

# Somerset Surgical Associates

## Patient Information

Patient Name \_\_\_\_\_ Sex: M F Today's Date \_\_\_\_\_  
Marital Status \_\_\_\_\_ Name of Spouse (if applicable) \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Preferred Language:  English  Spanish  Other Ethnicity:  Hispanic  Non-Hispanic  Refuse to report  
Race:  White  Black  Hispanic  Other  Refuse to report  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work # \_\_\_\_\_  
Student  Yes  No School \_\_\_\_\_  
Employer \_\_\_\_\_ Length of Employment \_\_\_\_\_  
Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Email address \_\_\_\_\_

By providing your email, you will be invited to register in our patient portal.

## Emergency Contact

Name/Relationship \_\_\_\_\_ Contact # \_\_\_\_\_

## Referring Physician Information

Referring Physician \_\_\_\_\_  
Phone # \_\_\_\_\_ Fax # \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
Primary Physician \_\_\_\_\_  
Phone \_\_\_\_\_ Fax # \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

## Pharmacy

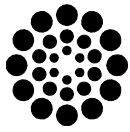
Name of Pharmacy \_\_\_\_\_ City \_\_\_\_\_  
Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

## Consent for RxHub Inquiry

I hereby provide my consent for Somerset Surgical Associates to obtain my Rx history using the Surescripts RxHub network. I understand this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Management (PBM) and retail pharmacies. I also understand that Surescripts RxHub follows strict security protocols to align with HIPAA requirements and respects patient privacy. All queries and responses are made automatically through secure system to system communications.

Your name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_





# Somerset Surgical Associates

Name: \_\_\_\_\_

**Allergies:**

Yes  No

If yes, please list: \_\_\_\_\_

**Your past surgical history: (check all that apply & indicate year)**

- appendectomy                       cholecystectomy                       hysterectomy
- hernia repair                               breast surgery                               colon surgery
- peripheral vascular surgery
- heart: type \_\_\_\_\_  orthopedic: type \_\_\_\_\_  transplant: type \_\_\_\_\_
- cancer: type \_\_\_\_\_  cosmetic: type \_\_\_\_\_

Detailed explanation or other surgery: \_\_\_\_\_

**Your past hospitalization:**

If any, please list the date and reason

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

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

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

**Family History: (check all that apply)**

	Diabetes	High BP	Heart Problems	Stroke	Mental Illness	Cancer	Other
Grandfather							
Grandmother							
Father							
Mother							
Siblings							
Children							

**Your social history:**

Do you presently smoke tobacco?  Yes  No  Former  Thinking of quitting

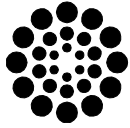
How many per day? \_\_\_\_\_

Do you drink alcohol?  Yes  No                      How many drinks per week? \_\_\_\_\_

Do you smoke marijuana?  Yes  No                      Frequency \_\_\_\_\_

Use cocaine and/or heroin?  Yes  No                      Frequency \_\_\_\_\_

Other illicit drugs?  Yes  No                      Frequency \_\_\_\_\_



# Somerset Surgical Associates

Name: \_\_\_\_\_

**Current Symptoms:** (check all that apply)

**General:**                     weakness     chills     fever     night sweats     sleep disturbance

**Allergy Immunology:**  current infection     chronic steroid use

**Eyes:**                       double vision     temporary loss of vision     blurred vision

**Endocrine:**                 hot flashes     cold intolerance     excessive thirst

**Respiratory:**               chronic cough     shortness of breath at rest     wheezing

**Cardiovascular:**          chest pain with exertion     palpitations     shortness of breath

**Gastrointestinal:**        constipation     diarrhea     exposure to hepatitis     vomiting

unexplained weight gain/loss

**Hematology:**              anemia     blood clot/deep vein thrombosis     prolonged bleeding

**Genitourinary:**          blood in urine     frequent urination     painful urination

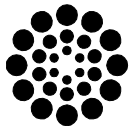
**Musculoskeletal:**        arthritis     muscle aches     painful joints

**Skin:**                       ulcers     eczema     keloid formation

**Neurologic:**               dizziness     fainting     seizures

**Psychiatric:**              anxiety     depressed mood     difficulty sleeping

Detailed explanation: \_\_\_\_\_



# Somerset Surgical Associates

## Payment Policy

### To patients who have an insurance policy with which Somerset Surgical Associates participates:

All co-payments, co-insurances, and deductibles are the insured/patient's financial responsibility. Co-payments are due at the time of check-in. Any deductibles and co-insurances are to be collected prior to surgical procedures as determined by your insurance contract. Remaining balances not covered by the insured/patient's insurance company are due within 30 days from the time of service.

### To patients who have an insurance policy with out-of-network benefits with which Somerset Surgical Associates DOES NOT participate:

All out-of-network fees are the insured/patient's financial responsibility and must be paid in full at the time of check-in. These charges will be submitted to the insurance company. If the insurance company fails to make payment, the insured/patient is held responsible for the full amount, including any additional charges.

### To patients who are uninsured:

All office visits must be paid in full at the time of service. Planned procedures under \$750 must be paid in full 1 week prior to the surgery date. For procedures over \$750, at least \$750 or half of the procedure fee must be paid prior to the surgery, whichever is greater, and a payment agreement must be signed for the remaining balance. For emergent procedures that took place prior to today, a \$300 payment must be made towards the balance and a payment agreement must be signed for the remaining balance.

### Applicable to all patients:

Any outstanding balances must be paid in full prior to any new appointments being made. Outstanding balances that are more than 60 days past due may be referred to an outside collection agency and will be subject to a collection fee of \$50 or 25% of the outstanding balance, whichever is greater. Patients who have been sent to collections will be discharged from the practice until the balance is paid in full with the collection agency.

### Missed or Cancelled Appointments:

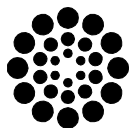
The office requires a 24-hour notice if an appointment needs to be canceled or rescheduled. Failure to provide notice will result in a \$75 *No-show* fee.

### Other Fees:

For any returned check, there will be a fee of \$30 applied to the account.

If you have any questions about the payment policy, please feel free to contact our Billing Department.

Your name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Somerset Surgical Associates

## Insurance Information

### Primary Insurance

Insurance Company: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

### Subscriber Information

Subscriber Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work # \_\_\_\_\_

Do you need an insurance referral for a specialist? \_\_\_\_ Yes \_\_\_\_ No

- If a referral is necessary and not presented at the time of your visit, you will be liable for the payment of your office visit.

Co-payment for specialist: \$ \_\_\_\_\_ Deductible: \$ \_\_\_\_\_

### Secondary Insurance

Insurance Company: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Co-payment for secondary: \$ \_\_\_\_\_ Deductible: \$ \_\_\_\_\_

### Workers Comp/Motor Vehicle Case

Is this a worker's compensation case?  Yes  No

Is this a motor vehicle case?  Yes  No

If yes, additional information is required. Please notify the receptionist for a relevant questionnaire.

### Proof of Identity

Due to current insurance company policies and regulations, we are required to obtain a valid copy of your current health insurance card and photo ID at EACH and EVERY visit to our office.

If the insurance information you have provided is later found to be invalid or expired, you will be responsible for any and all payments for services provided at Somerset Surgical Associates.

### Accepted Insurance Plans

Aetna • AmeriHealth • Cigna • Great West • Horizon/BCBS • Medicare • Oxford • United Healthcare

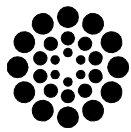
Out of network benefits with all other insurance carriers

As a courtesy, our office will submit all claims to the appropriate institutions and work diligently to obtain maximum reimbursement allowed by your policy.

**Note that** you will be responsible for all deductibles and/or co-insurances that apply to your outstanding claims.

I authorize the release of any medical or other information necessary to process my medical insurance claim. I authorize the payment of medical benefits to the physician. **If I am sent a payment directly from the insurance company for services my physician rendered, I promise to forward that check to Somerset Surgical Associates or face prosecution.**

Your name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Somerset Surgical Associates

## Authorization to Use and Disclose Health Information

I give the following individuals permission to discuss or to receive any medical documentation from this office:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I give permission to have messages left on my voicemail at the following telephone number(s):

Home: \_\_\_\_\_

Cellular: \_\_\_\_\_

Business: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**OR**

I refuse to share my medical documentation from this office with any individuals other than medical physicians.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Gunaseelan Ambrose, MD, FACS • Obi J Imegwu, MD, FACS • Cynthia Lee, MD, FACS  
Thangamani Seenivasan, MD, FACS • William M Sugarmann, MD, FACS

30 Rehill Avenue, Suite 3400, Somerville, NJ 08876  
(P) 908-725-2400 (F) 908-927-8990  
[www.somersetsurgicalassociates.com](http://www.somersetsurgicalassociates.com)