



Paul S. Collins, MD **Kevin L. Huguet, MD** **John M. Clarke, MD** **Brett A. Almond, MD** **Derrick D. Cox, MD**
General Surgery General Surgery General Surgery Vascular Surgery General Surgery
Vascular Surgery Laparoscopic Surgery Vascular Surgery Vascular Surgery Surgical Oncology
Thoracic Surgery

Dear Patient,

Welcome to the Practice of Bay Surgical Specialists. You are scheduled to see:

Dr. Almond

Dr Huguet

Dr Collins

Dr Cox

on _____ at _____ AM/PM

Enclosed you will find New Patient Information forms along with a map to our location. **Please take the time to complete the forms and bring them with you to your appointment.**

If you are taking any medications, please bring them in their original containers or bring a written list with the dosage and how often you take them. Also bring your Medicare, Medicaid or other insurance cards and driver's license or photo ID so we can make a copy for your records. If you have films for the doctor, be sure to bring them with you as well.

Your co-payment, if applicable, will be due at the time of your visit. We accept cash, check, MasterCard, Visa, American Express and Discover.

IF AN AUTHORIZATION OR REFERRAL IS REQUIRED FOR A SPECIALIST IT MUST BE RECEIVED BY OUR OFFICE PRIOR TO YOUR APPOINTMENT WITH OUR DOCTOR. PLEASE CONTACT YOUR PRIMARY CARE PHYSICIAN TO VERIFY THE REFERRAL HAS BEEN RECEIVED BY OUR OFFICE.

For the convenience of our patients we request that only one family member per patient accompany you during your appointment. There are circumstances where more members of the family are needed, and we understand this. However, due to limited seating in our reception area we ask that you comply with our request. Thank you for your attention to this information, and we look forward to providing your medical care.

Sincerely,

The Staff of Bay Surgical Specialists, PA

FOR MORE INFORMATION, PLEASE SEE OUR WEBSITE @ www.baysurgicalspecialists.com

List all **MEDICATIONS**, **SUPPLEMENTS**, **HERBS** and **OVER THE COUNTER MEDS** such as Aspirin, Advil, Ibuprofen, etc. List the **DOSE**, **FREQUENCY** and **REASON** for use:

Medicine	Dose & how often	Reason for use
<i>Example: Xanax</i>	<i>0.5 mg once daily</i>	<i>Anxiety</i>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

Family History Please indicate if anyone in your immediate family has had cancer below:

	Mother	Father	Sister	Brother	Daughter	Son
Colon Cancer	_____	_____	_____	_____	_____	_____
Breast Cancer	_____	_____	_____	_____	_____	_____
Ovarian Cancer	_____	_____	_____	_____	_____	_____
Age of diagnosis?	_____	_____	_____	_____	_____	_____

Is there any other cancer in your family? Yes No

If yes, what type of cancer? _____

What relative (Aunt/Uncle/Cousin, etc): _____

Age of diagnosis: _____

Social History

Do you use tobacco products? Yes _____ No _____ How much _____
 Do you drink alcoholic beverages? Yes _____ No _____ How much _____
 Do you drink caffeinated coffee, tea, soda? Yes _____ No _____ How much _____
 Do you do any other drugs? Yes _____ No _____ What? _____

Review of Systems

Do you currently have any of the following symptoms (check all that apply):

CONSTITUTIONAL SYMPTOMS

_____ Fever _____ Infection _____ Night sweats
 _____ Fatigue _____ Other general problems _____

EYES

_____ Blindness _____ Glaucoma _____ Retinal problems
 _____ Cataracts _____ Other eye problems _____

EARS, NOSE, MOUTH, AND THROAT

- Earaches Ringing in the ear Sensation of spinning
- Ear problems Nose bleed Sinus problems
- Sore tongue Dental problems Bleeding gums
- Sore throat Painful swallowing Difficulty swallowing
- Change in voice Other head or neck problems _____

BREAST (women only)

- Breast lumps Nipple discharge Breast pain
- Other _____

GYNECOLOGY (women only)

- Abnormal pap smear Endometriosis Abnormal vaginal bleeding
- Last Gynecological Exam/Date : _____ Age of menstruation: _____ Age of menopause: _____
- Have you had a hysterectomy? Yes No Are your ovaries removed? Yes No

CARDIOVASCULAR

- Heart disease High blood pressure Shortness of breath
- Chest pain Ankle swelling Leg pain when walking
- Rheumatic fever Fast heart beats Irregular heart beats
- Heart murmur Congestive heart failure Myocardial infarctions
- Pulmonary Embolism Thrombophlebitis
- Venous or Arterial Thrombosis Other heart problems _____

RESPIRATORY

- Asthma Chronic cough Coughing up blood
- Emphysema Tuberculosis Shortness of breath
- Other lung problems _____

GASTROINTESTINAL

- Weight loss Decreased appetite Difficulty swallowing
- Weight gain Hiatal hernia Peptic ulcers
- Esophagitis Nausea/vomiting Vomiting blood
- Gastritis Liver disease Hepatitis
- Gallstones Crohn’s disease Cirrhosis
- Ulcerative colitis Black stools Bloody stools
- Hemorrhoids Anal problems Diverticulitis
- Other stomach or intestinal problems _____

GENITOURINARY

- Kidney stones Frequent urination Painful urination
- Blood in urine Slow starting of urine Passing urine at night
- Kidney infection Bladder infection Enlarged prostate
- Other kidney/bladder problems _____

SKIN

Psoriasis Skin cancer Previous biopsies
 Melanoma Other skin problems _____

NEUROLOGICAL

Headaches Slurred speech Weakness on one side
 Seizures Stroke Temporary eye blindness
 Migraines Other brain or nerve problems _____

MUSCULOSKELETAL

Arthritis Osteoporosis Neck pain
 Back pain Artificial joints Disc problems
 Other muscle or bone problems _____

ENDOCRINE

Diabetes Hypoglycemia Goiter/Thyroid surgery
 Thyroid medications Heat/Cold intolerance
 Other endocrine problems _____

PSYCHIATRIC

Mental illness Depression Drug/alcohol abuse
 Other psychiatric problems _____

HEMATOLOGIC/LYMPHATIC

Anemia Sickle cell disease Enlarged lymph nodes
 Hemophilia Easy bruising Blood clotting problem
 Daily aspirin Other blood or lymph gland problems _____

ALLERGY/IMMUNE SYSTEM

Immune deficiency Plant/animal allergy AIDS/HIV
 Other allergy/immune problems _____

Patient Signature _____

Date _____

Reviewed by: _____
Physician/Provider

Date _____

**RECORDS RELEASE AUTHORIZATION
(TO OUR FACILITY)**

To: _____

I, _____, request that my complete medical records be released to:

Bay Surgical Specialists
960 Seventh Ave. North
St. Petersburg, FL 33705-1347
(727) 821-8101 phone
727-825-1357 fax

Records should include diagnosis, treatment, prognosis and recommendations.

Patient's Printed Name

Patient Signature

Social Security Number

Date

Date of Birth

Bay Surgical Specialists, PA

960 7th Avenue North
St. Petersburg, FL 33705
(727) 821-8101 Phone
(727) 825-1357 Fax

1615 Pasadena Ave. S., Ste 480
St. Petersburg, FL 33707
(727) 345-2929 Phone
(727) 345-0340 Fax

**RECORDS RELEASE AUTHORIZATION
(TO OTHER DOCTORS)**

I, _____, request that my complete medical
(print name)

records from Bay Surgical Specialists, PA be released to:

Records should include diagnosis, treatment, prognosis and recommendations.

Patient's Printed Name

Date

Patient Signature

Date

Social Security Number

Date of Birth

Bay Surgical Specialists, PA

960 7th Avenue North
St. Petersburg, FL 33705
(727) 821-8101 Phone
(727) 825-1357 Fax

1615 Pasadena Ave. S., Ste 480
St. Petersburg, FL 33707
(727) 345-2929 Phone
(727) 345-0340 Fax

**RECORDS RELEASE AUTHORIZATION
(FOR FAMILY OR FRIENDS)**

I, _____, give permission to the following
(Patient's Name or Guardian)

person(s) to have access to my complete medical records:

- 1. _____ Relationship: _____
- 2. _____ Relationship: _____
- 3. _____ Relationship: _____
- 4. _____ Relationship: _____

This includes a report of the diagnosis, treatment, prognosis and recommendations, as well as other data pertinent in the treatment of myself.

Patient Signature

Date

Patient's Printed Name

Patient's Date of Birth

Patient's Social Security Number



Financial Policy

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our financial policy.

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. Bay Surgical Specialists accepts cash, personal checks (in-state only), VISA, MasterCard, American Express and Discover. There is a service charge for returned checks. Patients with an outstanding balance that has been referred to collection must make arrangements for payment prior to scheduling appointments.

CO-PAYMENTS AND DEDUCTIBLES

These payments must be made at check-in. Copays and deductibles are part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles is considered a violation of the contract and can be considered fraud. Please help us to uphold the law by making your copayments at each visit and paying deductibles owed at the beginning of the year. If you need assistance or have questions, please contact **Susan Unger, Billing Supervisor between 8:30 a.m. and 5:00 p.m., Monday through Friday at 727-821-8101 ext 204.**

MANAGED CARE

If you are enrolled in a managed care insurance plan (i.e., HMO), you must obtain a referral from your Primary Care Physician before you can be seen at Bay Surgical Specialists. Retroactive referrals are not always granted by the Primary Care Physician. It is your responsibility to ensure that your visit has been authorized prior to your appointment.

MISSED APPOINTMENTS/LATE CANCELLATIONS

Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand Bay Surgical Specialists, PA Financial Policy. I agree to assign insurance benefits to Bay Surgical Specialists' Practice whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of Patient: _____

Date: _____



This notice describes how information you give to this office can be used and given with others. It also describes how you can obtain access to this information. Please read it carefully

NOTICE OF PRIVACY PRACTICES of BAY SURGICAL SPECIALISTS, PA

Bay Surgical Specialists, PA is dedicated to ensuring the privacy of your protected health information (PHI) both morally and legally. Protected health information is any information that identifies you. Bay Surgical Specialists, PA may disclose only information to a third party that is necessary for treatment or to collect payment. A third party used by Bay Surgical Specialists, PA includes your health insurance company, a service your health insurance company uses such as a laboratory or to the primary care physician whose name appears on your health insurance card. Occasionally, a third party includes another physician or healthcare facility that referred you to our practice. In such an event, only the minimum necessary protected health information required to continue your immediate care will be disclosed. Your PHI must be given to a third party in order to conform to the rules and regulations of your health insurance company, to diagnostic facilities such as a laboratory or to collect payment for service rendered. Bay Surgical Specialists, PA is permitted or required to use or disclose PHI without the individuals consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.

The office of Bay Surgical Specialists, PA will use your protected health information as a means to communicate with you by telephone or mail to discuss with you your health issues (such as calling you with laboratory results) or appointment management (such as reminding you of an upcoming appointment).

Other than previously stated, Bay Surgical Specialists, PA does not release in any way your protected health information without your expressed written authorization. You may at any time revoke all consents and authorizations in writing unless the disclosure has already taken place.

You have the right to choose not to sign the consent. You have the right to choose not to provide personal or health related information. In such cases, Bay Surgical Specialists, PA has the right to refuse to see you as it may contribute to inappropriate treatment and diagnosis or make it difficult for Bay Surgical Specialists, PA to receive payment for services rendered.

You have the right to examine your health records, to obtain a copy of your health records with a signed Release of Medical Records Authorization, and to request in writing, corrections to your health records. The written request must include the reason to support your request.

Bay Surgical Specialists, PA may at any time, revise this Notice of Privacy Practices. In the event of any revisions, a notice will be posted in the waiting room. You may contact Bay Surgical Specialists, PA to request a copy of the changed notice be mailed to you or you may request a copy of the revised notice at your next visit.

If you feel your Rights of Privacy have been compromised you have the right to file a written complaint stating how your rights have been violated. It is to be sent to Bay Surgical Specialists, PA Attn: HIPAA Compliance Officer at 960 7th Avenue North, St. Petersburg, FL 33705. Bay Surgical Specialists, PA may not retaliate as a result of the complaint. If you need further information regarding the Privacy Notice please call our office to speak with the HIPAA Compliance Officer at 727-821-8101.



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

This Notice of Privacy Practices tells me my rights, and Bay Surgical Specialists, PA duties regarding my protected health information. This Notice of Privacy Practices describes how my protected health information is to be used by Bay Surgical Specialists, PA to diagnose and treat me, to obtain payment of services rendered, and to communicate with me and with pertinent outside facilities while I am a patient of Bay Surgical Specialists, PA.

My protected health information is any information collected by Bay Surgical Specialists, PA about me. Bay Surgical Specialists, PA has the right to use and disclose my protected health information to diagnose and treat me. Bay Surgical Specialists, PA has the right to use and disclose my protected health information to collect payment for services rendered.

This Notice of Privacy Practices is posted on bulletin boards around the waiting room. If my registration papers were mailed to me a copy was included. I may request a copy of The Notice of Privacy Practices of Bay Surgical Specialists, PA at any time. If the current Notice of Privacy Practices is revised, I am entitled to review and obtain a new copy at any time. I have the right to review Bay Surgical Specialists, PA’s Notice of Privacy Practices before I sign this form.

I acknowledge that I have been given the opportunity to read The Notice of Privacy Practices of Bay Surgical Specialists, PA and have been given the opportunity to obtain a copy.

Signature of Patient or Personal Representative

Date

CONSENT AND ASSIGNMENT OF BENEFITS

Bay Surgical Specialists, PA is contracted to various health insurance programs, including Medicare, and accepts assignments only for those health insurances. If a contract exists between my insurance company and Bay Surgical Specialists, PA, Bay Surgical Specialists, PA will file my health insurance. I request that payment be made by my insurance on my behalf to Bay Surgical Specialists, PA. I agree to pay any portion of my charges rendered by Bay Surgical Specialists, PA that my contracted health insurance determines is my responsibility. In the event a charge is determined to be cosmetic, I agree to pay for the cosmetic services in full at the time service is rendered.

If I do not have a health insurance plan that Bay Surgical Specialists, PA is contracted with, I agree to pay all fees in full at the time services are rendered.

I understand that I am ultimately responsible for payment of my medical bill. If it becomes necessary for Bay Surgical Specialists, PA to collect payment, I understand that I will be responsible for legal costs, including attorney’s fees.

I understand that as a result of refusal to sign this form, or if I have altered this form in any way, Bay Surgical Specialists, PA may refuse to diagnose and treat me. I have the right to revoke this consent and assignment of benefits in writing except for services that have already occurred.

Printed Patient Name or Personal Representative

Date

Signature of Patient or Personal Representative

Date

MEDICARE PATIENTS (only) MUST ALSO READ AND SIGN BELOW

I request that payment of authorized Medicare services rendered by Bay Surgical Specialists, PA be paid to Bay Surgical Specialists, PA I agree to pay any portion of my charges rendered by Bay Surgical Specialists, PA that Medicare determines to be my responsibility. In the event a charge is determined to be cosmetic, I agree to pay for the cosmetic services in full at the time services are rendered.

Patient Signature

Date

Witness Signature

Date

Bay Surgical Specialists, PA

960 Seventh Ave. North
St. Petersburg, FL 33705-1347
(727) 821-8101 phone
727-825-1357 fax

