Complete all forms and bring them with you on your scheduled appointment date.

Thank you!

University Surgical Associates, PSC

General Surgery
Robert N. Cacchione, M.D.
William G. Cheadle, M.D.
Glen A. Franklin, M.D.
Richard N. Garrison, M.D.
Brian G. Harbrecht, M.D.
Farid J. Kehdy, M.D.
Gerald M. Larson, M.D.
Frank B. Miller, M.D.
J. David Richardson, M.D.
Jorge L. Rodriguez, M.D.
Christopher R. Schneider, M.D.
Jason W. Smith, M.D.
Gary C. Vitale, M.D.

Surgical Oncology
Michael B. Flynn, M.D.
Richard E. Goldstein, M.D., Ph.D.
Robert C. G. Martin, M.D.
Kelly M. McMasters, M.D., Ph.D
Hiram C. Polk, Jr., M.D.
Amy R. Quillo, M.D.
Charles R. Scoggins, M.D.

Transplant
Mary Eng, M.D.
Christopher M. Jones, M.D.
Michael R. Marvin, M.D.

Colorectal Surgery
Susan Galandiuk, M.D.
Jeffrey R. Jorden, M.D.
Michael H. McCafferty, M.D.

Vascular Surgery
Amit J. Dwivedi, M.D.
Marvin E. Morris, M.D.
Charles B. Ross, M.D.
Andrea E. Yancey, M.D.

Plastic and Reconstructive
Larry D. Florman, M.D.
Jarrod A. Little, M.D.
Terry M. McCurry, M.D.
Gordon R. Tobin, M.D.
Bradon J. Wilhelmi, M.D.

Otolaryngology, Head and Neck Surgery
Jeffrey M. Bumpous, M.D.
Swapna K. Chandran, M.D.
Arun K. Gadre, M.D.
Toni M. Ganzel, M.D.
Kevin L. Potts, M.D.
Welby Winstead, M.D.

Welcome to our practice.

It is very important that you fill out the enclosed patient registration form, medical history form, and financial policy form completely, prior to your appointment. Please be sure to bring these forms and your current insurance card or cards with you to your appointment. We **must** get copies of your insurance cards to enable us to bill claims properly. ***Please do not mail paperwork to our office, bring it with you!***

The anticipated cost of your initial visit can range in cost. It is difficult for us to provide you with a precise cost estimate for your visit, however, you must pay your copay prior to being seen by the doctor.

Some insurance plans require that you obtain a referral from your Primary Care Physician in order to see a Specialist. Please remember it is the **patient's responsibility** to know their individual insurance plans, each plan has different coverages and networks. If your insurance company requires you obtain a referral we **must have this prior to your appointment or you may bring it with you to your appointment. If you do not have your referral we cannot see you and your appointment will be rescheduled to our next available appointment date. There will be no exceptions!**

Insurance plans that may require a referral include:

Aetna HMO/Aetna MC/Aetna QPOS
Cigna HMO/Cigna MC
Humana HMO/Humana HMO-MBP
Indiana Medicaid/Hoosier Healthwise
Kentucky Medicaid/KENPAC
Passport
Tricare

This is not an inclusive list; please check with your benefits administrator if you have any questions concerning referrals.

Thank you for choosing our practice! We are here to help you in any way possible. Our office hours are Monday – Friday; 8:30 am to 5:00 pm. The clinical and business staff will be happy to help you with any appointment, please call to cancel well in advance so that we may offer this appointment space to someone else in need.

How did you hear about University Surgical Associates and/or your doctor?

☐ Internet ☐ Radio ☐ Direct Mail ☐ Today's Woman ☐ Louisville Magazine ☐ Newspaper
☐ Audience Playbill ☐ Your physician ☐ TV ☐ Friend or word of mouth ☐ Other _____

Referring Doctor: Family Doctor / PCP:

Address Address:

Phone: Phone:

Patient Information

Patient's Last Name:	First Name:	M.I.	Patient's Social Security #:	
Street Address:			Age:	Date of Birth:
City:	State: Zip:	Email Address:	Patient's Home Phone:	
Race:	Language:	Religion:	Patient's Cell Phone:	
Employment or Student Status (if not a minor): Full Time ☐ Part Time ☐ Self Employed ☐ Active Military ☐ Name of School:		Gender: (circle one) Male Female	Marital Status: S M D W	
Employment / Retirement Eff.Date:	Patient's Employer:		Patient's Occupation:	
Patient's Work Phone & Ext#:	Employer's Address:		Date Employment Started:	
Spouse's Date of Birth:	Spouse's Name:		Spouse's Social Security #:	
Spouse's Work Phone:	Spouse's Employer		Spouse's Occupation:	

[NOT NEEDED IF A CHILD]

Responsible Party / Child's Parent Information

Responsible Party or Father's Name:			Responsible Party or Mother's Name:		
Social Security #:	Date of Birth:	Relationship to Patient:	Social Security #:	Date of Birth:	Relationship to Patient:
Employer:		Work Phone & Ext:	Employer:		Work Phone & Ext:
Home Address if different from Patient's:			Home Address if different from Patient's:		
City, State & Zip:		Phone:	City, State & Zip:		Phone:

Primary Insurance

PLEASE NOTE: We MUST Make A Copy of Your Insurance Card.

Insurance Company Name:		Effective Date:	Subscriber's Date of Birth
Subscriber's Full Name:	Subscriber's Social Sec #:		Relationship to Patient:

Secondary Insurance

PLEASE NOTE: We MUST Make A Copy of Your Insurance Card.

Insurance Company Name:		Effective Date:	Subscriber's Date of Birth:
Subscriber's Full Name:	Subscriber's Social Sec #:		Relationship to Patient:

Emergency Contact

SOMEONE WITH A DIFFERENT PHONE NUMBER

Name:	Phone Number:	Relationship to Patient:

RELEASE OF INFORMATION: I hereby authorize the release of medical information or other information acquired during the course of examination and treatment to insurance carriers, physicians, or my legal representatives. I hereby request payment of benefits from all insurance carriers to University Surgical Associates P.S.C. I understand I am responsible for and will pay any amount not covered by insurance including collection costs and reasonable attorney fees if referred for collection.

Signature – Responsible Party Date

USA Doctor Registrar

University Surgical Associates, PSC
401 East Chestnut Street Suite 710
Louisville, Ky 40202

Dear Patient,

In order to help us stay within the guidelines of HIPAA, please list below any person /persons that you authorize us to disclose information to regarding your Protected Health Information. (**You do not need to list any of your doctors.)**

	Name	**Relationship**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Do we have your permission to leave information on your **answering machine** when you are not at home?

Yes _____ **No** _____

_____ _____
Patient's Name (Please Print) Date of Birth

_____ _____
Patient's (or Guardian's) Signature Date

Financial Policy

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. Please read the following policy. If you have any questions, please feel free to discuss them with our staff.

YOUR INSURANCE

We have made prior arrangements with many insurers and other health plans. We will bill those plans with whom we have an agreement and will collect any required copayment at the time of service. The copayment will be collected when you arrive for your appointment. For elective surgery you will be contacted to arrange for payment of the coinsurance and deductible. In the event your health plan determines a service to be "not covered" or you have "no insurance coverage", you will be responsible for the complete charge. We will also bill your health plan for all services we provide in the hospital. We will be glad to establish a payment plan to meet your needs.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

CANCELLATION/NO SHOW POLICY

An appointment must be cancelled 24 hours in advance. A patient that does not cancel their appointment at least 24 hours in advance or is a NO SHOW will be charged $25.00.

SUPPLIES POLICY

If we know there are supplies involved we will try to alert you of our charges before you come for your scheduled appointment. Your insurance may deny payment for this _____ service/supply. The patient/responsible party understand that this charge may be non covered and will be responsible for these charges at the time of service.

MEDICAL RECORD POLICY

When requesting disability forms to be completed we will require a $25.00 payment for the initial form and a $10.00 payment for follow-up forms in advance of their completion.

PRESCRIPTION POLICY

We ask that you call in your refill request for prescriptions during the hours of 9:00 am – 3:00 pm Monday thru Friday only. Prescription refills from 3:00 pm Friday – 9:00 am Monday are not available.

I have read and understand the financial policies of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____

Signature of Patient or Responsible Party if a Minor Date

_____

Signature of Co-responsible Party

_____

Please Print the Name of the Patient

UNIVERSITY SURGICAL ASSOCIATES, PSC PATIENT HISTORY FORM
(see also dictated note/letter from today's date)

Patient's Name:_____**Today's Date**_____

Age:____ Birth Date: _____ Race:_____SSN:_____

Family Physician: Dr. _____ **Referred by: Dr.** _____

Other Physicians you see: _____

Reason for Visit:_____

THIS BOX FOR MD USE ONLY

Location
Quality
Severity
Duration
Timing
Context
Modifying Factors
Associated Signs and Symptoms

Past Medical Problems: (check boxes that apply, describe below and list dates if possible)
□ High Blood Pressure □ Diabetes □ Heart Disease/Heart Attack □ Kidney Disease □ Lung Disease/COPD □ Seizures □ Stroke □ Cancer □ Emotional/Psychiatric Problems □ Hepatitis

_____

_____

_____

List all Previous Operations/Procedures (for example, colonoscopy, cardiac stent, etc.) List reason,date, & MD

_____

_____

_____

_____

_____

Cancer Treatments: Have you ever had Chemotherapy or Radiation Therapy? If so when and by whom:

_____

_____

Medications: (List name, dose, & how often taken)

_____

_____

_____

_____

Do you take aspirin/ aspirin-containing products / any blood thinners? ☐YES ☐NO (if yes, please list)

_____

Are you allergic to any medications? ☐YES ☐NO (if yes, please list) **ALLERGIC to LATEX?** ☐YES ☐NO

_____

Rev.July 2008

Social History

☐ Single ☐ Married ☐Separated ☐ Divorced ☐ Widowed Occupation_____

Do you use alcohol? ☐YES ☐NO How much and how often?_____

Do you use tobacco now? ☐YES ☐NO Did you ever use tobacco? ☐YES ☐NO

Describe tobacco use (for example, packs per day) _____

Heavy Sun Exposure in past? ☐YES ☐NO Blistering Sunburns in past? ☐YES ☐NO

Tanning Bed Use? ☐YES ☐NO

Family History List diseases (including specific types of cancer) that run in the family, which relative was affected, and at what approximate age.

_____

_____

_____

ROS: List all symptoms that you are experiencing currently

General	Yes	No
Weakness		
Weight loss		
Fever/chills		
Night sweats		

Eyes	Yes	No
Vision changes		
Double vision		

Head/Neck	Yes	No
Headache		
Blackout spells		
Changes in hearing		
Changes in taste/smell		
Thyroid Problems		
Neck lumps		
Ear pain		

Hematologic	Yes	No
Anemia		
Easy Bruising		
Clotting Problem		

Lung	Yes	No
Lung problems		
Shortness of breath		
Cough up blood		
Wheezing/Asthma		
Pneumonia		
Tuberculosis		

Musculoskeletal	Yes	No
New aches/pains in Bones/joints		
Arthritis		

Heart	Yes	No
Chest Pain		
Heart Attack		
Irregular Heart Beat		
Heart Failure		
Swelling in Ankles		
Palpitations		

Gastrointestinal	Yes	No
Abdominal pain		
Nausea/Vomiting		
Vomit Blood		
Difficulty Swallowing		
Heartburn /Indigestion		
Blood in Stool		
Black/Tarry Stool		
Change in stool size/color		
Constipation		
Yellow Jaundice		

Kidney	Yes	No
Blood in Urine		
Kidney/bladder infection		
Kidney stones		
Painful urination		
Difficulty urinating		

Breast	Yes	No
Lump		
Nipple discharge		
Pain		
Date Last Mammogram		

Reproductive History	Yes	No
Age at 1st period		yrs
Age at menopause		yrs
# Pregnancies		
# Live births		
Age at 1st pregnancy		yrs
Breast Fed		
If yes, your age at the time		yrs
Last Menstrual period		
Last Pap Smear		
Currently use Hormone Replacement Therapy		
If yes, how long		
Previously used Hormone Replacement Therapy		
If yes, when stopped		

Neurologic	Yes	No
Tingling		
Numbness		
Weakness		

Psychiatric	Yes	No
Depression		
Anxiety		
Mood swings		

Skin	Yes	No
Rash		
Skin cancer		
Change in mole		

FOR BARIATRIC PATIENTS ONLY:

Diets used and weight lost**:** _____

Sustained weight loss**:** _____ How long was weight lost? _____

How long over 100 lbs. overweight? _____ How many times have you lost over 25 lbs? _____

How long have you been overweight? _____years.

Are you currently under a physician's care for weight loss? ☐YES ☐NO Physician's Name:_____

PHYSICIAN COMMENTS:

_____

Physician Signature: _____ Date_____

(History Form Reviewed with Patient)

Rev. July 2008

USA
University Surgical Associates
A Team Approach to Treatment.

UofL HealthCare Outpatient Center
401 East Chestnut Street, Suite 710
Louisville, Kentucky 40202

Phone: 502.583.8303
Toll Free: 1.800.872.8033
Fax: 502.584.0302
www.usapsc.com

Did you know that your surgeon not only takes care of patients, but:

- Is a Professor of Surgery at the University of Louisville School of Medicine?
- Performs basic, translational, and clinical research to improve patient care?
- Teaches students, residents and fellows who come from around the world to learn the latest surgical procedures and participate in groundbreaking research?

We want to tell you about some of the exciting research and educational programs that are underway in the Department of Surgery at the University of Louisville School of Medicine. We are proud to be nationally recognized for groundbreaking advances in: **Cancer Detection and Treatment, Trauma and Critical Care, Minimally Invasive Surgery, Bariatric Surgery, Digestive Diseases, Endocrine Surgery, Vascular Surgery, Head and Neck Surgery, Plastic and Reconstructive Surgery, Hearing and Speech Disorders, Organ Transplantation, and Surgical Infections.**

A small sampling of our research includes:

1. The Sunbelt Melanoma Trial, a multicenter study that is the largest ever conducted in melanoma with more than 3,600 patients registered. It was conceived, written and directed from the Department of Surgery.

2. Genetic research relating to colorectal cancer and inflammatory bowel disease, which together affect hundreds of thousands of Americans every year. We have been using the latest technology such as gene chips to try to identify the cause of these disorders.

3. Minimally Invasive Parathyroid and Thyroid Surgery. We are one of the first centers to develop and test the procedure of Minimally Invasive Radioguided Parathyroidectomy, which allows patients with parathyroid tumors to undergo a much less invasive yet curative procedure through a small incision. We have also developed techniques for minimally invasive endoscopic thyroid surgery.

4. Studies of sound perception and speech production in children and adults that have undergone cochlear implant surgery

5. The University of Louisville Breast Cancer Sentinel Lymph Node Study, which involves more than 4,000 patients from 79 institutions across the US and Canada. It is the largest study of its kind and is largely responsible for the acceptance of this minimally invasive procedure for patients with breast cancer around the world.

6. Basic research into the molecular basis for the response to trauma, shock, inflammation, and infection.

7. New technologies for the treatment of liver tumors. Over the past decade, we have helped develop and test new minimally invasive techniques for treatment of liver tumors. This allows many patients who previously were not candidates for surgery to eliminate cancer in the liver.

8. New gene therapy approaches to cancer as an alternative to chemotherapy. In the past decade, we have developed several new treatments of liver tumors, colon cancer, pancreatic and stomach cancer, melanoma, breast cancer, and cervical cancer.

9. Studies to evaluate rare endocrine tumors using artificial intelligence.

10. We were one of the first U.S. centers to pioneer the use of the Lap Band System™ and other minimally invasive surgical treatments for obesity. We were the first center in America to perform an intragastric balloon and this was done in the setting of a clinical trial.

This is where you can help.

Research is responsible for the development of new approaches to surgery and the treatment of a variety of conditions and diseases. We have made much progress, yet our work is far from done. With additional funding support, we feel confident we can bring some of these exciting results to our patients more quickly.

Your investment in our research will bear dividends for years to come, helping others facing a diagnosis such as yours. Any amount helps, and you can specify where you would like your money to be used.

If you are interested in investing in our research by making a donation or want to learn more, please contact Lukas C. Dwelly, MPA, MA by email at lukas.dwelly@.louisville.edu or **502-235-1002.** He also may contact you following your treatment to gauge your interest and to discuss your experience with our office. In addition, you can discuss your interest with your surgeon or our office staff any time. You can also visit our Web site at louisvillesurgery.com. Thank you again for your confidence in our program.

If you wish to have your name removed from the list to receive fundraising requests supporting the Department of Surgery, please make your wishes known in writing to: Department of Surgery, Development Office, 530 South Jackson Street; Louisville, KY 40202, and all reasonable efforts will be taken to ensure you will not receive any such communications from us in the future.