



3220 Bluff Creek Drive, Suite 100
Columbia, Missouri. 65201
573.443.8773 • 800.443.1082
www.columbiasurgical.com

James B. Pitt, DO
John G. Adams, Jr. MD
Erik M. Grossmann, MD
Kimberly C. Suppes, MD
Nicole C. Nelson, DO
Erica H. Salinas, MD
Nicole M. Spencer, DO
Jennifer Sanford, MD
Amanda Fischer, MD
Jane A. Vaughan, APRN, FNP
Ashley Hardesty, MSN, FNP-C
Allison Arends, AGNP

PLEASE COMPLETE ALL FORMS BEFORE YOUR APPOINTMENT TO ENSURE THAT YOU ARE SEEN IN A TIMELY MANNER. PLEASE BRING PHOTO IDENTIFICATION, INSURANCE CARDS AND CURRENT MEDICATION LIST.

Dear Patient:

Enclosed you will find information regarding your appointment with Columbia Surgical Associates. **Please note: this is an office consultation visit only; no major surgery will be performed at this visit although minor diagnostic procedures may be performed (i.e. anoscopy, biopsy or an ultrasound). Your insurance co-pay will be due at the time of service. You can make payments by cash, check, money order, MasterCard, Visa, and Discover.**

Please bring the completed two sided forms with you to your appointment and arrive 15 to 30 minutes prior to your appointment time so that we may get your insurance information scanned into our system. The map to our location is on the back of this letter.

For elective surgeries (including, but not limited to gallbladder, and hernia surgery) our business office might contact your insurance company to determine your deductible and /or co-insurance which may be payable prior to the date of surgery.

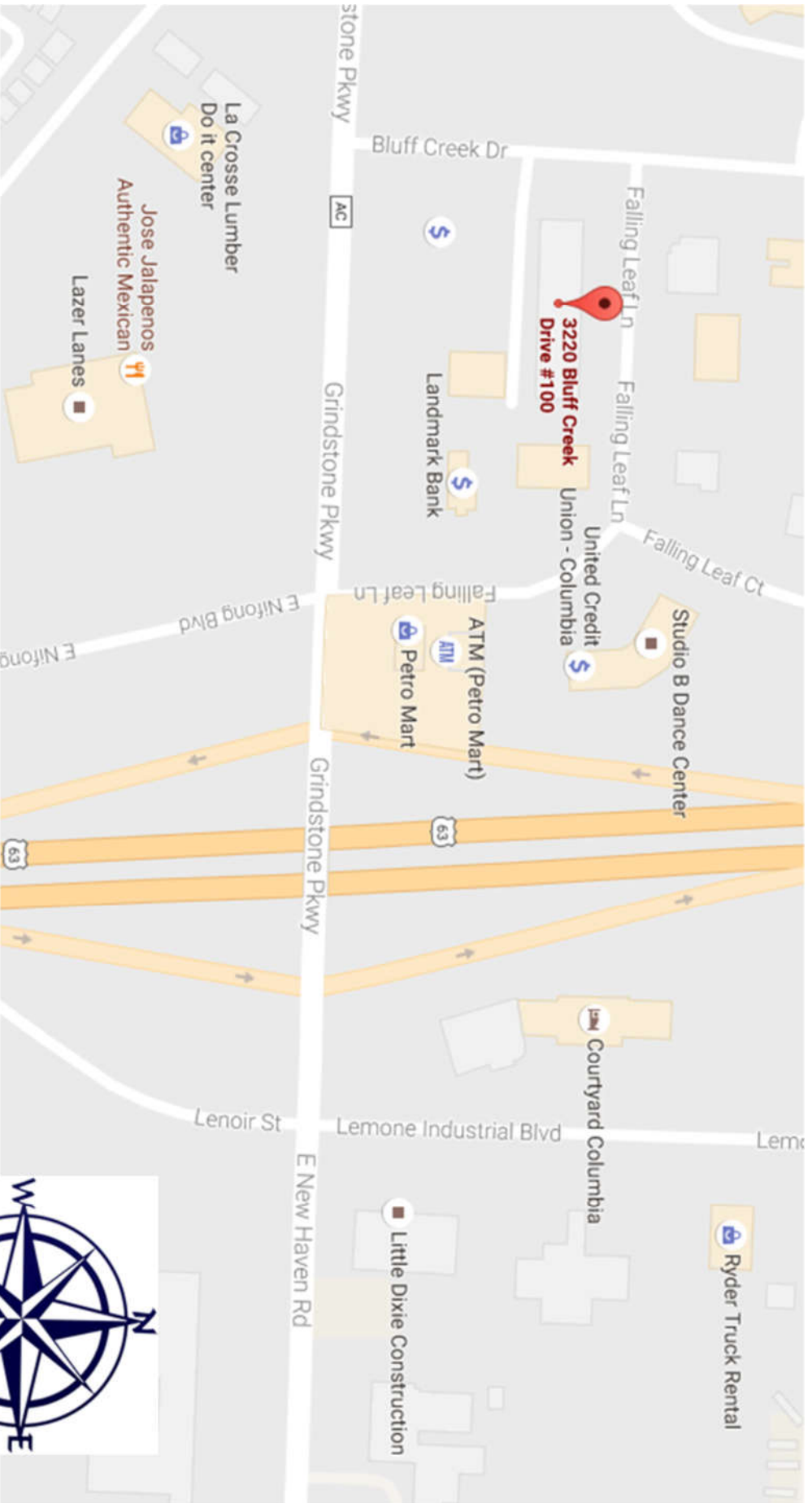
Your insurance company may require a referral form from your primary care physician (listed on your insurance card) so it is important that you contact their office prior to your appointment. This will assure that your visit with us will be covered by your health insurance plan. **Also, if you have had any recent x-rays (including mammograms), lab work, EKG's or any tests that pertain to the problem you are being seen for,** please bring them with you to your appointment.

If you are unable to keep your appointment, please notify us 24 hours prior to the scheduled time. We will make every effort to change the appointment to a more acceptable time.

If you have any questions about your appointment, feel free to call our office Monday through Friday, 8:00 a.m. to 5:00 p.m.

Sincerely,
Physicians and Staff
Columbia Surgical Associates

North to Stadium & Broad Way /Kirksville



South Discovery Parkway to Jefferson City



Patient Information

First Name: _____ **Last Name:** _____ **Middle Initial:** _____

Date of Birth: _____ **Sex:** Male Female

Social Security # _____ **Marital Status:** Single Married Divorced Widowed

Ethnicity: Non-Hispanic Hispanic

Race: White African American Asian Pacific Islander American Indian Unknown Decline to Say

Preferred Language: English Spanish Other: _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Communication Preference: Home Phone Cell Phone Mail Email

Employer: _____ **Work Phone:** _____ **EXT:** _____

Which Doctor Are You Seeing Today? _____

Referring Doctor 1: _____ **Phone:** _____

Referring Doctor 2: _____ **Phone:** _____

Family Doctor: _____ **Phone:** _____

Emergency Contact: _____ **Relation:** _____ **Phone:** _____

Insurance Information

Primary Insurance Company: _____

Name of Insured: _____ **DOB:** _____

I.D. # _____ **Group #:** _____ **SS #:** _____

Effective Date of Coverage: _____ **Relationship to Patient:** _____

Employer: _____

Secondary Insurance Company: _____

Name of Insured: _____ **DOB:** _____

I.D. # _____ **Group #:** _____ **SS #:** _____

Effective Date of Coverage: _____ **Relationship to Patient:** _____

Employer: _____

Patient Authorization

Patient Signature

Date

(Power of Attorney or Authorized Signature if Minor)

I understand that I am responsible for my payment of services to Columbia Surgical Associates, I authorize the release of any and all medical records information necessary to process claims and requests for payment from my Insurance Company in compliance with HIPAA regulations. Further, I understand that certain procedures may not be covered by my insurance company and, in such situations I understand I will be responsible for payment for such services.

Workers Compensation/Auto Accident Liability Information

- Is your visit today related to a work injury? Yes No
 Is your visit today related to an auto accident? Yes No
 Is your visit today related to any other liability claim? Yes No

If you have answered "NO" to all of the questions above, please sign below:

Patient Signature: _____ Date: _____

If you answered "YES" to any of the questions above, please complete the rest of this form and sign below:

Do you have authorization from the insurance carrier for today's visit: Yes No

Has this claim been filed with the Missouri State Department of Workers Compensation:
 Yes No

If "YES" please provide the Report of Injury Number: _____

I authorize Columbia Surgical Associates, Inc. and/or its representatives to release my medical records information and/or discuss continued treatment of care with the designated insurance company or Workers Compensation carrier or its representatives as necessary to process claims and requests for payment.

Patient Signature: _____ Date: _____

HIPAA Authorization

I have been informed by Columbia Surgical Associates that the "Notice of Information Practices" is available in the waiting room for review. I understand that I have the right to ask questions in order to seek clarification and/or request a copy of this document. Any medical or billing information may be discussed with the following people.

<input type="checkbox"/>	No information to be released to anyone
<input type="checkbox"/>	No information to be released without password
<input type="checkbox"/>	Release information to see contact grid
<input type="checkbox"/>	Patient unable to address at this time

Information Release Password

Patient Contacts	Release of Medical Info/PHI	Relationship	Primary Phone	Alternative Phone

Patient Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

History of Present Illness

Reason for today's visit: _____

What makes this better or worse: _____

Date illness started: _____ Severity of pain 1-10 (10 being worst): _____

Quality of pain (stabbing/pressure-like/etc.): _____

Nurse Only:

Pulse: _____

BP: _____

Weight: _____

Height: _____

BMI: _____

Surgical History

Please list all surgeries:

	Surgery	Year	Complications/Details
	Colonoscopy		
	Prostate Surgery		
	Hernia		
	Gall Bladder		
	Appendectomy (Appendix)		
	Hysterectomy w/ or w/o Removal of Ovaries		
	Heart Catheterization		
	Heart Bypass		
	Any Vascular Surgeries (Please Explain)		
	Breast		
	Thyroid		
	Other:		
	Other:		

Please list all Hospitalizations (Not listed above):

Hospitalization Reason	Date	Hospital

Preferred Learning Style(s):

<input type="checkbox"/> Computer if available	<input type="checkbox"/> Discussion	<input type="checkbox"/> TV/Video if available
<input type="checkbox"/> Demonstration	<input type="checkbox"/> Reading material/handouts	<input type="checkbox"/> Other: _____

Place Patient Sticker Here

For Women Only

Do you think you may be currently pregnant: Yes No

How many times have you been pregnant: _____

What age were you at your first pregnancy: _____

How many children do you have: _____

What age did you start having periods: _____

Date of last menstrual cycle: _____

Are you now on or have you ever been on Hormone Replacement Therapy: Yes No

Have you had a mammogram: Yes No

If **YES**, When: _____ Results: Normal Abnormal

Social History

Who lives in your home: _____

Are you currently working: Yes No

Reason (if **No**) Unemployed Retired Disabled Other: _____

Your Occupation: _____ Full-Time Part-Time Student

Do you smoke: No/Never Former/Quit-Date: _____

Yes, I am interested in quitting. Yes, Not interested in quitting

Packs Per Day: _____

Do you use other tobacco products: No/Never Former/Quit-Date: _____

Yes, I am interested about quitting. Yes, Not interested in quitting

Amount Per Day: _____

Do you Drink Alcohol: Yes No

If **YES**, How Often: Rarely (1-2 a year) Daily Weekly (1-2) Monthly (1-2)

Yes, I am interested in quitting. Yes, Not interested in quitting

Do you drink more than 6 cups of caffeinated beverages per day: Yes No

Patient Signature: _____ **Date:** _____

Family Medical History

Please check "Yes" and list the relation if any family members have suffered from any of the conditions below.
Check "No" if no family members have suffered from any of the listed conditions.

<input type="checkbox"/> Unknown/Adopted	Family Member	
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abdominal Aneurysm	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer – Breast	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer – Colon	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer - Uterine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer - Ovarian	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer – Other: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Colon/Rectal Polyps	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis \ Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Malignant Hyperthermia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Problems with Anesthesia: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
PVD (Peripheral Vascular Disease)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ulcerative Colitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Crohn's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No

The above information is completed to the best of my knowledge

Patient Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

Do you now or have you recently had any problems related to the following systems? Check Y (Yes) or N (No). If you mark Yes to any of the following, please indicate which doctor is treating you for that problem. If you haven't seen a physician yet, please contact your Internist or Family Physician to address those issues.

Review of Systems

<u>Cardiovascular:</u>			<u>Hematological/Lymphatic:</u>			<u>Respiratory:</u>		
Chest Pain	<input type="checkbox"/> Y	<input type="checkbox"/> N	Persistent Enlarged Glands	<input type="checkbox"/> Y	<input type="checkbox"/> N	Wheezing	<input type="checkbox"/> Y	<input type="checkbox"/> N
Murmur	<input type="checkbox"/> Y	<input type="checkbox"/> N	Blood Clotting Problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Chronic Cough	<input type="checkbox"/> Y	<input type="checkbox"/> N
Leg Swelling	<input type="checkbox"/> Y	<input type="checkbox"/> N	Bleeding Problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Shortness of Breath	<input type="checkbox"/> Y	<input type="checkbox"/> N
Irregular Heartbeat	<input type="checkbox"/> Y	<input type="checkbox"/> N	<u>Musculoskeletal:</u>			<u>Gastrointestinal:</u>		
<u>Constitutional Symptoms:</u>			Joint Pain	<input type="checkbox"/> Y	<input type="checkbox"/> N	Abdominal Pain	<input type="checkbox"/> Y	<input type="checkbox"/> N
Fever	<input type="checkbox"/> Y	<input type="checkbox"/> N	Neck Pain	<input type="checkbox"/> Y	<input type="checkbox"/> N	Nausea	<input type="checkbox"/> Y	<input type="checkbox"/> N
Chills	<input type="checkbox"/> Y	<input type="checkbox"/> N	Back Pain	<input type="checkbox"/> Y	<input type="checkbox"/> N	Vomiting	<input type="checkbox"/> Y	<input type="checkbox"/> N
Weight Loss	<input type="checkbox"/> Y	<input type="checkbox"/> N	Assistive Devices	<input type="checkbox"/> Y	<input type="checkbox"/> N	Intolerance to Greasy Foods	<input type="checkbox"/> Y	<input type="checkbox"/> N
Weight Gain	<input type="checkbox"/> Y	<input type="checkbox"/> N	<u>Neurological:</u>			Blood in Stool	<input type="checkbox"/> Y	<input type="checkbox"/> N
<u>Endocrine:</u>			Headache	<input type="checkbox"/> Y	<input type="checkbox"/> N	Jaundice	<input type="checkbox"/> Y	<input type="checkbox"/> N
Excessive Thirst	<input type="checkbox"/> Y	<input type="checkbox"/> N	Tremors	<input type="checkbox"/> Y	<input type="checkbox"/> N	Incontinence of Stool	<input type="checkbox"/> Y	<input type="checkbox"/> N
Hot Intolerant	<input type="checkbox"/> Y	<input type="checkbox"/> N	Dizzy Spells/Fainting	<input type="checkbox"/> Y	<input type="checkbox"/> N	Difficulty Swallowing	<input type="checkbox"/> Y	<input type="checkbox"/> N
Cold Intolerant	<input type="checkbox"/> Y	<input type="checkbox"/> N	Numbness/Tingling	<input type="checkbox"/> Y	<input type="checkbox"/> N	Heartburn Indigestion	<input type="checkbox"/> Y	<input type="checkbox"/> N
Tired	<input type="checkbox"/> Y	<input type="checkbox"/> N	<u>Skin:</u>			<u>Psychological:</u>		
<u>Genitourinary:</u>			Changes in hair or nails	<input type="checkbox"/> Y	<input type="checkbox"/> N	Do you feel Anxious/Nervous	<input type="checkbox"/> Y	<input type="checkbox"/> N
Painful Urination	<input type="checkbox"/> Y	<input type="checkbox"/> N	Itching	<input type="checkbox"/> Y	<input type="checkbox"/> N	<u>Allergic and Immune:</u>		
Urinary Frequency	<input type="checkbox"/> Y	<input type="checkbox"/> N	Rash	<input type="checkbox"/> Y	<input type="checkbox"/> N	Allergic reaction to medication or x-ray dye	<input type="checkbox"/> Y	<input type="checkbox"/> N
Difficulty Urinating	<input type="checkbox"/> Y	<input type="checkbox"/> N	<u>Eyes:</u>			<u>Ear, Nose, Mouth and Throat</u>		
Incontinence	<input type="checkbox"/> Y	<input type="checkbox"/> N	Blurred vision	<input type="checkbox"/> Y	<input type="checkbox"/> N	Loss of sense of smell	<input type="checkbox"/> Y	<input type="checkbox"/> N
			Double vision	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hearing loss	<input type="checkbox"/> Y	<input type="checkbox"/> N
			Loss of vision	<input type="checkbox"/> Y	<input type="checkbox"/> N			
<u>Other:</u>								

Advanced Directive

Do you have an advanced directive? Yes No

If **No**, would you like information about setting up one? Yes No

If **Yes**, will you provide a copy for your medical record? Yes No

Personal Medical History

Please Check "Yes" for any medical conditions YOU suffer from and check "No" if you do not suffer from the condition

Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hiatal Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Atrial Fibrillation /Irregular Heartbeat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of Blood Transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Stones	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer – Breast	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer – Colon	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Malignant Hyperthermia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer – Other:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Meningitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cirrhosis of the Liver	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Colon/Rectal Polyps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema/COPD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
PVD Peripheral Vascular Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers – Leg	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy/Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers - Stomach	<input type="checkbox"/> Yes	<input type="checkbox"/> No
GERD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Varicose Veins	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Head Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Renal Failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hearing Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sleep apnea - CPAP	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sleep apnea - BiPAP	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please list any major or chronic illnesses not listed above:

None



3220 Bluff Creek Drive, Suite 100
Columbia, Missouri. 65201
573.443.8773 • 800.443.1082
www.columbiasurgical.com

INSURANCE TERMS AND DEFINITIONS

James B. Pitt, DO
John G. Adams, Jr. MD
Erik M. Grossmann, MD
Kimberly C. Suppes, MD
Nicole C. Nelson, DO
Erica H. Salinas, MD
Nicole M. Spencer, DO
Jennifer Sanford, MD
Amanda Fischer, MD
Jane A. Vaughan, APRN, FNP
Ashley Hardesty, MSN, FNP-C
Allison Arends, AGNP

DEDUCTIBLE:	AMOUNT OF EXPENSES THAT MUST BE PAID OUT OF POCKET BEFORE AN INSURER WILL PAY ANY EXPENSES.
CO-INSURANCE:	A PERCENTAGE OF PATIENT'S FINANCIAL RESPONSIBILITY.
CO-PAY:	A PAYMENT DEFINED IN THE INSURANCE POLICY PAID BY THE INSURED PERSON AT THE TIME OF OFFICE APPOINTMENT.
OUT-OF-POCKET MAXIMUM:	TOTAL MAXIMUM AMOUNT PAID BY PATIENT OUT OF POCKET IN A BENEFIT PERIOD.
FACILITY:	LOCATION WHERE PATIENT'S SURGICAL PROCEDURE IS PERFORMED.
SURGEON:	PROFESSIONAL THAT PERFORMS THE PATIENT'S PROCEDURE.

There will usually be 2 to 4 charges in connection to your procedure. The first charge will be the facility charge. The facility charge will come from Columbia Surgical Center, University Hospital, or Boone Hospital. Although the Surgical Center is located in the same building, they will be charging the facility charge because their location is used by our surgeons to perform the procedure you are having done.

The second charge will be the surgeon/surgery charge. The surgeon/surgery charge will come from Columbia Surgical Associates, as well as the office visit charge. We charge you after the procedure has been done by one of our surgeons. This charge will come after the procedure/surgery is done because we do not know exactly what will be done until our surgeon performs what is needed for you, the patient.

The third charge you may have is an anesthesiology charge. You only have this charge if you have sedation or a general anesthetic. This is not billed through us and will be billed separately.

The final charge you may have is a pathology charge. You will only have a pathology charge if you have something that needs biopsied or removed. This is not billed through us and will be billed separately.