J. BRANDON MORGAN, M.D.
GENERAL SURGERY

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Thank you for choosing our office for your surgical needs. We look forward to seeing you and helping you feel your best!

In our efforts to reduce wait times, we ask that you show up at the time of your visit. If you are more than 40 mins early for your appt, others who are scheduled before you will be seen first.

If you are unable to keep your appointment, please notify our office at least 24 hours in advance.

Please fill out the paperwork **completely** in the comfort of your home with your records and medications readily available.

Please have the following available upon check-in, otherwise your appointment may be rescheduled.

* **Your completed paperwork**
* **A list of current medications and allergies**
* **Driver's License or Picture ID**
* **Insurance Card(s)**
* **Any co-pay, deductible, or amount not covered by insurance**
    - **Payment options include**
        - **Cash (exact change only)**
        - **Debit/Credit Card**
        - **Personal Check**
* **If you do not have insurance, $240.00 is due at the time of your appointment. All other fees will be billed to you.**

If you have any questions or need directions, please contact our office.

We look forward to your visit.

Patient Financial Agreement

The following information is provided to all our patients, new and established, to inform patients of our office financial policies and of patient financial responsibility requirements.

We will be happy to bill your insurance as a courtesy; however, all charges, regardless of insurance coverage are the patient's responsibility. We do expect payment for your portion at the time of service (co-pays, co-insurance, deductibles). We ask that if your insurance has not paid within 45 days that you follow up with them. Our office contracts with most insurance carriers. If you are seen for both a wellness/annual exam and an illness of separate problem is also addressed, proper coding will be used which may result in a charge for both services. Additionally, some medically indicated lab work may not be covered by all wellness policies. Your individual contract with your insurance carrier will determine how your insurance will pay. We make every effort to bill each visit with the proper diagnosis and procedure codes according to national coding guidelines. Please understand that we cannot make exceptions to our coding practices due to federal and state legal compliance concerns, and we are unable to bill for services other than those documented in your medical record. We routinely send our laboratory testing to third-party laboratory companies. The providers may or may not participate with your health plan. You may request that we refer your testing to another location. This request will need to be made with each visit. Paperwork (for example Family Medical Leave Act (FMLA) & Short-Term Disability applications) will be completed within 2 weeks of presentation.

I have read and understand the above information and agree to comply with these financial policies.

Print Name: _____ **Signature:** _____ **Date:** _____
(Or legal guardian/Representative)

Patient HIPAA (Health Insurance Portability & Accountability Act) Authorization

Because of the changes made by Congress, we are required to get your explicit permission regarding how your medical information is handled. You may request a copy of the Notice of Privacy Practices from our staff. Please read each authorization carefully and indicate your approval by signing on the line provided.

I authorize the release of all medical records maintained by J. Brandon Morgan, M.D. PLLC, which relates to services I have received from, or the results of tests ordered by J. Brandon Morgan, M.D. PLLC. These records may be released as needed for my care for the processing of insurance claims, to satisfy the requirements of a managed care organization of which I am a member, and/or to my attorney regarding pending or anticipated litigation under a worker's compensation, motor vehicle accident, and/or third-party liability claim. I am giving permission for J. Brandon Morgan, M.D. PLLC to obtain my prior films, scans, labs, and any records including demographic, pharmacy and medication history that may identify me and that relates to my past, present, and/or future physical or mental health or condition and related health care services. I understand that it is my responsibility to obtain previous studies, if asked to do so. If it is necessary for an employee of J. Brandon Morgan, M.D. PLLC to obtain my prior films, labs, and/or other records, I am giving my permission to call and/or fax on my behalf to get the medical records and films needed. I authorize direct payment of benefits from my insurance plan to J. Brandon Morgan, M.D. PLLC I understand that I am responsible for payment of professional fees charged by J. Brandon Morgan, M.D. PLLC, which are not covered or not properly reimbursed under the terms of my insurance plan. J. Brandon Morgan, M.D. PLLC will file your insurance. You, the patient, are responsible for any personal balance. Any account turned over to an outside collection agency will accrue additional fees on the unpaid balance including any attorney/court costs in collecting that balance. I will provide J. Brandon Morgan, M.D. PLLC with the phone numbers I authorize to be used to contact me. I authorize the use of any messaging person or system, voice mail and/or answering machine to convey information regarding my care. Contact via e-mail is authorized if I provided my e-mail address to J. Brandon Morgan, M.D. PLLC. I authorize the use of fax or e-mail to send my information to myself or other parties that have a right to receive my information. I understand that every effort is made to protect my privacy, however, no absolute privacy guarantee is given when faxes or e-mails are used.

I have been offered a copy of J. Brandon Morgan, M.D. PLLC Notice of Privacy Practices for my own records.

Print Name: _____ **Signature:** _____ **Date:** _____
(Or legal guardian/Representative)

Patient Release of Information

My signature will also serve as a PHI document release should I request treatment, or records be sent to other Doctors/ Facilities in the future or consent for data to be exchanged electronically between providers/hospitals.

Print Name: _____ **Signature:** _____ **Date:** _____
(Or legal guardian/Representative)

PATIENT INFORMATION:

Full Name:_____
Date of Birth:_____/_____/_____
Gender: ☐ Male or ☐ Female
SSN:_____-_____-_____

Mailing Address:_____
City:_____ State:_____ Zip:_____

Home Phone:_____
Cell Phone:_____
Email:_____

CONSENT TO: (check all that apply)

☐ call ☐ text ☐ email ☐ portal

RACE:

☐ white ☐ black ☐ other:_____

ETHNICITY:

☐ Hispanic ☐ non-Hispanic

MARITAL STATUS:

☐ married ☐ single ☐ divorced ☐ widowed

VITALS: **(office use)**

height: _____ weight:_____
blood pressure: _____/_____
pulse: _____ temperature: _____°

CARE TEAM:

Pharmacy:_____
Primary Care Physician:_____
Cardiologist:_____
Nephrologist:_____
Oncologist:_____

DIALYSIS PATIENTS ONLY:

Facility:_____
City:_____ State:_____
Dialysis Days: (check one
☐ Monday-Wednesday-Friday
☐ Tuesday-Thursday-Saturday

65+ PATIENTS ONLY:

Have you had any falls within the last 6 months?
☐ yes ☐ no

Do you use any of these?
☐ crutches/cane/walker ☐ wheelchair ☐ no aid

EMERGENCY CONTACT #1:

Name:_____
Relationship:_____
Phone #:_____

RELEASE OF INFORMATION: (this means that this person can request records on your behalf unless we are told otherwise)

Name:_____
Relationship:_____
Phone #:_____
Patient Signature: _____

PATIENT MEDICATION AND ALLERGY INFORMATION

Are you allergic to any medicine? ☐ Yes ☐ No

If yes, what?_____

Pharmacy: _____City/State: _____

Did you receive a flu shot within the last year? ☐ Yes ☐ No

If yes, when?_____

Medication	Dose	Frequency	Reason	Prescriber

FAMILY HISTORY: ☐ none ☐ unknown

stroke:
☐ mother ☐ father ☐ brother ☐ sister
high blood pressure:
☐ mother ☐ father ☐ brother ☐ sister
heart disease:
☐ mother ☐ father ☐ brother ☐ sister
cancer (& type):
☐ mother:_____ ☐ father:_____
☐ brother:_____ ☐ sister:_____

SURGICAL HISTORY:

☐ none
☐ appendix
☐ hernia
☐ hysterectomy
☐ colonoscopy; what year?_____
☐ gallbladder
☐ cardiac
☐ back
☐ other:_____

SOCIAL HISTORY:

Do you smoke?
☐ yes ☐ no ☐ former

If yes, how many packs per day? _____
For how many years? _____

If former, what year did you quit? _____

Do you vape?
☐ yes ☐ no ☐ former

Do you chew/dip?
☐ yes ☐ no ☐ former

Do you drink alcohol?
☐ none
☐ occasional ☐ moderate ☐heavy

Do you use recreational drugs?
☐ yes ☐ no

If yes, which drug?
☐ marijuana ☐ cocaine ☐ meth ☐ heroin

MEDICAL HISTORY:
(choose all that apply)

☐ none
☐ A-fib
☐ AIDS/HIV
☐ Anemia
☐ Anesthesia Problems
☐ Angina
☐ Anxiety Disorder
☐ Arthritis
☐ Asthma
☐ Autoimmune Disease
☐ Bleeding Disorder
☐ Blood Transfusion
☐ Bronchitis
☐ COPD
☐ Cancer:_____
☐ Colon Polyps
☐ Congestive Heart Failure
☐ Coronary Artery Disease
☐ Deep Vein Thrombosis
☐ Depression
☐ Diabetes
☐ Diverticulitis
☐ GERD/reflux
☐ Gout
☐ Head/Neck Injury
☐ Headaches
☐ Heart Attack
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ Hernia
☐ Hiatal Hernia
☐ High Cholesterol
☐ Hypertension
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Kidney Disease
☐ Kidney Stones
☐ Liver Disease
☐ Lung Disease
☐ Migraines
☐ Nervous Disorder
☐ Pulmonary Embolism
☐ Seizures/Epilepsy
☐ Sleep Apnea
☐ Stomach Ulcer
☐ Stroke
☐ Tuberculosis

check only the symptoms that you have had within the past 6 months:

CONSTITUTIONAL
☐ fever
☐ night sweats
☐ weight gain
☐ weight loss
☐ exercise intolerance
☐ sedation
☐ lethargy
☐ chills
☐ malaise (fatigue)

EYES
☐ dry eyes
☐ irritation
☐ vision change
☐ eye disease/injury

ENMT
☐ difficulty hearing
☐ ear pain
☐ frequent nose bleeds
☐ nose problems
☐ sinus problems
☐ sore throat
☐ bleeding gums
☐ snoring
☐ dry mouth
☐ mouth ulcers
☐ oral abnormalities
☐ teeth abnormalities
☐ ringing in ears
☐ sinusitis

CARDIOVASCULAR
☐ chest pain on exertion
☐ arm pain on exertion
☐ shortness of breath when walking
☐ shortness of breath when lying down
☐ palpitations
☐ known heart murmur
☐ light-headed on standing
☐ ankle swelling

RESPIRATORY
☐ cough
☐ wheezing
☐ shortness of breath
☐ coughing up blood
☐ sleep apnea

GASTROINTESTINAL
☐ abdominal pain
☐ nausea
☐ vomiting
☐ constipation
☐ change in appetite
☐ black or tarry stools
☐ frequent diarrhea
☐ vomiting blood
☐ dyspepsia (indigestion)
☐ GERD (reflux)

GENITOURINARY
☐ urinary loss of control
☐ difficulty urinating
☐ increased frequency
☐ hematuria (blood in urine)
☐ incomplete emptying

MUSCULOSKELETAL
☐ muscle aches
☐ muscle weakness
☐ arthralgias (joint pain)
☐ back pain
☐ swelling in extremities
☐ neck pain
☐ difficulty walking
☐ cramps
☐ osteoporosis
☐ fractures

INTEGUMENTARY
☐ abnormal mole
☐ jaundice
☐ rash
☐ itching
☐ dry skin
☐ growths/lesions
☐ laceration
☐ non-healing area
☐ changes in hair/nails
☐ psoriasis
☐ changes in skin color
☐ breast lump

NEUROLOGICAL
☐ loss of consciousness
☐ weakness
☐ numbness
☐ seizures
☐ dizziness
☐ frequent or severe headaches
☐ migraine
☐ restless legs
☐ tremor
☐ gait dysfunction
☐ paralysis

PSYCHIATRIC
☐ depression
☐ sleep disturbances
☐ restless sleep
☐ alcohol abuse
☐ anxiety
☐ hallucinations
☐ suicidal thoughts
☐ mood swings
☐ memory loss
☐ agitation
☐ dementia
☐ delirium

ENDOCRINE
☐ fatigue
☐ increased thirst
☐ hair loss
☐ increased hair growth
☐ cold intolerance

HEMATOLOGIC / LYMPHATIC
☐ swollen glands
☐ easy bruising
☐ excessive bleeding
☐ anemia
☐ phlebitis

ALLERGIC / IMMUNOLOGIC
☐ runny nose
☐ sinus pressure
☐ itching
☐ hives
☐ frequent sneezing