SURGICAL ASSOCIATES, P.C.

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

Filename: PrivacyNotice.SASG.lwp

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUAL HEALTH INFORMATION.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your Individually Identifiable Health Information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your health information
- Your privacy rights in regard to your health information
- Our obligations concerning the use and disclosure of your health information

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT: Privacy Officer, 3004 2nd St. SE, Moultrie, GA 31768, 229-985-1080

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice-including but not limited to, our doctors and nurses-may use or disclose your IIHI in order to treat or assist others in your treatment. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment or any legally-appointed personal representative who is responsible for your care.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as a legally-appointed personal representative. Also, we may use and disclose your IIHI to obtain payment from third parties that may be responsible for costs, such as a legally-appointed personal representative. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.
3. **Health Care Options.** Our practice may use and disclose your IIHI to operate our business. For example, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.
4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment. Only minimal information will be revealed if a message is left.
5. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

1. **Public Health Risks**. Our practices may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
   - Maintaining vital records, such as births and deaths
   - Reporting child abuse or neglect
   - Preventing or controlling disease, injury or disability
   - Notifying a person regarding potential exposure to a communicable disease
   - Notifying a person regarding a potential risk for spreading or contracting a disease or condition
   - Reporting reactions to drugs or problems with products or devices
   - Notifying individuals if a product or device they may be using has been recalled
2. **Health Oversight Activities.** Our practice may disclose your health information to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions, or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your health information in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your health information in response to a discovery request, subpoena,

SURGICAL ASSOCIATES OF SOUTH GEORGIA, P.C.
3004 2nd Street, S.E. • Moultrie, Georgia 31768
Phone: 229-985-1080 • Fax: 229-890-9743

THOMAS L. ESTES, M. D., F.A.C.S. HOWARD L. MELTON, M. D., F.A.C.S. ROBERT M. BROWN, M. D.

Patient Registration

Appointment with: Dr. Estes ❒ Dr. Melton ❒ Dr. Brown ❒ Acct#________________ Date: ________

Patient's Name: ________________________ Social Security #______________ Age: ____

Date of Birth: ________ Single ❒ Married ❒ Divorced ❒ Widowed ❒ *Male ❒ Female ❒* Race: ____

Address: __________________________City: __________ Zip: _____ Phone:________

Employer: ______________________ Phone: _________ Length of Employment: _________

Employer's Address: ____

Person responsible for bill: __________ Social Security # _________ Relationship to patient.:________

Phone: __________ Address: __________________ City: ____________ Zip: ________

Spouse or Parent's Name: ____________________ Spouse/Parent's Employer: ______________

Address: ____ Phone: ____________

Name of nearest relative/friend not living with you that has a telephone: ________________

Phone: __________ Relationship to patient: ____________ Patient referred by: ____________

Name of Primary Insurance Company: ____

Name of policy holder: ______________________ Policy#: ___________ Group#: ________

List ANY other insurances below:

____

____

PLEASE READ AND SIGN:

- I hereby give consent to the providers or staff of Surgical Associates of South Georgia (SASG) to contact me regarding my appointments, tests results or medical information at the following phone number(s): ________________

  Signature: ____________________________ Date: ____________

- I hereby give consent to the providers or staff of SASG to furnish any appointment, test results, or medical information to the following individuals (list):________________________________

  Signature: ____________________________ Date: ____________

- I hereby give consent to the providers or staff of SASG to leave any appointment, test results, or medical information on my answering machine or voice mail. Signature: ____________________ Date: __________

Assignment of Benefits and Release of Information

I hereby authorize insurance benefits to be paid directly to the physician providing services and recognize my responsibility to pay all non-covered services. I also authorize the physician to release any information necessary to process an insurance claim.

Signature ______________________ Date __________

For Office Use Only

Date Entered ______________

Insurance Verified By:

Who: ______________

Date: ______________

Filename: Patient Registration.SASG.lwp

Surgical Associates of South Georgia, P.C.

Thomas L. Estes, M. D., F.A.C.S.
Howard L. Melton, M. D., F.A.C.S.
Robert M. Brown, M. D.

FINANCIAL POLICY

SURGICAL ASSOCIATES OF SOUTH GEORGIA, P.C., located at 3004 Second Street, Southeast, is dedicated to providing our patients with the highest standard of surgical care. Our surgeons are Thomas L. Estes, M.D., F.A.C.S., Howard L. Melton, M.D and Robert M. Brown, M.D. We offer a broad base practice including general, vascular, and laparoscopic surgery.

EMERGENCIES: There is always a physician on call for emergency care. If you have an emergency, please call the office at 985-1080 during office hours before driving to the emergency room. Your call will alert the office to your problem and will minimize delays in the hospital emergency room. Many problems can be best treated in our office during regular office hours.

PRESCRIPTION REFILLS: Prescription changes or refills are made during office hours to allow time to locate and evaluate your records. Please have your pharmacy name and telephone number available. No refills are available at night or on the weekends.

CREDIT POLICY: Charges for medical services in the office are due and payable at the time services are rendered.

INSURANCE: If you have health insurance, our office will gladly file your claim for you, however, it should be understood that **YOUR INSURANCE POLICY IS AN AGREEMENT BETWEEN YOU AND YOUR INSURANCE COMPANY. YOUR DOCTOR'S BILL IS AN AGREEMENT BETWEEN YOU AND YOUR PHYSICIAN.** You are responsible for your bill regardless of the status of your insurance claim. Insurance companies, according to their contracts, have a schedule of fees which they will pay. Your doctor's fees may be more or less than the schedule of your insurance company. **YOU ARE DIRECTLY RESPONSIBLE FOR YOUR ACCOUNT IRRESPECTIVE OF YOUR INSURANCE SCHEDULE.**

INSURANCE APPEALS: Should your insurance disallow or deny any part of your claim our office will appeal the decision at the patient's request. There will be a charge for this appeal based on the amount of time involved with gathering data, copying records, follow-up phone calls, etc. Fees may range from $5 to $25.

*NOTE: The patient will remain responsible for the balance of the account regardless of the appeals process. If additional payment is made by the insurance carrier after the appeal that portion of the patient's payment will be refunded.

PARTICIPATING PLANS: Our physicians have chosen to become participating providers in the following programs.

MEDICARE*MEDICAID*BLUE CROSS*NOVA NET*1ST MED
SOUTHCARE*ONE HEALTH*STATE MERIT*UNITED HEALTHCARE

Participating plans do not imply that the patient will not receive a bill, but rather the patient will only be billed for the allowed amount. Patients will remain responsible for any "co-insurance" or "cost-share" payments specified by their plans.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1 1/2% per month.

If unusual circumstances should make it impossible to meet your obligation, please talk to our financial representative. She will be glad to assist you with arrangements for making payments.

If you have any questions about the above information or need any assistance, please call 229-985-1080. We will be glad to assist you in any way.

SIGNATURE: ______________________ DATE: __________

A:/WP51/FIN.SAS

3004 Second Street SE . Moultrie, GA 31768 . Phone 229/985-1080 . Fax 229/890-9743

Surgical Associates of South Georgia, P.C.

Thomas L. Estes, M. D., F.A.C.S.
Howard L. Melton, M. D., F.A.C.S.
Robert M. Brown, M. D.

MEDICATION LIST

Dr. Estes Dr. Melton Dr. Brown

Patient Name: ______________________ Date ______________

Pharmacy: ______________________ Phone # ______________

Allergies: ____

NAME	DOSE	ROUTE	FREQUENCY

Filename: MEDLIST.SAS

3004 Second Street SE . Moultrie, GA 31768 . Phone 229/985-1080 . Fax 229/890-9743

SURGICAL ASSOCIATES OF SOUTH GEORGIA, P.C.

Patient's Name: ______________________________ Age: ______ Today's Date: ______________

Your overall general health is very important. Please answer the following questions so that we might know what additional services you might need now or in the future.

	ALL PATIENTS COMPLETE THIS PORTION		Comments
1	Have you had a colonoscopy in the last 10 years?	☐ Yes ☐ No	
2	Do you currently use any type of tobacco (cigarettes, pipe, chewing, etc.)?	☐ Yes ☐ No	
3	Do you have any moles, lesions, or skin tags for us to look at today?	☐ Yes ☐ No	
4	Have you had a screening "lipid" blood test in the last 5 years?	☐ Yes ☐ No	
	MALE PATIENTS ONLY		
5	Have you had a prostate exam in the last 12 months?	☐ Yes ☐ No	
6	Have you had a blood test for prostate cancer in the last 12 months?	☐ Yes ☐ No	
	FEMALE PATIENTS ONLY		
7	Do you do monthly self-breast exams?	☐ Yes ☐ No	
8	Have you had a breast exam by a physician in the last 12 months?	☐ Yes ☐ No	
9	Is there a possibility that you are pregnant?	☐ Yes ☐ No	
10	Do you have a history of sexually transmitted disease (including HIV) infection?	☐ Yes ☐ No	
11	Have you had a mammogram in the last 12 months?	☐ Yes ☐ No	
12	Have you had a bone density test (DEXA) in the last 24 months?	☐ Yes ☐ No	

What are three questions you'd like to ask your doctor about today's visit?

1. ____
2. ____
3. ____

Patient's Signature: ______________________ Today's Date: ______________

Did a doctor send you to our office? ☐ Yes ☐ No Who? ______________________

Who is your Primary Care Physician? ______________________

What is the reason for today's visit? ______________________

Allergies to Drugs, IVP Dye, Fish/Shellfish, etc? ☐ Yes ☐ No (List) ______________________

PAST MEDICAL HISTORY- DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Cardiovascular:	**Heart Attack**	☐ Yes ☐ No	**Neurologic:**	**Stroke**	☐ Yes ☐ No
	High Blood Pressure	☐ Yes ☐ No		**Seizures**	☐ Yes ☐ No
	Heart Failure	☐ Yes ☐ No		**Migraines**	☐ Yes ☐ No
	Bypass Surgery	☐ Yes ☐ No	**Urinary:**	**Prostate Cancer**	☐ Yes ☐ No
	High Cholesterol	☐ Yes ☐ No		**Bladder Cancer**	☐ Yes ☐ No
Respiratory:	**COPD/Emphysema**	☐ Yes ☐ No		**Kidney Failure**	☐ Yes ☐ No
	Asthma	☐ Yes ☐ No		**Kidney Stones**	☐ Yes ☐ No
	Pulmonary Embolism	☐ Yes ☐ No		**Kidney Infection**	☐ Yes ☐ No
	Lung Cancer	☐ Yes ☐ No	**Liver:**	**Cirrhosis**	☐ Yes ☐ No
	Pneumonia	☐ Yes ☐ No		**Hepatitis**	☐ Yes ☐ No
Endocrine:	**Diabetes**	☐ Yes ☐ No	**Gastro:**	**Stomach Ulcer**	☐ Yes ☐ No
	Thyroid Problems	☐ Yes ☐ No		**Reflux Disease**	☐ Yes ☐ No
Vascular :	**Carotid Artery Disease**	☐ Yes ☐ No		**Hiatal Hernia**	☐ Yes ☐ No
	Peripheral Vasc.Disease	☐ Yes ☐ No		**Barrett's**	☐ Yes ☐ No
	Blood Clot in legs	☐ Yes ☐ No		**Colon Cancer**	☐ Yes ☐ No
	Varicose Veins	☐ Yes ☐ No		**Crohns/UC**	☐ Yes ☐ No
Other:	**HIV/AIDS**	☐ Yes ☐ No		**Colon Polyps**	☐ Yes ☐ No

____

____

SURGICAL HISTORY – (Please list all your past surgeries and procedures)

Do you have an artificial heart valve? ☐ Yes ☐ No **Do you have an artificial joint?** ☐Yes ☐ No

____

____

____

____

SOCIAL HISTORY

What is your occupation? ______________________

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Use of Alcohol: ☐Never ☐Rarely ☐Moderately ☐Daily ____________

Use of Tobacco: ☐Never ☐Previously but quit ____________ ☐ Current packs per day ____________

Use of Drugs: ☐Never ☐Type/Frequency ____________

FAMILY HISTORY-Does your father, mother, sister, brother or children have any medical problems?

Father ______________________ Mother ______________________

Siblings ______________________ Children ______________________

BOTH SIDES OF THIS FORM REVIEWED BY:

PHYSICIAN ______________________ DATE: ____________ OVER PLEASE

PLEASE ANSWER ALL QUESTIONS

Have you had any of the following?

CONSTITUTIONAL
- Good general health lately........ No Yes
- Recent weight change........ No Yes
- Fever........ No Yes
- Fatigue........ No Yes
- Headaches........ No Yes

EYES
- Eye disease or injurt........ No Yes
- Wear glasses/contact lens........ No Yes
- Blurred or double vision........ No Yes
- Glaucoma........ No Yes

ENT
- Hearing loss........ No Yes
- Ringing in the ears........ No Yes
- Earaches or drainage........ No Yes
- Sinus problems........ No Yes
- Nose bleeds........ No Yes
- Mouth sores........ No Yes
- Bleeding gums........ No Yes
- Bad breath or bad taste........ No Yes
- Sore throat or voice change........ No Yes
- Swollen glands in neck........ No Yes

CARDIOVASCULAR
- Heart trouble........ No Yes
- Chest pains........ No Yes
- Sudden heart beat changes........ No Yes
- Swelling of feet, ankles or hands........ No Yes

RESPIRATORY
- Frequent coughing........ No Yes
- Spitting up blood........ No Yes
- Shortness of breath........ No Yes
- Asthma or wheezing........ No Yes

GASTROINTESTINAL
- Loss of appetite........ No Yes
- Change in bowel movements........ No Yes
- Nausea or vomiting........ No Yes
- Frequent diarrhea........ No Yes
- Painful bowel movements or constipation........ No Yes
- Blood in stool........ No Yes
- Stomach pain........ No Yes

GENITOURINARY
- Frequent urination........ No Yes
- Burning or painful urination........ No Yes
- Blood in urine........ No Yes
- Change of force of strain when urinating........ No Yes
- Incontinence or dribbling........ No Yes
- Kidney stones........ No Yes
- Sexual difficulty........ No Yes

MUSCULOSKELETAL
- Joint pain........ No Yes
- Joint stiffness or swelling........ No Yes
- Weakness of muscles or joints........ No Yes
- Muscle pain or cramps........ No Yes
- Back pain........ No Yes
- Cold extremities........ No Yes
- Difficulty in walking........ No Yes

SKIN
- Rash or itching........ No Yes
- Change in skin color........ No Yes
- Change in hair or nails........ No Yes
- Varicose veins........ No Yes
- Breast problems........ No Yes

NEUROLOGICAL
- Frequent or recurring headaches........ No Yes
- Light headed or dizzy........ No Yes
- Convulsions or seizures........ No Yes
- Numbness or tingling sensations........ No Yes
- Tremors........ No Yes
- Paralysis........ No Yes
- Stroke........ No Yes
- Head injury........ No Yes

PSYCHIATRIC
- Memory loss or confusion........ No Yes
- Nervousness........ No Yes
- Depression........ No Yes
- Sleep problems........ No Yes

ENDOCRINE
- Grandular or hormone problem........ No Yes
- Thyroid disease........ No Yes
- Diabetes........ No Yes
- Excessive thirst or urination........ No Yes
- Heat or cold intolerance........ No Yes
- Dry skin........ No Yes
- Change in hat or glove size........ No Yes

HEMATOLOGIC/LYMPHATIC
- Slow to heal after cuts........ No Yes
- Easily bruise or bleed........ No Yes
- Anemia........ No Yes
- Phlebitis........ No Yes
- Past transfusion........ No Yes
- Enlarged glands........ No Yes

ALLERGIC/IMMUNOLOGIC
History of skin reaction or other adverse reactions to:
- Penicillin or other antibiotics........ No Yes
- Morphine, Demerol or other narcotics.. No Yes
- Novocaine or other anesthetics........ No Yes
- Aspirin or other pain remedies........ No Yes
- Tetanus antitoxin or other serums...... No Yes
- Iodine, methiolate or other antiseptic... No Yes

Other drugs/medications ____________________

Known food allergies ____________________

Physician Signature: ____________________