

Dear Patient:

The physicians and staff of Foxhall Surgical Associates, P.C. would like to take this opportunity to welcome you to our practice. This is undoubtedly an anxious time for you. We anticipate you may have many questions about your medical condition, what to expect from your visits with us and how we will work with your other health care providers. It is our belief, that by working together we may achieve the best possible outcome for you. We are happy to assist you to ensure you receive the most comprehensive, up to date treatment in an environment that fosters understanding, compassion, consideration and respectful care.

We feel open and effective communication is essential in helping you achieve your health related goals. As such, we have enclosed our Practice Brochure which includes our Office & Financial Policies & Procedures, as well as Patient Rights and Responsibilities. We hope these materials assist you in understanding how our practice works and how you may best work with us. We encourage you to familiarize yourselves with these materials.

*To facilitate your first visit to our office, enclosed are the following:*

- 1. Practice Brochure*
- 2. Patient Registration Form - 1 page, front & back, to be completed and signed*
- 3. Patient Medical History - 2 pages, to be completed & signed*
- 4. Practice Privacy Notice - (required by HIPAA) - on back side of second Medical History form*
- 5. Breast Health Form - 1 page, complete & sign to dotted line*

Please **bring completed forms 3, 4 and 5 if applicable, along with your insurance card(s) and photo identification.** We appreciate you arriving promptly for your appointment, so that we may prepare your medical record in a timely manner. **Remember to bring any applicable medical records and films.** Missing documents may delay your appointment.

We are pleased and honored to have been chosen as your surgical healthcare providers. Please feel free to seek assistance from our Staff, should you have questions regarding these documents.

Thank you for placing your trust and confidence in us. We look forward to assisting you both now and in the future.

Sincerely,

*Peter E. Petrucci, M.D.*

*Michael L. Palmer, M.D.*

*Martin G. Paul, M.D.*

*Meredith G. Garrett, M.D.*

*Brian M. Long, M.D.*

**PATIENT REGISTRATION**

**FOXHALL SURGICAL ASSOCIATES, P.C.**

- Peter E. Petrucci, M.D.
- Michael L. Palmer, M.D.
- Martin G. Paul, M.D.
- Meredith G. Garrett, M.D.
- Brian M. Long, M.D.

3301 NEW MEXICO AVE., N.W., SUITE 206  
 WASHINGTON, DC 20016  
 (202) 895-1440

ADDL/PCP:


↓ PLEASE COMPLETE BELOW EACH LINE ↓

Please provide demographic information below which can be used as a means to contact you or your designated representative.

PATIENT'S NAME: FIRST			MIDDLE			LAST			SEX <input type="checkbox"/> M <input type="checkbox"/> F		BIRTH DATE		AGE			
HOME ADDRESS: STREET PLEASE INCLUDE APARTMENT #					CITY					STATE		ZIP				
PATIENT'S EMPLOYER							ADDRESS									
PATIENT SOCIAL SECURITY NO.		PATIENT OCCUPATION			FINANCIALLY RESPONSIBLE PERSON <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other				MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> S <input type="checkbox"/> Sep.			PHARMACY PHONE ( )				
SPOUSE'S NAME			SPOUSE'S EMPLOYER & EMPLOYER'S ADDRESS											WORK PHONE ( )		
IN CASE OF EMERGENCY, CONTACT							RELATIONSHIP					PHONE ( )				
IN CASE OF EMERGENCY, ALTERNATE CONTACT							RELATIONSHIP					PHONE ( )				
REFERRING PHYSICIAN / PERSON / FACILITY							ADDRESS					PHONE ( )				
PRIMARY CARE PHYSICIAN / PERSON / FACILITY							ADDRESS					PHONE ( )				
OTHER PHYSICIAN / PERSON / FACILITY							ADDRESS					PHONE ( )				

**COMMUNICATION CONSENT**

PLEASE INDICATE HOW WE MAY CONTACT YOU (CHECK ALL THAT APPLY)

<input type="checkbox"/> HOME PHONE ( )		<input type="checkbox"/> WORK PHONE ( )		<input type="checkbox"/> CELL PHONE ( )	
<input type="checkbox"/> FAX NUMBER ( )		<input type="checkbox"/> EMAIL ADDRESS			

You may revise this Communication Consent at any time in writing; otherwise, we will assume we can contact you at any of the phone numbers and/or email as you have indicated above.

**SUBSCRIBER INFORMATION OR FINANCIALLY RESPONSIBLE PARTY**

<b>SUBSCRIBER INSURANCE AND/OR FRP INFORMATION (OTHER THAN SELF)</b>	SUBSCRIBER'S NAME			SUBSCRIBER'S EMPLOYER				
	DATE OF BIRTH	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	WORK PHONE	HOME PHONE			
<b>PRIMARY INSURANCE</b>	INSURANCE COMPANY NAME			INSURANCE COMPANY NAME				
	I.D. NO.	GROUP	I.D. NO.		GROUP			
	EFFECTIVE DATE			EFFECTIVE DATE				
	ADDRESS			ADDRESS				
	SUBSCRIBER (Person's Name)			SUBSCRIBER (Person's Name)				
<b>SECONDARY INSURANCE</b>	INSURANCE COMPANY NAME			INSURANCE COMPANY NAME				
	I.D. NO.	GROUP	I.D. NO.		GROUP			
	EFFECTIVE DATE			EFFECTIVE DATE				
	ADDRESS			ADDRESS				
	SUBSCRIBER (Person's Name)			SUBSCRIBER (Person's Name)				

FSA Account No.
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Please answer all questions on the yellow history form. This information is important to your health and records.

**FOXHALL SURGICAL ASSOCIATES, P.C.**

**Patient Financial Policy**

We are committed to providing you with the best possible care, and will help you receive your maximum allowable insurance benefits. In order to do this, we need your assistance and your understanding of our payment policy. (Please refer to the Financial Responsibilities document) We realize there are currently hundreds of different products and benefit packages. However, it is our experience that many insurance carriers do not always outline the full benefits provided to their patients for out of network benefits. We encourage you to call the number listed on the back of your insurance card and seek assistance directly from your insurance carrier. In addition, our billing staff are available and happy to help you understand fully your financial responsibility and applicable insurance coverage. You may be asked to fax a copy of your insurance card to the office so staff may better assist you.

We are happy to provide you with high quality medical services, regardless of our participation status in your insurance plan. Our surgeons currently participate in **Medicare** If you are insured by Medicare, we will submit your insurance claims, provided the information we have obtained from you is accurate and complete. For all other plans, we request payment in full at the time services are performed in the office. We accept cash and checks, and for your convenience, Visa or MasterCard. To assist you, we will file claims on your behalf so that your carrier may apply amounts to your deductible or reimburse you directly. **Please be aware that due to current federal regulations, we are obligated to collect all applicable co-payments, co-insurance, and bill for all services.**

Regardless of the Practice's participation in your insurance plan you may choose to be seen by one of our surgeons. However, payment for services **not covered by insurance assigned to us is fully patient responsibility**. Balances older than 30 days may be subject to additional collection fees. We do provide financial disclosure forms to our patients prior to elective surgery and will offer assistance with appeal processes as needed. Please feel free to discuss these issues with the Billing Office.

We understand many PPO and managed care insurance carriers have their own Usual, Customary and Reasonable (UCR) fees. We take pride in the fact that our surgeons are at the leading edge of their respective fields and believe our charges to be fair and reasonable for the services provided. Most, if not all, of our charges fall within the UCR of many out of network insurances. We encourage you to contact us promptly for assistance in the management of your account. We are here to help you and will be happy to answer any questions you may have about your treatment or insurance coverage.

**Patient Financial Agreement**

I acknowledge receipt of Foxhall Surgical Associates, P.C.'s Practice Brochure detailing Office Procedures, Financial Policies, Patient's Rights & Responsibilities and Understanding Your Insurance Coverage.

I hereby authorize the office of Foxhall Surgical Associates, P.C. to apply for benefits (file my insurance) on my behalf for services rendered. I certify that the information I have reported with regard to my insurance coverage is true and accurate. I will promptly notify the Practice of any changes in my health insurance coverage. I further authorize the release of any necessary information, including medical information, for this or any related claim to my insurance company in order to determine these benefits payable.

I further request that payment of authorized benefits be made payable of Foxhall Surgical Associates, P.C.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read the above Patient Financial Policy.

A copy of this agreement may be used in place of the original.

\_\_\_\_\_ / / \_\_\_\_\_

**Signature of Patient, Policy Holder or Legal Guardian**

**Date**

**Printed Name:** \_\_\_\_\_

**(Please Complete the Other Side of this Form)**

**PATIENT MEDICAL HISTORY:**

Today's Date: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  Female  Male

Home Phone # (\_\_\_\_\_) \_\_\_\_\_ Work Phone # (\_\_\_\_\_) \_\_\_\_\_ Cell Phone # (\_\_\_\_\_) \_\_\_\_\_

Best time to reach?  a.m.  p.m. Best number to use:  Home  Cell  Work

Height \_\_\_\_\_ Weight \_\_\_\_\_ Primary Language  English  Spanish Other \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Date Last Seen \_\_\_\_\_ Cardiologist \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Other Physician(s) \_\_\_\_\_

Do you have an Advanced Directive (Living Will)?  Yes  No If yes, copy should be on file in your medical record. If not available, who is legal representative: Name, phone number & address: \_\_\_\_\_

**Present Illness / Condition**

What type of Exam / Consultation are you here for?  
 \_\_\_\_\_  
 \_\_\_\_\_

What Diagnostic Tests, related to this problem, have you had? If applicable, remember to bring copies of any pertinent reports & x-ray films. List facility name & date(s) performed.  
 \_\_\_\_\_  
 \_\_\_\_\_

Symptom(s) Describe:  
 Date(s) of onset:  
 Location (Where on body symptom occurs):

**Your Health History –Do you now have OR have you ever been treated for the following ? Check all that apply.**

<p><b>Cardiac / Heart Disease</b></p> <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Chest Pain <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood pressure <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Pulmonary Hypertension <input type="checkbox"/> Pacemaker / ICD <input type="checkbox"/> Rheumatic Heart <input type="checkbox"/> Rhythm disturbances Specify: <input type="checkbox"/> NONE	<p><b>Cancer or Tumor</b></p> <input type="checkbox"/> Type _____ <input type="checkbox"/> Chemo _____ <input type="checkbox"/> Radiation _____ <input type="checkbox"/> Skin - Basal / Squamous other _____ <input type="checkbox"/> NONE <p><b>Endocrine</b></p> <input type="checkbox"/> Diabetes Circle : Diet / Pill / Insulin /Pump <input type="checkbox"/> Thyroid Problems / Goiter <input type="checkbox"/> Adrenal disease <input type="checkbox"/> NONE	<p><b>Respiratory</b></p> <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Emphysema / COPD <input type="checkbox"/> Hoarseness <input type="checkbox"/> Pneumonia <input type="checkbox"/> Sleep Apnea CPAP - Y / N? <input type="checkbox"/> Snoring <input type="checkbox"/> History of smoking <input type="checkbox"/> NONE	<p><b>Neurological / Mental Health</b></p> <input type="checkbox"/> Stroke <input type="checkbox"/> Stroke Mini (TIA) <input type="checkbox"/> Epilepsy or Seizures Disorders <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Chemical dependency <input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Depression / Anxiety <input type="checkbox"/> Emotional Illness <input type="checkbox"/> Claustrophobia <input type="checkbox"/> Panic attack <input type="checkbox"/> Learning Disabilities <input type="checkbox"/> NONE
<p><b>Bleeding Circulation</b></p> <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding tendency <input type="checkbox"/> Blood clots <input type="checkbox"/> Poor circulation <input type="checkbox"/> Sickle Cell <input type="checkbox"/> Transfusion of blood/plasma <input type="checkbox"/> NONE	<p><b>Genitourinary</b></p> <input type="checkbox"/> Kidney disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Prostate / Testicle problem <input type="checkbox"/> Urinary Tract Infection <input type="checkbox"/> Difficulty urinating <input type="checkbox"/> NONE	<p><b>Gastrointestinal</b></p> <input type="checkbox"/> Hernia <input type="checkbox"/> Gallbladder <input type="checkbox"/> Gastric Reflux <input type="checkbox"/> Intestinal Blockage <input type="checkbox"/> Liver Disease <input type="checkbox"/> Intestinal or Gastric Ulcers <input type="checkbox"/> NONE	<p><b>Musculoskeletal</b></p> <input type="checkbox"/> Arthritis <input type="checkbox"/> Gout <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Polio <input type="checkbox"/> Back / neck Problems <input type="checkbox"/> Wheelchair or Walker required <input type="checkbox"/> NONE
<p><b>Hearing &amp; Vision</b></p> <input type="checkbox"/> Hearing loss <input type="checkbox"/> Hearing Aide <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Cataract(s) <input type="checkbox"/> Glaucoma <input type="checkbox"/> Legally Blind <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> NONE	<p><b>Implantable Devices</b></p> <input type="checkbox"/> NONE <input type="checkbox"/> Dialysis Port / Pump <input type="checkbox"/> Other Ports / Pumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Other (list) _____ <b>Important!</b> <b>Bring implant card with you.</b>	<p><b>Infectious Diseases</b></p> <input type="checkbox"/> HIV <input type="checkbox"/> Hepatitis <input type="checkbox"/> MRSA <input type="checkbox"/> C Diff <input type="checkbox"/> Recent Mono <input type="checkbox"/> TB - Tuberculosis <input type="checkbox"/> VRE <input type="checkbox"/> NONE	<p><b>Skin</b></p> <input type="checkbox"/> Rashes <input type="checkbox"/> Sore / Open areas <input type="checkbox"/> Skin Ulcer Where? _____ <input type="checkbox"/> NONE

Have you been hospitalized for any of the above conditions?  
 Briefly Explain: \_\_\_\_\_  
 Date(s) ? \_\_\_\_\_  
 Hospital Name, City State: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Your Surgical History - Check all that apply & Specify Year (s)			
<input type="checkbox"/> No prior surgery <input type="checkbox"/> Angioplasty <input type="checkbox"/> Appendectomy <input type="checkbox"/> Arthroscopy <input type="checkbox"/> Breast Biopsy <input type="checkbox"/> Heart Bypass List any other surgeries: Type _____ Year _____ Type _____ Year _____ Type _____ Year _____ Type _____ Year _____	<input type="checkbox"/> Cataract <input type="checkbox"/> Colon / Intestinal <input type="checkbox"/> D & C <input type="checkbox"/> Gallbladder <input type="checkbox"/> Heart Catheter <input type="checkbox"/> Heart Valve replaced	<input type="checkbox"/> Hemorrhoidectomy <input type="checkbox"/> Hernia <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Kidney removal <input type="checkbox"/> Mastectomy L R <input type="checkbox"/> Pacemaker	<input type="checkbox"/> Prostate <input type="checkbox"/> Spine (Back/Neck) <input type="checkbox"/> Splenectomy <input type="checkbox"/> Tonsils & Adenoids <input type="checkbox"/> Total Hip L R <input type="checkbox"/> Total Knee L R

Do you have any ALLERGIES? Check all. Be Specific. All sections MUST be checked.		
	If no, check appropriately. If yes, complete as indicated.	Reaction(s) - Be specific
Latex	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Circle:</i> hives, wheezing, itching from rubber, sneakers, or balloons
Adhesive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Iodine	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Drug(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Food	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Circle:</i> banana, kiwi, avocado, tomato, seafood	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Are you on any MEDICATIONS? If no, check appropriately. If yes, complete as indicated. List each Medication, Dosage & Frequency.		
Antidepressants / Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Blood Thinner / Aspirin / Baby Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Circle:</i> Coumadin, Warfarin, garlic tablets, omega 3
Cardiac / Heart meds including Blood pressure pills, Diuretics	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Eye drops including over the counter	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hormone (HRT) or Bone Density meds	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Herbal remedies / Vitamins	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Circle:</i> multi vitamin, vitamin E, Fish oil, calcium, glucosamine chondroitin,
Inhalers including nasal	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pain meds / narcotics	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Prednisone /Steroids in last 3mo?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Seizure / epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you on Other Medications ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Family History (Close blood relatives): Check all that apply and Specify relationship including maternal or paternal.	
<input type="checkbox"/> Bleeding / Clotting Problems _____ <input type="checkbox"/> Cancer: _____ <input type="checkbox"/> Diabetes _____ <input type="checkbox"/> Heart Disease _____ <input type="checkbox"/> High Blood Pressure _____ Other: _____	<input type="checkbox"/> Kidney Disease _____ <input type="checkbox"/> Mental Illness _____ <input type="checkbox"/> Neurological _____ <input type="checkbox"/> Thyroid Disease _____ <input type="checkbox"/> Tuberculosis _____

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
 If Legal Guardian, Relationship to Patient \_\_\_\_\_ Date \_\_\_\_\_  
 Surgeon's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

If surgery is scheduled, you need to provide the hospital's nurse pre-op interviewer a detailed list of medications including medication name, dosage, and frequency instructions.

If surgery is scheduled, you need to provide the hospital's nurse pre-op interviewer a detailed list of all allergies.

If surgery is indicated, patient must complete below for anesthesiologist:

Anesthesia History	Yes	No	Explain (specify: nausea, vomiting, other)
Have you ever had anesthesia?			
Have you ever had a problem with anesthesia including malignant hyperthermia or difficult intubation?			
Has any member of your family had a problem with anesthesia?			
Loose, capped or broken teeth: bridges or dentures?			
Trouble opening mouth or jaw clicking?			
Do you exercise regularly?			If yes: low / moderate / active
Do you have shortness of breath after walking up 2 flights of stairs?			
Do you smoke?			#packs per day _____ # years _____
Are you an ex-smoker? When stopped?			
Do you drink alcoholic beverages?			How often _____ how much _____
Do you use any street drugs?			
Have you ever had a blood transfusion?			If "yes", what year(s)?
Do you have objections to receiving blood transfusions?			
Do you have problems with chronic pain?			
Any religious/cultural practices we should know about?			
<i>Females Only</i> – Is there any chance you could be pregnant?			Last Menstrual Period?

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ If Legal Guardian, Relationship to Patient \_\_\_\_\_

Surgeon's Signature: \_\_\_\_\_ Date \_\_\_\_\_

**If applicable, Hospital Use Only:**

ATC Reviewer: \_\_\_\_\_ Date \_\_\_\_\_ /Time \_\_\_\_\_

Anesthesia Reviewer: \_\_\_\_\_ Date \_\_\_\_\_ /Time \_\_\_\_\_

# FOXHALL SURGICAL ASSOCIATES, P.C.

## ACKNOWLEDGMENT OF PRACTICE BROCHURE & PRIVACY NOTICE & CONSENT FOR RELEASE OF INFORMATION

I acknowledge receipt of Foxhall Surgical Associates, P.C.'s Practice Brochure detailing Office Procedures, Financial Policies, Patient's Rights & Responsibilities, and Understanding Your Insurance Coverage. I acknowledge receipt of Foxhall Surgical Associates, P.C.'s Privacy Notice.

I am aware that my "Protected Health Information" (PHI) will be disclosed to those involved in my care and treatment, to insurance company(ies) and business associates of the Practice, for the purposes of carrying out treatment, payment or health care operations.

I understand that further authorization(s) may be necessary, as required by law, should additional disclosures of my PHI be requested. I may request further review of the privacy notification statements, at any time, prior to consenting to any disclosure of my PHI.

In addition, I give my permission to my physician and his/her staff to discuss my medical care and/or billing issues with the following. Unless otherwise indicated, this authorization is valid until revoked in writing by me or my legal representative.

Family & Other Care Providers that you authorize us to speak to or contact on your behalf:

- My husband / wife / other and family (please list):

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\_\_\_\_\_  
Printed Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal Guardian

\_\_\_\_\_  
Date