iv. **Business Associates.** In addition, we may share PHI with certain others who help us with our activities, including those we hire to perform services.

B. **Your Other Health Care Providers.** We may also share PHI with your doctor and other health care providers when they need it to provide Treatment to you, to obtain Payment for the care they give to you, to perform certain Health Care Operations, such as reviewing the quality and skill of health care professionals, or to review their actions in following the law.

C. **Disclosure to Relatives, Close Friends and Your Other Caregivers.** We may share your PHI with your family member/relative, a close personal friend, or another person who you identify if we: (1) first provide you with the chance to object to the disclosure and you do not object; (2) reasonably infer that you do not object to the disclosure; or (3) obtain your agreement to share your PHI with these individuals. If you are not present at the time we share your PHI, or you are not able to agree or disagree to our sharing your PHI because you are not capable or there is an emergency circumstance, we may use our professional judgment to decide that sharing the PHI is in your best interest. We may also use or share your PHI to notify (or assist in notifying) these individuals about your location and general condition.

D. **Public Health Activities.** We are required or are permitted by law to report PHI to certain government agencies and others. For example, we may share your PHI for the following:

i. to report health information to public health authorities for the purpose of preventing or controlling disease, injury, or disability;

ii. to report abuse or neglect to government authorities, including a social service or protective services agency, that are legally permitted to receive the reports;

iii. to report information about products and services to the U.S. Food and Drug Administration;

iv. to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of developing or spreading a disease or condition;

v. to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance; and

vi. to prevent or lessen a serious and imminent threat to a person for the public's health or safety, or to certain government agencies with special functions such as the State Department.

E. **Health Oversight Activities.** We may share your PHI with a health oversight agency that oversees the health care system and ensures the rules of government health programs, such as Medicare or Medicaid, are being followed.

F. **Judicial and Administrative Proceedings.** We may share your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

G. **Law Enforcement Purposes.** We may share your PHI with the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a subpoena.

H. **Decedents.** We may share PHI with a coroner, medical examiner or funeral director as authorized by law. The personal representative of the decedent has the authority to exercise rights regarding the decedent's health information such as authorizing certain uses and disclosures of the information. We may share your PHI with a family member who was involved in your care or payment for your care prior to death, unless such disclosure would be inconsistent with any prior expression you have communicated to us. Under federal law, PHI does not include individually identifiable health information regarding a person who has been deceased for more than 50 years.

I. **Organ and Tissue Procurement.** We may share your PHI with organizations that facilitate organ, eye, or tissue procurement, banking, or transplantation.

J. **Research.** We may use or share your PHI if the group that oversees our research, the Institutional Review Board/ Privacy Board, approves a waiver of permission (authorization) for disclosure or for a researcher to begin the research process.

K. **Workers' Compensation.** We may share your PHI as permitted by or required by state law relating to workers' compensation or other similar programs.

L. **Disaster Relief.** We may share your PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

M. **School Immunization Requests.** We may share your PHI for purposes of school immunization requests if the school is required by law to have documentation of such immunization(s) for enrollment.

N. **Fundraising.** We may contact you to raise funds for Signature Medical Group, Inc. You may tell us you do not wish to be contacted for this purpose, and will agree to remove you from the list. To do so, please contact the Privacy Officer.

O. **As required by law.** We may use and share your PHI when required to do so by any other law not already referred to above.

3. Uses and Disclosures Requiring Your Written Permission (Authorization).

A. **Use or Disclosure with Your Permission (Authorization).** For any purpose other than the ones described above in Section 2, we may only use or share your PHI when you grant us your written permission (authorization). For example, you will need to give us your permission before we send your PHI to your life insurance company.

B. **Marketing.** We must also obtain your written permission (authorization) prior to using your PHI to send you any marketing materials paid for by a third party. However, we may communicate with you face to face about products or services related to your treatment, case management, or care coordination, or alternative treatments, therapies, health care providers, or care settings. For example, we may not sell your PHI without your written authorization.

C. **Uses and Disclosures of Your Highly Confidential Information.** Federal and state law requires special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including: (1) any portion of your PHI that is kept in psychotherapy notes; (2) about mental health and developmental disabilities services; (3) about alcohol and drug abuse prevention, treatment and referral; (4) about HIV/AIDS testing, diagnosis or treatment; (5) about sexually transmitted disease(s); (6) about genetic testing; (7) about child abuse and neglect; (8) about domestic abuse of an adult with a disability; (9) about sexual assault; or (10) In Vitro Fertilization (IVF). Before we share your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written permission.

4. Your Rights Regarding Your Protected Health Information.

A. **For Further Information; Complaints**. If you want more information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we made about access to your PHI, you may contact our HIPAA Privacy Officer. You may also file written complaints with the Office for Civil Rights ("OCR") of the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. We will not take any action against you if you file a complaint with us or with the OCR.

B. **Right to Receive Confidential Communications.** You may ask us to send PHI to a different location than the address that you gave us, or in a special way, or to contact you at a different phone number. You will need to ask us in writing. For example, you may ask us to send a copy of your medical records to a different address than your home address. We will accept all reasonable requests.

C. **Right to Revoke Your Written Permission (Authorization).** You may change your mind about your authorization or any written permission regarding your PHI by giving or sending a written "revocation statement" to the Privacy Officer at the address below. The revocation will not apply to the extent that we have already taken action where we relied on your permission.

D. **Right to Inspect and Copy Your Health Information.** You may request copies (for a reasonable fee) and/or access to your medical record file, billing records, and other records. You have a right to a copy of your records, if part of a "designated record set" in

electronic format, as reasonably available. You can review your medical records and/or ask for hard copies. Under limited circumstances, we may deny you access to a portion of your records. If you want to receive a copy of your records, you may obtain a record request form from Signature. Return the completed form to your Signature provider.

E. **Right to Amend Your Records.** You have the right to request that your PHI be corrected if you believe it contains a mistake or is missing information in medical record files used to make decisions about your Treatment and payment for your Treatment. If you want to amend your records, you must tell us the reason for the change in writing by completing the amendment request form you can obtain from the Privacy Officer or your provider. After which, you can return the completed form to the Privacy Officer. We may deny your request if: (1) it does not include a reason for the change; (2) the information you want to change was not created by Signature or is not part of the medical record kept by Signature; or (3) the information contained in the record is complete and accurate.

F. **Right to Receive an Accounting of Disclosures.** You may ask for an accounting of certain disclosures of your PHI made by us. These disclosures must have occurred before the time of your request, and we will not go back more than six (6) years before the date of your request. If you request an accounting more than once during a twelve (12) month period, we will charge you based on the rate sheet. Direct your request for an accounting to the Signature Privacy Officer.

G. **Right to Request Restrictions.** You have the right to ask us to restrict or limit the PHI we use or disclose about you for treatment, payment, or health care operations. With one exception, we are not required to agree to your request. If we do agree, we will comply unless the information is needed to provide emergency treatment. Your request for restrictions must be made in writing and submitted to the Signature Privacy Officer. We must grant your request to a restriction on disclosure of your PHI to a health plan if you have paid for the health care item in full out of pocket.

H. **Right to Receive a Copy of this Notice.** If you ask, you may obtain a copy of this Notice, even if you have agreed to receive the notice electronically.

5. Effective Date and Duration of This Notice

A. **Effective Date.** This Notice is effective as of July 1, 2015.

B. **Right to Change Terms of this Notice.** We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all Protected Health Information that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the new notice in common areas throughout our facility, and on our Internet site at www.signaturemedicalgroup.com. You also may obtain any new notice by contacting the Privacy Officer.

PRIVACY OFFICER CONTACT

Questions or Concerns: Please contact the Privacy Officer with any concerns or for additional information:

Privacy Officer, Jeanne Cantalin

Signature Medical Group, Inc.

314-843-1445 Ext.127

jcantalin@signaturehealth.net

Or at:

1-844-257-7766

compliance@signaturehealth.net