WISCONSIN
SURGERY CENTER

Phone: 414-384-2100
Fax: 414-384-2700

PATIENT REGISTRATION FORM

PATIENT - THIS SECTION REFERS TO PATIENT ONLY

Please print and complete all information requested on this form.

Name | Age | Date of Birth

SS No. | Sex ☐ Male ☐ Female | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Maiden Name | Address

City | State | Zip Code

Email | Home Phone | Cell Phone

Employer | Work Phone

The State of Wisconsin Office of Health Care Information requires Wisconsin Surgery Center to provide them with information as to our patient's race and ethnicity. Please check the appropriate areas below.

Race ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Black ☐ White ☐ Other _____
☐ Unknown or choose not to answer

Ethnicity ☐ Hispanic ☐ Not of Hispanic Origin ☐ Unknown or choose not to answer

RESPONSIBLE PARTY-THIS SECTION REFERS TO THE PERSON RESPONSIBLE FOR PAYMENT

Check which one applies ☐ Self ☐ Spouse/Significant Other ☐ Patient is a minor. *See insurance information below.*

PERSON TO CONTACT IN CASE OF EMERGENCY

Name | Relationship | Phone

PRIMARY INSURANCE INFORMATION

Please check which one applies to you and complete information below. ☐ Insurance ☐ Workman's Compensation ☐ Self Pay

Insurance Company' s Name and Address

Phone Number | Insured's Name (who holds insurance) | Insured's Date of Birth

Relationship to Patient

HIC/Policy Number | Group Number

WORK COMP and MVA —REQUIRED INFORMATION

Case worker' s name | Phone | Claim# | Date of Injury (REQUIRED)

SECONDARY INSURANCE INFORMATION

Insurance Company' s Name and Address

Phone Number | Insured's Name (who holds insurance) | Insured's Date of Birth

Relationship to Patient

HIC/Policy Number | Group Number

I hereby authorize Wisconsin Surgery Center, LLC to furnish my Insurance carrier all information that my insurance company may request concerning my illness or injury. I hereby assign to Wisconsin Surgery Came, LLC all money to which I am entitled to for medical and surgical expenses rendered to myself or dependent. I understand must I am responsible for my amount not covered by Insurance. Any bill coming from Wisconsin Surgery Center are the facility charges and do not pertain to my Physician charges.

PATIENT OR GUARANTOR' S SIGNATURE | DATE

MEDICARE PATIENTS ONLY

I request that payment of authorised Medicare benefits be made on my behalf to Wisconsin Surgery Center for any services furnished by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. Furthermore, this authorization serves this provider in obtain benefits from my Medicare Supplemental insurer. This authorization is in effect until I choose to revoke it.

SIGNATURE | DATE

WISCONSIN SURGERY CENTER, LLC

Credit Policy

Your physician has chosen to perform your procedure at Wisconsin Surgery Center which is an Ambulatory Surgical Center. All procedures performed here will have a facility and physician charge that are incurred. In the event that you require an anesthesiologist, there will be separate charges for them in addition to ours, and your physicians.

Many patients are covered by health insurance contracts, which provide for reimbursement for specific medical fees. If you are not familiar with your policy, it is suggested that you discuss coverage with your carrier before charges are incurred. All insurance policies are contracts between you and your insurance carrier. Your facility bill is an agreement between you and your facility. Our fees may be more or less than the payment schedule of any insurance companies' arbitrary determination of Usual & Customary. Our facility is a "Preferred Providers" for certain HMO's and PPO's and the contracts that we have signed with these specific carriers supersede our Usual & Customary policy. For our patients who are subscribers to these insurance plans, you will not be billed for amounts above our negotiated fee schedule, with the exception of co-pays, co-insurances and deductibles amounts as stated per your contract.

You will receive a statement each month for any unpaid balances. Balances due are payable within 60 days of your first statement. We will charge a $ 25.00 fee for all returned checks. In the event that your account is forwarded onto our collection agency, you will be responsible for their fees associated with us having to submit your account to collectlons. We accept MASTERCARD/ VISA.

Wisconsin Surgery Center accepts Medicare Assignment. We will submit insurance claims for you as a courtesy, but it remains the patient's responsibility to make sure your claims are paid. Wisconsin Surgery Center does not handle any referral processes for your procedures.

Extended payment plans can be arranged through our billing office. These plans are based upon financial circumstances of each patient.

I, the undersigned, have read and understand the above credit policy.

Signature Insured/ Authorized Person _____ Date _____

Patients Name, Print _____

Wisconsin Surgery Center, LLC
Ambulatory Surgical Center

PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosure of personal health information. (PHI) The individual is also provided the right to request confidential communications or that if communications of PHI be made by alternative means such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

- ☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/ office address
- ☐ O.K. to fax to this number
- ☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Other _____

I hereby give Wisconsin Surgery Center staff permission to discuss my medical care, lab results, billing, and medication, with the following individuals:

- ☐ Spouse _____
- ☐ Son/Daughter _____
- ☐ Other _____

Patient Signature/ Authorized Person _____ Date _____

Print Name/Relationship _____ Birth Date _____

Wisconsin Surgery Center

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Print Patient Name: _____

Patient Date of Birth: _____

Patient or Guardian' s Signature: _____

Date: _____

Patient Sticker

Wisconsin Surgery Center
Patient History

Patient Name: _____ DOB: _____

MEDICATION ALLERGIES: _____

LATEX ALLERGY ☐ Y ☐ N

IODINE or IVP DYE ALLERGY ☐ Y ☐ N

No Known Drug Allergies ☐

Adhesive ☐ Y ☐ N

Check (✔) conditions you currently have or have had in the past

Do you have or have you had a history of:

- ☐ AIDS/ HIV positive
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Bronchitis
- ☐ Cancer What kind? _____
- ☐ Chemical Dependency
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy/ Seizures
- ☐ Fainting
- ☐ Fibromyalgia
- ☐ Glaucomal Cataracts
- ☐ Gout
- ☐ Hepatitis What kind? _____
- ☐ Herpes What kind? _____
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Malignant Hyperthermia/Family HIO Malignant Hyperthermia
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Pacemaker/ICD (defibrillator)
- ☐ Pain/ numbness/tingling
- ☐ Prostate Problems
- ☐ Psychiatric Care
- ☐ Seasonal Allergies
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis

Other: _____

_____

_____

CARDIOVASCULAR

- ☐ CABG
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Irregular beat
- ☐ Low Blood Pressure
- ☐ Murmur
- ☐ Poor circulation
- ☐ Rapid Heart Rate
- ☐ Swelling of ankles

GASTROINTESTINAL

- ☐ Abd. Pain
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ GERD / Reflux
- ☐ IBS, Crohns, Colitis
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Vomiting/ vomiting blood

GYN

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Extreme menstrual pain
- ☐ Hot Flashes

Date of last menstrual period _____

Are you pregnant? _____

Number of Children _____

Any pregnancy complications? _____

SUBSTANCE USE:

- ☐ Caffeine How much? _____
- ☐ Tobacco How much? _____
- ☐ Alcohol How much? _____
- ☐ Street drugs How much? _____

Which kinds? _____

Have you every had a blood

transfusion? _____

What year? _____

Ht:: _____

Wt: _____

Do you have a Power of Attorney or a Living Will?

☐ Y ☐ N

Complete back side also)

HOSPITALIZATION / SURGERIES	
YEAR	**Reason for hospitalization and prior surgeries**

☐ No problems with anesthesia

☐ Problems with anesthesia. EXPLAIN: _____

_____

_____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

Signature _____ Date _____

Reviewed by (RN) _____ Date _____ Time _____

WISCONSIN SURGERY CENTER
MEDICATION LIST

Patient Name: _____

MEDICATION ALLERGIES: _____

Medication	Dosage	Frequency

WISCONSIN SURGERY CENTER
PRIVACY PRACTICES

Wisconsin Surgery Center Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and Disclosures

Treatment-Your Private Healthcare Information (PHI) may be used by staff members or disclosed to other health care professional for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment-your PHI may be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we provide. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Healthcare Operations- We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services and auditing functions.

Other Permitted uses and Disclosures

- As required by law
- For communicable diseases
- For Workers compensation
- For military activities
- National security
- For public health
- For health oversight
- For law enforcement
- For research
- In cases of abuse/neglect
- In cases of criminal act
- To coroners, funeral directors, and organ donations
- To the FDA
- When an inmate
- For legal proceedings

Appointment reminders -We may use or disclose your PHI, as necessary to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care.

Disclosure to family members about a Decedent-We may disclose a decedent's protected health information to family members and others who were involved in the care or payment for care of the decedent prior to death, unless doing so is inconsistent with any prior expressed preference of the patient that is known to the covered entity.

Other uses and Disclosures requiring a signed authorization

Disclosure of your PHI or its use for any purpose other than those listed above requires your specific written authorization. For example, attorney requests, relatives, a close friend or any other person that you identify. If you change your mind, after authorizing a use or disclosure of your information, you may submit revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Individual Rights

You, the patient, the patient representative or patient surrogate (a representative who acts on behalf of another person; written documentation naming that person to make decisions for the patient must be provided on the day of care) have certain rights under the federal privacy standards, These include;

- The right to request restrictions on the use and disclosure of your PHI. For example, patient has the right to keep information abut a treatment from their health plan as long as they pay out-of-pocket in full for that treatment, and make the requested restriction in writing. A practice cannot deny this request, except for cases in which Medicare and Medicaid are involved.
- The right to receive confidential communications concerning your medical condition and treatment. You must inform us in writing how you wish to be contacted. (Using a form provided by our practice).
  The right to inspect and receive a copy of your PHI.
- The right to amend or submit corrections to your PHI.
- The right to receive a report or listing that identifies persons or entities to which the practice has disclosed their information.
- The right to receive a printed copy of this notice.
- The right to be notified following a breach of your unsecured PHI.
- To be treated with respect, consideration, and dignity.

Wisconsin Surgery Center

We are protected by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all PHI that we maintain.

Requests to Inspect PHI

As permitted by federal regulation, we require that requests to inspect or copy PHI be submitted in writing. You may obtain a form to request access to your records by contacting

Medical Records Department
Privacy officer
414-384-2100

Complaints

If you would like to submit a comment or complaint about Privacy Practices, you can do so by sending a letter outlining your concerns to

Privacy Officer
Wisconsin Surgery Center
3305 S. 20th street, #150
Milwaukee, WI 53215

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of concern to the address above.

You will not be penalized or otherwise retaliated against for filing a complaint.

How the Medicare Beneficiary Ombudsman works for you

An "Ombudsman" is a person who reviews issues and helps to resolve them. Congress requires that Medicare have a Beneficiary Ombudsman who helps people with Medicare. The Ombudsman shares information with the Secretary of Health and Human Services, Congress, and other organizations about what works well, and what doesn't work well, to continuously improve the quality of the services and care you get through Medicare by reporting problems and making recommendations.

The Ombudsman makes sure information is available for you about

- Your Medicare benefits
- Whether you have the information you need to make good health care decisions
- Your rights and protections under the Medicare program
- How you can get issues resolved

How does the Medicare Beneficiary Ombudsman help you through other organizations

The Ombudsman works with organizations like State Health Insurance Assistance Programs (SHIPS) and Quality Improvement Organizations to ensure they resolve your issues promptly. This allows these organizations to provide information, counselling and assistance to help you with

- Your Medicare questions, including your benefits, coverage, premiums, deductibles and coinsurances.
- Grievances (complaints)
- Appeals (you can appeal if you think a service or item you received should have been covered or paid for and Medicare denies your request, you question the amount that was paid, or your plan stops paying for coverage you are already receiving).
- Problems joining or leaving a Medicare "Advantage Plan (like HMO or PPO) or any other Medical Health Plan or Medicare Prescription Drug Plan.

For more Information

- Visit www.medicare.gov
- Visit the Ombudsman webpage at www.cms.hhs.gov/center/ombudsman.asp
- Call your Quality Improvement Organization if you have a complaint about the quality of Medicare covered services. A Quality Improvement Organization consists of a group of doctors and health care experts who check on and improve the care given to people with Medicare. Visit www.medicare.gov or call 1-800-633-4227 to get there telephone number. TTY users should call 1-877-486-2048
- Department of Health Services, Division of Quality Assurance, P.O. Box 2969, Madison, /WI 53701-2969 or call toll free 1-800-642-6552 or 608-266-0371
- Call your State Health Insurance Assistance Program (SHIP) for help with questions about appeals, buying a Medigap policy, and Medicare rights and protections. The SHIP program is a State program that gets money from the Federal Government to give free local health insurance counselling to people with Medicare. You can find their number by visiting www.medicare.gov on the web, under "Search Tools", select "Find helpful phone numbers and websites". Or call 1-800-MEDICARE (1-800-633-4227) to get their telephone numbers. TTY users should call 1-877-486-2048.
- State contact representatives (800) 242-1060
- Contact person
  The name and address of the person you can contact for further information concerning our privacy practice is:

Attn: Privacy Officer
Wisconsin Surgery Center
3305 S.20th street, #150
Milwaukee, WI 53215

THIS NOTICE IS EFFECTIVE ON September 1, 2013