

**Carrollton Surgical Group, P. A.**  
**157 Clinic Avenue, Suite 302**  
**Carrollton, Georgia 30117**  
**770-834-3336**

**Authorization for Release of Records to Patient Representative**

Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Patient's name: \_\_\_\_\_ SS#: \_\_\_\_\_

Date of birth: \_\_\_\_\_

I, \_\_\_\_\_ (print patient's name) do hereby authorize  
Carrollton Surgical Group, P. A. to discuss and/or release my medical information to the  
individuals listed below:

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

Medical Information may include the following items.

- |  |   |
|--|---|
| <input type="checkbox"/> Test Results (Xray, Pathology, Lab) | <input type="checkbox"/> Surgery Related Information    |
| <input type="checkbox"/> Patient Instructions                | <input type="checkbox"/> Medication Related Information |
| <input type="checkbox"/> Test Preparation Information        | <input type="checkbox"/> Medical Opinion                |

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\*\*Please note that it is the responsibility of the patient to notify our office in writing or  
by telephone if they want to remove a patient representative from this form.

**Carrollton Surgical Group, P.A.**  
**Cancellation Policy**  
**Effective March 2008**

**Cancellation Charge for Surgeries at Hospital:**

In the event that your surgery is cancelled within 5 days of the scheduled surgery there will be a \$100.00 charge for which you will be responsible. The charge will only be waived under circumstances which are determined to be the result of an emergency. The decision to waive the cancellation charge will be determined by our office. If you feel sick prior to your surgery please contact our office Monday thru Friday between the hours of 7:00 a.m. and 6:00 p.m. The telephone number is 770.834.3336. You will need to speak to a nurse regarding the symptoms you are having so that they can assist you. There could very likely be a solution to the problem without canceling your scheduled surgery. If you have problems after office hours and your surgery is scheduled for the following morning please go to the hospital as scheduled and let the anesthesiologist decide if you are qualified to proceed with surgery. There are different preparations for scheduled surgeries which have to be followed closely. Please pay careful attention to the instructions our office gives you so that you can avoid doing something which may result in your not being prepared for surgery. If failure to comply with the proper instructions to prepare you for a surgery is the cause of a surgery cancellation there will be a \$100.00 cancellation fee for which you will be responsible. Please note that a preparation sheet indicating that the patient is to eat nothing or drink nothing after midnight means that you can not put anything in your mouth after midnight. This statement includes peppermint drops, chewing gum, tobacco, etc. If you are unsure at any time about the proper preparations for your surgery please call our office and speak with a nurse.

**Cancellation Charge for Scheduled Procedures in the Office:**

There will be a \$50.00 charge for cancellation of a procedure scheduled to be done in the office if the procedure is cancelled within 5 days of the scheduled procedure for which you will be responsible. This charge will only be waived under circumstances which are determined to be the result of an emergency. The decision to waive the cancellation charge will be determined by our office.

**This is to certify that I fully understand the Cancellation Policy of Carrollton Surgical Group, P. A., and, in addition I understand the proper procedure to prepare for my surgery and the necessity of following these instructions precisely. I further agree to contact the office to speak with a nurse to clarify any questions that may arise.**

---

**Patient Signature**

**Date**

**Witness**

Last Name:	First Name:	Middle:		
Preferred:	Maiden:	Prefix:	Suffix:	Credentials:
Date of Birth:	Sex:	SSN:	Race:	
Marital Status:	DL# :	Primary Language:	Religion:	
Mailing Address:				
PO Box Address:				
Zip:	City:	State:		
Home Phone:	Work Number:	Cell:	Primary:	
Fax:	Pager:	Email Address:		
Employer:	How long Employed:	Occupation:		
Address:	City:	State:	Zip:	
Emergency Contact:	Home Phone:	Cell Phone:		
Relationship:				
Nearest Relative not living with you:	Home Phone:	Cell Phone:		
Spouse's Name:	SSN:	Date of Birth:		
Spouse's Employer:	Work Phone:			
If patient is under age 18, please complete the following:				
Mother's Name:	SSN:	Date of Birth:		
Employer:	Work Phone:			
Father's Name:	SSN:	Date of Birth:		
Employer:	Work Phone:			

AUTHORIZATION TO TREAT RELEASE OF RECORDS AND INSURANCE AUTHORIZATION: I assign to Carrollton Surgical Group, P.A. all payments for medical services, including major medical benefits rendered to me or to my dependants. I understand that I am responsible for any amount not covered by assigned insurance. I authorize Carrollton Surgical Group, P.A. to furnish information to insurance carriers, physicians, or hospitals concerning illnesses and treatments. I authorize any physician, hospital or medical care facility to provide all information on medical history and treatment to Carrollton Surgical Group, P.A. and I authorize photocopies of this form to be as valid as the original. I have read and understand the above and give Carrollton Surgical Group, PA permission to treat me or my child.

Date:

Signature: \_\_\_\_\_

**CARROLLTON SURGICAL GROUP, P. A.**  
**FINANCIAL POLICY**  
**EFFECTIVE NOVEMBER 2008**

**Insurance:** If we participate with your insurance carrier, our office will file a claim on your behalf for all charges. However, we will collect the required co-payment *before* services are rendered. In the event a health plan determines a service to be “non-covered”, the patient will be responsible for all charges. Many insurance policies require a co-insurance payment which is due from the patient for certain surgical procedures and office services. We have to estimate what this amount is and the actual amount due may be more or less than the initial estimate. We require that this percentage amount be paid *prior* to surgery. Any overpayment will be refunded to the patient and any amount due will be billed to the patient. If you present invalid insurance coverage you will be held responsible for payment in full on your account. We accept cash, checks, traveler’s checks, all major credit cards and debit cards in payment on your account. We can also assist you with obtaining an interest free loan thru Care Credit. We will be glad to assist you in arranging an acceptable method of payment.

Carrollton Surgical Group employs a Physician’s Assistant. Occasionally circumstances arise in which the Physician’s Assistant may assist with surgery. All insurance companies do not pay for the services of a Physician’s Assistant. The patient will be held responsible for payment of those services. The patient may choose not to have the Physician’s Assistant assist with surgery. Your request will need to be presented to the office before your surgery is scheduled and you must keep in mind that your surgery may have to be postponed if another surgeon is not available to assist the primary surgeon.

Some members of our nursing staff are Medical Assistants. Please let the nurse know if you wish to speak with an LPN

This is to certify that I authorize a representative from Carrollton Surgical Group, P. A. to act on my behalf in an effort to appeal my claim for medical benefits with my insurance company. **\*\*Initial** \_\_\_\_\_

**Self-Pay:** A \$200.00 minimum is required for office visits for patients who do not have health coverage. All procedures will require a down payment which will be determined at the time of scheduling.

**Minor Patients:** For all services rendered to minor patients, the adult accompanying the patient will be held responsible for payment of all charges.

**Payments:** Payments are due on a monthly basis. If a patient fails to make a scheduled payment, the *total* balance will be expected within ten days. Should a patient at any time disregard our payment policy, the amount due will be forwarded to magistrate court and an appropriate amount will be added to the balance due on the account. Your employer may be contacted to verify employment.

**FMLA Forms, Cancer Insurance Forms, Disability Forms and Copies of Medical Records:** If you require completion of FMLA Forms, Cancer Policy Insurance Forms or forms related to Disability claims there will be a \$10.00 charge which must be paid at the time the forms are picked up or in advance if you would like the forms to be mailed. There is a fee which is set forth by the State of Georgia which will be charged for copying medical records.

Our main goal is to provide quality patient care and we need your cooperation in order to make that possible. Please note that if you cancel your surgery within two days of the scheduled surgery date it will be necessary for you to schedule an office visit with your doctor prior to rescheduling the surgery.

By signing below, the patient agrees to the terms of our financial policies and we appreciate your cooperation.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Please Print the Name of the Patient

Date: \_\_\_\_\_

MEDICAL HISTORY

PATIENT \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

REFERRED BY \_\_\_\_\_ PRIMARY PHYSICIAN \_\_\_\_\_

CHIEF COMPLAINT \_\_\_\_\_ HOW LONG? \_\_\_\_\_

MAIN SYMPTOMS \_\_\_\_\_

PRIOR SURGERIES:

TONSILLECTOMY?	YES	NO	HERNIA REPAIR?	YES	NO
APPENDECTOMY?	YES	NO	HEMORRHOIDECTOMY?	YES	NO
PACEMAKER?	YES	NO	OTHER SURGERIES:	_____	
GALLBLADDER?	YES	NO	_____	_____	
HYSTERECTOMY?	YES	NO	_____	_____	

CURRENT/PRIOR MEDICAL PROBLEMS \_\_\_\_\_

ANY TROUBLE WITH:

HEART?	YES	NO
LUNGS?	YES	NO
KIDNEYS?	YES	NO
LIVER?	YES	NO
BLOOD PRESSURE?	YES	NO
GALLBLADDER?	YES	NO
GASTROINTESTINAL?	YES	NO
THYROID?	YES	NO

IF YES, EXPLAIN:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HAVE YOU HAD:

CANCER?	YES	NO
STROKE?	YES	NO
DIABETES?	YES	NO
ASTHMA?	YES	NO
HEART ATTACK?	YES	NO

IF YES, EXPLAIN:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FAMILY MEMBER HAD:

CANCER?	YES	NO
DIABETES?	YES	NO
HIGH BP?	YES	NO
HEART DISEASE?	YES	NO

IF YES, EXPLAIN:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MEDICATIONS CURRENTLY TAKING: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ARE YOU ALLERGIC TO ANY MEDICATION? YES NO \_\_\_\_\_

DO YOU USE TOBACCO? YES NO AMOUNT? \_\_\_\_\_

DO YOU USE ALCOHOL/DRUGS? YES NO HOW OFTEN? \_\_\_\_\_

DO NOT WRITE BELOW THIS LINE—OFFICE USE ONLY

GYN/OB HISTORY: LMP \_\_\_\_\_ G \_\_\_\_\_ P \_\_\_\_\_ A \_\_\_\_\_ LC \_\_\_\_\_ PAP SMEAR \_\_\_\_\_ MAMMOGRAM \_\_\_\_\_

WEIGHT \_\_\_\_\_ HEIGHT \_\_\_\_\_ BP \_\_\_\_\_ PULSE: \_\_\_\_\_ NURSE: \_\_\_\_\_ DATE: \_\_\_\_\_