Swamy Clinic, P.A. & SHERMAN SURGERY CENTER Demographics ***E-mail address (Optional):***_____

Patient Name:_____DOB:_____Age:_____SSN:_____

Street Address:_____City/State:_____Zip:_____

Home Phone:(_____)_____-_____Cell Phone: (_____)_____-_____ Sex: M / F __Married __Single __Divorced __Widowed

Employer:_____Occupation:_____Address:_____Phone:_____

(If Applicable)Spouse Name:_____Employer:_____Occupation:_____

Nearest Relative/Friend (not living with you):_____Phone: (_____)_____-_____

Responsible Party: SELF **OR** Other:_____Relationship:_____
(IF YOU ARE THE PARENT/GUARDIAN OF THE PATIENT PLEASE FILL OUT THE FOLOWING WITH YOUR INFORMATION)

PRIMARY INSURANCE COMPANY:_____Address:_____

Insurance Phone:_____Policy/Identification#:_____Group Name & #:_____

Insured Name (**if other than self)**:_____DOB:_____SSN:_____

SECONDARY INSURANCE COMPANY: _____Address:_____

Insurance Phone:_____Policy/Identification#:_____Group Name & #:_____

Insured Name (**if other than self)**:_____DOB:_____SSN:_____

PCP/Family Physician Name:_____City/State:_____Phone: (_____)_____-_____

How were you referred to this clinic?:_____City/State:_____Phone: (_____)_____-_____

Is this visit work related? Y / N Date of Injury:_____Describe Injury:_____

★**Pharmacy**:_____City/State:_____Phone#:_____

Information Required by State: Ethnic Background: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐ American Indian/Eskimo Aleut ☐ Asian or Pacific Islander ☐ Black ☐ White

☐ Other (*Includes other responses not listed. Patients who consider themselves as multiracial or mixed should choose this category*).

Patient Consent for Use and Disclosure of Protected Health Information

I give permission / I do not give permission for THE SWAMY CLINIC PA to leave messages regarding my medical care, which may include lab and pathology results on my:
__Home Answering Machine __Cell Phone __Work Voicemail __Other:_____

With this consent THE SWAMY CLINIC may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment options, such as appointments, reminder calls or cards and billings statements. By signing this form, I am consenting to allow The Swamy Clinic PA to use and disclose my Private Health Information to carry out treatment options. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, THE SWAMY CLINIC may decline to provide me treatment.

HIPPA CONSENT

The patient understands that:

1. Protected health information may be disclosed or used for treatment, payment or health care operations.
2. The practice has a Notice of Privacy Practices and that the patient has the right to ask for this notice.
3. The practice reserves the right to change the Notice of Privacy Practices at any time.
4. The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.
5. The patient may revoke this consent in writing at any time and all future disclosure will cease.
6. The practice may condition receipt of treatment upon execution of this consent.
7. Please indicate any person/s to whom you would like information released to:

Name/Relationship:_____ Name/Relationship:_____

Name/Relationship:_____ Name/Relationship:_____

This consent was signed by: _____ _____
Printed name of patient/Legal Representative — Relationship (if other than patient)

_____ _____
Signature — Date

PLEASE STATE THE REASON FOR YOUR VISIT WITH US TODAY:_____

_____

PRE-ADMISSION HISTORY

In order to provide the best quality care for your procedure, you or your family need to answer the following questions.

INFORMATION PROVIDED IN THIS FORM IS USED WHEN HAVING SURGERY,
PLEASE MAKE SURE ALL PERTINENT INFORMATION IS COMPLETED AND CORRECT.

Have you had:	**Yes**	**No**
Recently, a cold or flu		
Heart condition		
High blood pressure		
Low blood pressure or fainting		
Do you have any of the following? (Please circle) Asthma, Bronchitis, Emphysema or other lung disease		
Epilepsy or seizures		
Do you have any of the following? (Please circle) Jaundice, hepatitis, mononucleosis		
Cancer/Please Specify:		
Back or neck problems		
Recent Abnormal chest x-ray		
Recent Abnormal electrocardiogram		
Glaucoma		
Any mental or emotional problems		
Anticoagulant Therapy (blood thinners)		
Any blood disorders		
Kidney disease		
Fracture of facial bones		
Fracture of neck or back		
Muscle weakness, numbness, paralysis		
Blood transfusion		
Stroke		
Any prosthetic device		
Diabetes: If so, controlled by: ☐Diet ☐Oral Meds ☐Insulin		
Other medical illnesses		
A positive HIV/AIDS blood test		
Motion sickness		
History of Sickle Cell Trait or Disease		
Thyroid problem		
M R S A / Staph Infection		
Reactions to Band-aids, balloons, tape, rubber gloves, or elastic products		
Do You:	**Yes**	**No**
Have false or loose teeth		
Have dental caps or bridges		
Wear contact lenses		
Smoke: How many pkg/day?		
Use alcoholic beverages		
Have a history of substance abuse		
Have any problems to discuss with the Anesthesiologist		
Have a pacemaker		
Have own blood donated		
Object to a transfusion		
Have any cultural/Ethnic practices affecting care		
Women Only: To the best of your knowledge, are you pregnant?		
Date of last menstrual cycle:		
Religious Preference:		
Support System (next of kin) Phone#:		

Age:_____ Height:_____ Weight:_____

Any conditions in which you are under the care of a physician (please describe):

_____

_____

_____

_____

List previous surgeries (Starting with most recent):
Please give approximate date to the best of your knowledge

Month	Year	Description
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Anesthetic History:
Date of last anesthetic:_____ Abnormal reactions? Yes No
Relatives with abnormal reactions to anesthesia? Yes No
Comments:_____

_____

List all medications you are presently taking:

Medication Name	Dosage	Freq	Last Dose
_____			
_____			
_____			
_____			
_____			
_____			
_____			
_____			
_____			

Do you take aspirin? If yes, how often:_____

List Allergies (food or drugs) and reaction:

_____

_____

_____

_____

I certify that the above information is correct.

PATIENT SIGNATURE/DATE_____

Swamy Clinic · Sherman Surgery Center · Dermatology & Plastic Surgery

The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. Payment for services rendered is due at the time they are provided. For your convenience, we accept cash, checks, VISA, MasterCard, and Discover Card.

INSURANCE

We cannot file your insurance unless all of your insurance information is given at the time of your visit. It is imperative that a current copy of your insurance card is provided for accurate billing. If your insurance company has not paid within 90 days, you may receive notification in the mail requesting assistance by you in determining if there is a problem, or if additional information is required in processing the claim. Insurance benefits will be obtained by our verification clerk. All patients will be responsible for their portion due at the time of service. Example: If your insurance pays at 80%, you must pay 20% at the time of service. Co-pays and deductibles are required at the time of service with no exceptions.

*It is extremely important for you to educate yourself about your individual insurance benefits. If you are scheduled for a procedure that could be considered a surgery, like a biopsy, cryotherapy, excision, etc, you could be responsible for these charges. To protect yourself, contact your insurance company prior to any procedure to be certain of your benefits and coverage.

NON-COVERED SERVICES

All cosmetic services are not covered by insurance and these services must be paid in full at the time of the visit.

CANCELLATION OF SURGERY

Surgeries need to be cancelled at least one week prior to the scheduled procedure. The Swamy Clinic and Sherman Surgery Center reserve the right to withhold up to 25% of the pre-paid cost of your surgery when issuing refunds for surgeries cancelled less than one week from the scheduled surgery date. Please make sure that if you elect not undergo a scheduled surgery that you cancel within a timely manner. The business office and the physicians will decide when to withhold a percentage of a prepayment for a cancelled surgery; all cancellations will be reviewed individually. If you cancel your surgery, you may choose to reschedule it with us and leave your credit on your account with no penalty.

LABS

If you are aware that your insurance carrier requires you to utilize certain labs for blood work or biopsies, it is your responsibility to inform our office prior to the lab being performed. Our office sends your insurance card information with the specimen to an outside facility. You will receive an explanation of benefits from your insurance carrier. Lab charges are separate charges from our office charges.

I have read the financial policy, and I understand and agree to this financial policy.

_____ _____

Signature of patient or responsible party Date

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILTY

I hereby assign all medical and/or surgical benefits to include Medicare, private insurance and any other health plans to: Swamy Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all services not paid for by my insurance company; including co-payments, deductible amounts, or services that are not a covered benefit by my plan. I hereby authorize said assignee to release all information necessary to secure the payment. I authorize Swamy Clinic to release any information acquired in the course of my exam or treatment to my insurance company, primary care physician, pediatrician or another physician. I recognize that I am responsible for all charges incurred whether or not paid by my insurance company. I also recognize and agree that I will pay any amount not paid by my insurance company within 30 days. In the event I fail to comply with this financial policy, I understand that my account will be turned over to a collection agency which charges a collection fee, accrual of interest and credit reporting. I UNDERSTAND and agree that, (REGUARDLESS OF MY INSURANCE STATUS), I am ultimately responsible for the balance on my account for any professional services rendered. I will notify you of any changes in my health status or health insurance. If I am a member of an HMO or PPO group and the insurance company has not paid the claim within 90 days of the visit, I understand I am responsible for the balance due. A photo static copy hereof is as valid as the original. I hereby state that all information provided is true and correct to the best of my knowledge.

_____ _____

Signature Date

IF YOUR INSURANCE REQUIRES REFERRALS

We are unable to make sure we have everyone's referral all the time. You are responsible for making sure that we have your referral. You are either to bring the referral with you to your appointment or call ahead to make sure we have it in our office before your appointment. Please do not ask our receptionists to call your primary care physician to obtain the referral for you. I have chosen _____ to be my primary care physician. I understand that if the above is not true, if I am not eligible under the terms of Medical Insurance Agreement, or my referral is not valid for this date of service, I am liable for all charges for the services rendered and if billed, I agree to pay in full for all services rendered within 30 days of receiving the bill. PCP's phone number: _____.

_____ _____

Signature of insured, member or guardian Date

Disclosure For Acceptance Of Credit And Debit Cards

The Swamy Clinic continues to welcome your payment using a Credit/Debit card (Visa, MasterCard, & Discover). **Effective July 20, 2010, a new policy concerning refunds when the payment is made with a Credit/Debit Card goes into effect.**

If you are due a refund from The Swamy Clinic for a payment you made with a Credit/Debit card, our office will deduct **3% of the total credit due** from your refund in order to cover processing cost of the initial Credit/Debit charge processed. **Refunds will automatically be credited to the Credit/Debit card that was used for the original charge**. If you do not wish to have a refund issued to the Credit/Debit card that was used for the original sale, please contact the business office and request that your refund is issued by check. Whether the refund is issued via Credit/Debit card or check from our office, you will still be assessed the 3% charge.

Effective January 1, 2011 Any Credit/Debit card transaction equal or great than $1,000.00 will be assessed a convenience fee of 5% of the transaction.

The Swamy Clinic accepts Credit/Debit cards in accordance with the policies as listed above and is in no way obligated to accept payment in the form of Credit/Debit cards. The choice of using a Credit/Debit card is given to our patients/customers as a convenience in lieu of using alternative forms of payment. The Swamy Clinic does not mandate that any payment issued or due be made by Credit/Debit card. If you, the patient, does not wish to pay with your Credit/Debit card because of the policies that have been instated The Swamy Clinic accepts payments in the form of Cash, Personal/Business Checks, Cashiers Check and Money Orders.

Please sign below to acknowledge this policy. Signing this acknowledgement in no way authorizes The Swamy Clinic to process additional charges to your Credit/Debit card at any time.

_____

Patient/Legal Guardian Signature Date

_____

The Swamy Clinic Witness Date