mississippibreastcenter.com
PHILLIP B. LEY, MD, FACS

Dear Patient,

Welcome to the Mississippi Breast Center of the Surgical Clinic Associates. We understand how stressful the need for medical care can be and would like to help make your visit to our office as smooth as possible.

Please complete the attached patient information sheets and bring with you to your appointment. We will also need to have your insurance card(s) and a picture ID to scan into our system.

It is very important for you to have the information listed below at the time of your visit. Please check with your insurance company regarding this information BEFORE your appointment.

1. What is the amount of your co-pay?

2. Does your insurance company require that your primary care physician obtain a referral to our office?

3. Is the doctor you are scheduled to see in your network?

4. Which hospital(s) or outpatient surgical facilities are in your network?

5. Do you have out of network benefits?

6. Does your insurance company require precertification or prior authorization?

Please contact us with any additional questions you may have.

Sincerely,

Surgical Clinic Associates, P.A.

AMOUNTS DUE FROM PATIENTS FOR OFFICE VISITS ARE EXPECTED TO BE PAID AT THE TIME SERVICE IS PROVIDED AND FOR SURGERY WHEN YOUR SURGERY IS SCHEDULED. THIS INCLUDES CO-PAYS, CO-INSURANCE, DEDUCTIBLES, NON-COVERED SERVICES AND SELF PAY BALANCES; UNLESS OTHER ARRANGEMENTS ARE AGREED TO BY THE SURGICAL CLINIC ASSOCIATES, P.A.

mississippibreastcenter.com
PHILLIP B. LEY, MD, FACS

Surgical Clinic Associates, P.A.
501 Marshall Street, Suite 500 | Jackson, MS 39202
601.948.1411 • 601.948.0090

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the release of my x-ray films and/or my medical records, copies, or such and request they be sent ASAP to:

_____ Scott M. Berry, M.D.

_____ G. Edward Copeland, III, M.D.

_____ Alexander J. Haick, Jr., M.D.

_____ Phillip B. Ley, M.D., F.A.C.S.

_____ Jason G. Murphy, M.D.

_____ Anthony B. Petro, M.D.

_____ C. Randle Voyles, M.D.

PATIENTS INFORMATION AS LISTED ON ALL RECORDS:

Patient Name: ____________________

Patient Date of Birth: ____________________ Patient SS#: ____________________

Patient Address: ____________________

Patient Phone Number: ____________________

Disclose the following PHI for treatment dates ____________to____________ (if no dates entered, send all)

(Please check the applicable item or items)

( ) Entire Chart ( ) Progress Notes ( ) Procedure Op Notes/ Hospital Summary ( ) Lab ( ) X-ray Report

( ) Telephone Message ( ) Pathology Report ( ) Other Specified: ____________________

The above information is disclosed for the following purposes: (Please check all applicable)

( ) Medical Care ( ) Legal ( ) Insurance ( ) Personal ( ) Other: ____________________

I understand that medical records may include information regarding a sexually transmitted disease, AIDS, or HIV infection as well as information about behavioral or mental health services or treatment for alcohol and drug abuse.

I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by confidentiality rules. I also understand that the degree of confidentiality can be modified with a facsimile transmission and that the Practice and Physician are not responsible for records once they have been transmitted.

I choose to have my records faxed. ____________ (please initial)

PATIENT REGISTRATION FORM

PLEASE PRINT AND COMPLETE IN FULL

*Date:*______________ *Doctor:*________________________ *Referring Doctor:*___________________________________

LAST NAME:______________________________ FIRST NAME:________________________ MI:____________________

ADDRESS:____

CITY:____ STATE:___________________ ZIP:______________________

HOME PHONE:___________________ WORK PHONE:__________________ CELL PHONE: ____________________

Date of Birth:_________/________/___________ Age: _________ Sex: ☐ F ☐ M SSN:__________________________

Marital Status: (CIRCLE) **SINGLE** **MARRIED** **WIDOWED** **DIVORCED** **SEPARATED**

Race: (CIRCLE) **AFRICAN AMERICAN** **ASIAN** **CAUCASIAN** **HISPANIC** **NATIVE AMERICAN** **OTHER**

If Patient is a child, lives with: _____BOTH PARENTS _____MOTHER _____FATHER _____OTHER

Name of person (with whom the child lives):____

RESPONSIBLE PARTY NAME:____

ADDRESS:____

CITY:____ STATE:___________________ ZIP:______________________

HOME PHONE:___________________ WORK PHONE:__________________ CELL PHONE: ____________________

Sex (CIRCLE) FEMALE or MALE Relationship:____

RESPONSIBLE PARTY EMPLOYER:____

NAME:_______________________________________ ADDRESS:____

CITY:____ STATE:___________________ ZIP:______________________

MAIN OFFICE PHONE:___________________ Occupation:____

EMERGENCY CONTACT PERSON:____

RELATIONSHIP:_______________________________________ HOME PHONE:_________________________________

WORK PHONE:____

PRIMARY INSURANCE:_________________________ **POLICY HOLDER NAME:**_____________________________

Date of Birth:_________/________/__________ SOCIAL SECURITY NUMBER:_________________________________

SECONDARY INSURANCE:______________________ **POLICY HOLDER NAME:**_____________________________

Date of Birth:_________/________/__________ SOCIAL SECURITY NUMBER:_________________________________

PRIVATE PAY____

PATIENT HISTORY FORM

Surgical Clinic Associates, P.A.

Patient Name:____ Date:________________

Date of Birth:____________________________ Age:____________________________

Reason For Visit:____

REFERRING DOCTOR:____

PAST MEDICAL HISTORY

- [ ] Abnormal Weight Gain
- [ ] Abnormal Weight Loss
- [ ] Alcoholism
- [ ] Alzheimer's Disease
- [ ] Angina
- [ ] Anxiety Disorder
- [ ] Arthritis
- [ ] Asthma
- [ ] Auto Immune Disease
- [ ] Bronchitis
- [ ] Cancer List Type:________ _________________________
- [ ] Congestive Heart Failure
- [ ] Crohn's Disease
- [ ] Diabetes Mellitus (Type I) (Type II) (Unkn)
- [ ] Diverticulitis of Colon
- [ ] Esophageal Reflux
- [ ] Free Bleeder
- [ ] Heart Palpitations
- [ ] Heart Attack (Previous Myocardial Infarction)
- [ ] Hepatitis (A, B, or C) - Circle One
- [ ] HIV/AIDS
- [ ] Hypertension
- [ ] Obesity
- [ ] Peptic Ulcer Disease
- [ ] Pneumonia
- [ ] Seizures
- [ ] Sickle Cell Anemia
- [ ] Sleep Apnea
- [ ] Stroke (Cardiovascular Accidents)
- [ ] Ulcerative Colitis
- [ ] Vascular Disease

PAST SURGICAL HISTORY

PAST SURGICAL HISTORY	SURGERY DATES
[ ] Adenoids	---------------
[ ] Appendix	---------------
[ ] Back Surgery	---------------
[ ] Breast Surgery	---------------
[ ] Colon Surgery	---------------
[ ] C-Section	---------------
[ ] Gall Bladder	---------------
[ ] Heart Surgery	---------------
[ ] Hemorrhoids	---------------
[ ] Hernia Operation	---------------
[ ] Hysterectomy	---------------
[ ] Lung Surgery	---------------
[ ] Reflux Surgery	---------------
[ ] Thyroid	---------------
[ ] Tonsils	---------------
[ ] Vascular Surgery	---------------
[ ] Other:__________	---------------

FAMILY HISTORY

- [ ] Breast Cancer ---------------
- [ ] Ovarian Cancer ---------------
- [ ] Colon Cancer ---------------
- [ ] Heart Attack ---------------
- [ ] Sickle Cell Anemia ---------------

MEDICAL ALLERGIES

- [ ] NONE
- [ ] Medication: ______________ Reaction: ___________
- [ ] Medication: ______________ Reaction: ___________
- [ ] Medication: ______________ Reaction: ___________

HABITS

- [ ] NONE
- [ ] SMOKING AMOUNT______________________
- [ ] ALCOHOL AMOUNT______________________
- [ ] OTHER:______________________AMOUNT________

REPRODUCTIVE HISTORY

- [ ] NUMBER OF PREGNANCIES____________

SIGNATURE: ____ DATE:__________________

I, the above signed patient, have answered these questions to the best of my knowledge.

REVIEW OF SYSTEMS FOR TODAY'S VISIT (PATIENT ID________________________________)

CONSTITUTIONAL:

______Fatigue ______Fever Chills ______Malaise ______Body Aches ______Night Sweats ______Weight Loss
______Weight Gain ______Loss of Appetite

EYES:

______ Blurred Vision

HENT:

______ Lumps ______Tenderness ______Swelling ______Nipple Discharge ______Abnormal Changes in Breast Size

CARDIOVASCULAR:

______ Chest Pain ______Irregular Heart Beats ______Rapid Heart Rate ______Dyspnea on Exertion

RESPIRATORY:

______ Shortness of Breath ______Wheezing ______Cough ______Hoarseness ______Abnormal Septum Production
______Hemoptysis

BOWELS:

______ Nausea ______Vomiting ______Diarrhea ______Constipation ______Loss of Appetite Dysphoria
______ Heartburn ______Hematemesis ______Excessive Belching ______Abdominal Pain ______Jaundice
______ Blood in Stool ______Hemorrhoids ______Narrow Stools ______Excessive Flatulence ______Bloating

BLADDER:

______ Urgency ______Frequency ______Hernaturia ______Incontinence

INTEGUMENT:

______ Rash ______Pigmentation Changes ______New Skin Lesions ______Changes to Existing Skin Lesions or Moles

NEUROLOGIC:

______ Muscular Weakness ______Tingling or Numbness ______Speech Difficulties ______Seizures

MUSCULOSKELETAL:

______ Joint Pain ______Joint Swelling ______Muscle Pain ______Muscular Weakness ______ Muscle Cramps
______Back Pain ______Neck Pain ______Shoulder Pain

ENDOCRINE:

______ Loss of Hair ______Constipation ______Weight Gain ______Weight Loss

PSYCHIATRIC:

______ Anxiety ______Depression ______Hallucinations ______Dekusions ______Feeling Confused ______Difficulty Sleeping
______ Compulsive Behaviors ______Impulsive Behaviors ______Suicidal Ideation ______Homicidal Ideation
______Excessive Anger ______ Marital Problems ______Family Problems

HERNE-LYMPH:

______ Easy Bleeding ______Easy Bruising ______Lymph Node Enlargement or Tenderness

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mississippibreastcenter.com
PHILLIP B. LEY, MD, FACS

MEDICATION LIST

SURGICAL CLINIC ASSOCIATES, P.A.
501 MARSHALL STREET, SUITE 500
T 601.948.1411 **F** 601.948.0090

PATIENT NAME:______________________________ DATE:____________________

	MEDICATION NAMES	DOSAGE/MG	PRESCRIBING PHYSICIAN
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Surgical Clinic Associates, P.A.
501 Marshall Street, Suite 500 | Jackson, MS 39202
601.948.1411 • 601.948.0090

FAMILY PRACTICE/AFTER HOURS CLINIC AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize and request The Family Practice/After Hours Clinic (covered entity) to use or disclose the following protected health information (PHI) from the medical records of the patient listed below to:

Patient Name: ____

Patient Date of Birth: ____________________ Patient SS#: ____________________

Patient Address: ____

Patient Phone Number: ____

***If someone other than patient named above is receiving the requested PHI, please complete below:*

Release Requested PHI to (Name): ____

Date of Birth: ______________Phone Number: ______________Fax # (if applicable):______________

Address: ____

Disclose the following PHI for treatment dates____________to____________(Please check one of the following)
( ) Progress Notes ( ) Procedure Op Notes/ Hospital Summary ( ) Lab ( ) X-ray Report
( ) Telephone Message ( ) Entire Chart ( ) Other Specified: ______________________

The above information is disclosed for the following purposes: (Please check all applicable)
( ) Medical Care ( ) Legal ( ) Insurance ( ) Personal ( ) Other: ____________

I understand that medical records may include information regarding a sexually transmitted disease, AIDS, or HIV infection as well as information about behavioral or mental health services or treatment for alcohol and drug abuse.

I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by confidentiality rules. I also understand that the degree of confidentiality can be modified with a facsimile transmission and that the Practice and Physician are not responsible for records once they have been transmitted. I choose to have my records faxed. ___ (please initial)

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and will not apply to information already released under this authorization. Unless otherwise revoked, this authorization is effective for six months from the date signed.

Signature of Patient or Legal Representative:______________________________Date: ____________

If Legal Representative-Relationship to Patient:______________________________________

Witnessed by: ______________________________________ Date:____________________

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PHILLIP B. LEY, MD, FACS

SURGICAL CLINIC ASSOCIATES, P.A.
501 MARSHALL STREET, SUITE 500
JACKSON, MS 39202

DUE TO HIPPA REGULATIONS WE ARE UNABLE TO DISCUSS YOUR MEDICAL OR FINANCIAL CARE WITH YOUR FAMILY MEMBERS OR FRIENDS WITHOUT YOUR WRITTEN PERMISSION. PLEASE DESIGNATE BELOW WHO YOU WANT US TO TALK WITH ON YOUR BEHALF.

THANK YOU.

I *YOUR NAME HERE*____________________ give full authorization for the following person(s) to obtain any medical or billing information.

____________________________RELATIONSHIP____________________

____________________________RELATIONSHIP____________________

____________________________RELATIONSHIP____________________

____________________________RELATIONSHIP____________________

____________________________RELATIONSHIP____________________

____
(PRINT) PATIENT'S NAME

__________________________________ ____________________
(SIGN) PATIENT'S SIGNATURE DATE

mississippibreastcenter.com
PHILLIP B. LEY, MD, FACS

SIGNATURE FORM

FINANCIAL RESPONSIBILITY AND RELEASE OF INFORMATION

I understand that i am financially responsible to surgical clinic associates, p.A. For charges not covered by my insurance carrier. Payment for services is due at time of service unless prior arrangements have been made. I also agree that, should i fail to assume this financial responsibility and credit action is necessary, i will pay for these costs in addition to the amount of the doctor's charges. I authorize surgical clinic associates, p.A. To release to the social security administration or its intermediaries or carriers, or other insurance carrier any medical or other information needed for this or a related insurance claim. A copy of this authorization may be used in place of the original.

____________________ X______________________________

DATE **SIGNATURE OF PATIENT OR GUARDIAN**

EXTENDED PAYMENT REQUEST (ONE TIME AUTHORIZATION) (MEDICARE AND MEDICAID PATIENTS ONLY)

I request that payment of authorized medicare benefits or other insurance benefits be made on my behalf to surgical clinic associates, p.A. For any services furnished to me by that provider. This one time signature will be maintained on file as verification for all subsequent services which are provided to me by this provider. I authorize any holder of medical information about me to release to the centers for medicare and medicaid services and its agents or other insurance carriers any information needed to determine these benefits or benefits payable for related services.

____________________ X______________________________

DATE **SIGNATURE OF PATIENT OR GUARDIAN**

MEDIGAP AUTHORIZATION (MEDICARE PATIENTS ONLY)

i request that payment of authorized medigap benefits is made on my behalf to the surgical clinic associates, p.A. For any services furnished by that provider. I authorize any holder of medical information about me to

RELEASE TO____________________________ANY INFORMATION NEEDED TO

DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

MEDICARE NUMBER____

SECONDARY INSURANCE_________________________POLICY #_______________

____________________ ______________________________

DATE **SIGNATURE OF PATIENT OR GUARDIAN**

PAYMENT RESPONSIBILITY NOTICE

The Surgical Clinic Associates, P.A. and its physicians have contractual relationships with private and governmental entities listed below:

AETNA
BLUE CROSS BLUE SHIELDS OF MISSISSIPPI
MEDICARE
MISSISSIPPI HEALTH PARTNERS
MISSISSIPPI HEALTH CONNECTION
STATE OF MISSISSIPPI EMPLOYEES
MISSISSIPPI PHYSICIANS CARE NETWORK
STATE OF MISSISSIPPI
UNITED HEALTH CARE

We have agreed to charge you based on these entities' fee schedules, or allowed amounts. However, this does not mean that you have no payment responsibility. You are personally responsible for paying the following items:

1. **Annual or other deductibles**
2. **Co-insurance amounts**
3. **Co-Payment amounts**
4. **Non-covered amounts.** *(For Medicare, you are not responsible for these charges unless we get you to sign an advance notice. For other entities, we will get you to sign an advance notice only if it is required.)*

Please refer to your entities' coverage booklet and/or web site for further information.

We have agreed to file our charges with your health insurance entity for you; but, 60 days after the date of service you may be held responsible for paying if your insurance has not paid. By signing below, I confirm that I have read, understand and agree with this payment responsibility notice.

*Patient Signature:*____

*Date:*________________________

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PHILLIP B. LEY, MD, FACS

601
932
PINK

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____, have received the Notice of Privacy Practices from
(Print Patient Name)
Surgical Clinic Associates, P.A.

X____Date:____
(Patient Signature)

In lieu of patient signature I, ____, a staff member of Surgical Clinic Associates, P.A., state that ____ has been given our current Notice of Privacy Practices.

X____Date:____