



CAPE FEAR VALLEY HEALTH

David A. Goodman, M.D.
FACS, FRCS (England)
Board Certified

Ravinder Annamaneni, M.D.
FACS, FRCS (England)
FRCS (Ireland)
Board Certified

Kelly Van Fossen, D.O.
FACOS
Board Certified

Ijeoma A. Ejeh, M.D.
FACS
Board Certified

Thomas J. Harrell, M.D.
Board Certified

Ferncreek General
Surgery

4140 Ferncreek Drive
Suite 601
Fayetteville, NC 28314
(910) 485-3880
Fax (910) 485-5341

Thank you for choosing CFV Ferncreek General Surgery.
Your appointment is scheduled for:

PLEASE ARRIVE 30 MINUTES PRIOR TO YOUR APPOINTMENT TIME

We are enclosing some forms for you to complete prior to your appointment. Please bring the completed forms with you to your appointment.

If one of our Physicians has treated you previously, please notify us.

It is important that all of your information be available to our physician to properly assess you at the time of your visit. Please have with you all documentation for your visit. These documents should include: x-ray and ultrasound films, lab work and any studies that may be useful.

If you do not bring these documents, we may have to reschedule your appointment.

If you find that you are unable to keep your appointment, please call our office (910) 485-3880, at least 24 hours in advance.

We are located at 4140 Ferncreek Drive Suite 601. Ferncreek Drive is off of Raeford Road near the All American Freeway. We are located in building 600, the last brick building in the plaza on the right.

We look forward to seeing you. If you have any questions or concerns prior to your visit, please feel free to contact our office.

CFV-FERNCREEK GENERAL SURGERY

PATIENT HISTORY

This information is designed to aid the physician in understanding and assisting you with your condition. It is CONFIDENTIAL and will not be passed on to others without your consent.

NAME _____ DATE OF BIRTH _____ AGE _____

OCCUPATION _____ SEX M F ETHNIC ORIGIN _____

MARITAL STATUS: SINGLE MARRIED SEPARATED DIVORCED WIDOWED

WHY ARE YOU SEEING THE DOCTOR TODAY?

ALLERGIES

MEDICATIONS _____

OTHER _____

CURRENT MEDICATIONS THIS SECTION MUST BE FILLED OUT

PHARMACY NAME _____ **PHONE #** _____

SMOKING NO YES HOW MUCH PER DAY? _____ AGE STARTED _____

ALCOHOL NO YES HOW MUCH PER WEEK? _____ AGE STARTED _____

ILICIT DRUG USE NO YES HOW MUCH? _____

WOMEN ONLY: Menstrual Periods: Age of Onset _____ Date of last Period _____
Regular Periods YES NO Age at Menopause _____
Pregnancies Number _____ Children—How Many? _____
Age of Oldest Child _____ Did you Breastfeed? YES NO

PREVIOUS ILLNESSES

LIST DATES PLEASE _____

PREVIOUS SURGERIES

LIST DATES PLEASE _____

PREVIOUS TREATMENT

FOR THIS CONDITION
LIST HOSPITAL/DOCTORS _____

SIGNED _____ DATE _____

DO YOU HAVE NOW OR HAVE A HISTORY OF:

	YES	NO		YES	NO
WEIGHT LOSS	<input type="checkbox"/>	<input type="checkbox"/>	ACID REFLUX	<input type="checkbox"/>	<input type="checkbox"/>
FEVER/CHILLS	<input type="checkbox"/>	<input type="checkbox"/>	DIFFICULTY SWALLOWING	<input type="checkbox"/>	<input type="checkbox"/>
BLINDNESS	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCER	<input type="checkbox"/>	<input type="checkbox"/>
DEAFNESS	<input type="checkbox"/>	<input type="checkbox"/>	BLEEDING FROM STOMACH	<input type="checkbox"/>	<input type="checkbox"/>
CHRONIC COUGH	<input type="checkbox"/>	<input type="checkbox"/>	BLEEDING FROM RECTUM	<input type="checkbox"/>	<input type="checkbox"/>
COUGHING BLOOD	<input type="checkbox"/>	<input type="checkbox"/>	CHRONIC DIARRHEA	<input type="checkbox"/>	<input type="checkbox"/>
PROGRESSIVE VOICE LOSS	<input type="checkbox"/>	<input type="checkbox"/>	CHANGE IN BOWEL HABIT	<input type="checkbox"/>	<input type="checkbox"/>
FREQUENT NOSEBLEEDS	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>
CHEST PAIN	<input type="checkbox"/>	<input type="checkbox"/>	YELLOW JAUNDICE	<input type="checkbox"/>	<input type="checkbox"/>
HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>	GALLSTONES	<input type="checkbox"/>	<input type="checkbox"/>
ABNORMAL HEART RHYTHM	<input type="checkbox"/>	<input type="checkbox"/>	INFLAMED PANCREAS	<input type="checkbox"/>	<input type="checkbox"/>
HEART VALVE DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	APPENDECTOMY	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY/URINE INFECTION	<input type="checkbox"/>	<input type="checkbox"/>
HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY STONE	<input type="checkbox"/>	<input type="checkbox"/>
ENLARGED HEART	<input type="checkbox"/>	<input type="checkbox"/>	DIFFICULTY WITH URINATION	<input type="checkbox"/>	<input type="checkbox"/>
ANGIOPLASTY	<input type="checkbox"/>	<input type="checkbox"/>	HYSTERECTOMY	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>
LEG PAIN WHEN WALKING	<input type="checkbox"/>	<input type="checkbox"/>	STROKE/PARALYSIS	<input type="checkbox"/>	<input type="checkbox"/>
ANKLE SWELLING	<input type="checkbox"/>	<input type="checkbox"/>	SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>
EXCESSIVE SHORTNESS OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>	BREAST LUMP	<input type="checkbox"/>	<input type="checkbox"/>
PNEUMONIA	<input type="checkbox"/>	<input type="checkbox"/>	SKIN CANCER	<input type="checkbox"/>	<input type="checkbox"/>
TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	THYROID DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>
CHRONIC BRONCHITIS	<input type="checkbox"/>	<input type="checkbox"/>	BLEEDING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>
EMPHYSEMA	<input type="checkbox"/>	<input type="checkbox"/>	PHLEBITIS/BLOOD CLOTS	<input type="checkbox"/>	<input type="checkbox"/>
HIV INFECTION	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES —YEAR _____	<input type="checkbox"/>	<input type="checkbox"/>
CANCER-LOCATION _____	<input type="checkbox"/>	<input type="checkbox"/>	CONTACT WITH SHEEP	<input type="checkbox"/>	<input type="checkbox"/>
FLUID IN ABDOMEN	<input type="checkbox"/>	<input type="checkbox"/>	ORAL CONTRACEPTIVE USE	<input type="checkbox"/>	<input type="checkbox"/>
HISTORY OF CONFUSION	<input type="checkbox"/>	<input type="checkbox"/>	ABNORMAL LIVER TESTS	<input type="checkbox"/>	<input type="checkbox"/>
VOMITING BLOOD	<input type="checkbox"/>	<input type="checkbox"/>	INCREASED CALCIUM LEVEL	<input type="checkbox"/>	<input type="checkbox"/>
ENLARGED SPLEEN	<input type="checkbox"/>	<input type="checkbox"/>	TRAVEL ABROAD/OVERSEAS	<input type="checkbox"/>	<input type="checkbox"/>
ABDOMINAL SWELLING	<input type="checkbox"/>	<input type="checkbox"/>	WHERE?	_____	_____
ABDOMINAL MASS	<input type="checkbox"/>	<input type="checkbox"/>	OTHER ISSUES	_____	_____
LIVER MASS	<input type="checkbox"/>	<input type="checkbox"/>	PREVIOUS HISTORY OF CANCER	_____	_____
PANCREATIC MASS	<input type="checkbox"/>	<input type="checkbox"/>			

FAMILY HISTORY OF:

	YES	NO		YES	NO
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	BREAST CANCER	<input type="checkbox"/>	<input type="checkbox"/>
GALLSTONES	<input type="checkbox"/>	<input type="checkbox"/>	OVARIAN CANCER	<input type="checkbox"/>	<input type="checkbox"/>
BLEEDING DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>	LUNG CANCER	<input type="checkbox"/>	<input type="checkbox"/>
LIVER CANCER	<input type="checkbox"/>	<input type="checkbox"/>	PANCREATITIS	<input type="checkbox"/>	<input type="checkbox"/>
BILE DUCT CANCER	<input type="checkbox"/>	<input type="checkbox"/>	BOWEL CANCER	<input type="checkbox"/>	<input type="checkbox"/>
PANCREATIC CANCER	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH CANCER	<input type="checkbox"/>	<input type="checkbox"/>
PHLEBITIS/BLOOD CLOTS	<input type="checkbox"/>	<input type="checkbox"/>	COLON POLYPS/CANCER	<input type="checkbox"/>	<input type="checkbox"/>
SICKLE CELL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
MEN SYNDROME (MULTIPLE ENDOCRINE NEOPLASIA)	<input type="checkbox"/>	<input type="checkbox"/>	OTHER FAMILY PROBLEMS	_____	_____

PLEASE INDICATE THAT THE ABOVE IS ACCURATE AND TO THE BEST OF YOUR KNOWLEDGE BY SIGNING BELOW:

SIGNED

DATE

**CFV-FERNCREEK GENERAL SURGERY
NEW PATIENT INTAKE SHEET**

PATIENT INFORMATION

Name (First, M.I., Last): _____ SSN# _____ M F
Address: _____ Date of Birth: _____ Age: _____

Phone# _____ Work# _____
Employer: _____ Driver's License#/State: _____
Employers Address: _____ Marital Status: S M W D
Referring Physician: _____ Primary Care Physician: _____

EMERGENCY CONTACT AND PHONE NUMBER:

******E-MAIL ADDRESS:**

RESPONSIBLE PARTY/GUARANTOR INFORMATION

NOTE: If patient is the responsible party/guarantor, enter "SELF" and go to Insurance Information

Name(First, M.I.,Last): _____ SSN# _____ M F
Address: _____ Date of Birth: _____ Age: _____

Phone # _____ Work# _____
Employer: _____ Drivers License#/State: _____
Employer's Address: _____ Relationship to Patient: _____

INSURANCE INFORMATION

NOTE: IF YOU HAVE YOUR CARD(S) AND YOU ARE THE PATIENT, YOU MAY SKIP THIS SECTION

Payer/Insurance Name: _____
Address: _____
Policy Holder's Name: _____ SSN# _____ M F
Certificate# _____ Group# _____
Relationship to Patient Self Spouse Parent Date of Birth _____
Policy Holder's Employer and Address: _____

SECONDARY INSURANCE

Payer/Insurance Name: _____
Address: _____
Policy Holder's Name: _____ SSN# _____ M F
Certificate# _____ Group# _____
Relationship to Patient: Self Spouse Parent Date of Birth: _____
Policy Holder's Employer and Address: _____

PATIENT MEDICAL RECORDS RELEASE STATEMENT

I HEREBY ASSIGN, TRANSFER, AND SET OVER TO CFV-FERNCREEK GENERAL SURGERY all of my rights, title and interest to my medical reimbursement benefits under all of my insurance policies. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. However, if CFV- Ferncreek General Surgery is in a direct contact with my third-party insurance payer, the financial responsibility provisions of the contract between my insurance payer and CFV-Ferncreek General Surgery will determine my ultimate financial responsibility.

I authorize CFV-Ferncreek General Surgery to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare or any other third-party payers. I authorize CFV-Ferncreek General Surgery to release all medical information to my referring physician and my primary (family) physician. I authorize CFV- Ferncreek General Surgery to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to CFV- Ferncreek General Surgery.

I authorize CFV-Ferncreek General Surgery to leave messages on my phone machine regarding

Appointment reminders

Financial obligations to CFV-Ferncreek General Surgery

I agree that these provisions will remain in effect until I provide written revocation to CFV- Ferncreek General Surgery.
I have received the HIPAA Notice of Privacy Policies for CFV- Ferncreek General Surgery.

Patient Signature: _____ Date: _____
Responsible Party/Guarantor (if applicable) _____ Date: _____

CFV—FERNCREEK GENERAL SURGERY – FINANCIAL POLICY

The physicians of CFV-Ferncreek General Surgery are committed to providing you with the highest level of quality medical care and personal service. The expense involved in providing this care is considerable, and in order to be able to continue to be of service to you and others it is necessary to ask that all patients and/or responsible parties meet their financial obligations associated with their care.

Because we see patients with many different types of medical coverage and insurance plans, it is impossible for us to be familiar with all the covered benefits, co-pays, and deductibles for every patient. Although we are here to assist you, it is still your responsibility to ensure that all services rendered to you by CFV-Ferncreek General Surgery are paid in full.

Payment at time of service is required. . We accept cash, check and Visa/MasterCard credit payments. Payment plans are provided by Cape Fear Valley Health System.

Patients with private medical insurance coverage. We have contracts with several insurance companies, and if your plan is one of these we can bill the company directly. In this situation, there may be a contractual discount on the charge to the company for services. If we do not contract with your company then the full charge will apply. You may be asked to satisfy the account yourself and to later contact your insurance company to obtain reimbursement. **Your payment is required at the time of service.**

Co-payments and deductibles. Co-payments and deductibles are amounts that your insurance plan requires us to collect from you at the time of service. You pay your insurance company a lower premium because you have a co-pay or deductible. If you do not pay your portion of the charges in full at the time of service then the balance, as stated on the encounter form you receive at the office, will be expected within 10 days. If you know that your deductible has not been met, or that your insurance company will not cover the service, we request that you notify us at the time of your visit. If we later receive payment from you insurance company, and discover that you have overpaid your portion of the charges, then we will gladly refund any overpayment.

Medicare patients. We participate with Medicare, which means we accept a greatly discounted amount for the services that we provide. Medicare will be billed for all covered services. For office visits **20% of the amount allowed** by Medicare for the visit is due from the patient and **will be collected at the time of service.** Medicare designates some services as non-covered, which means they will not pay for them. If you wish to receive such services you will be responsible for the full charge.

Medicaid patients. We participate with Medicaid, which means that we accept a greatly discounted amount for the services that we provide. Medicaid will be billed for all covered services. **Medicaid co-pays will be collected at the time of service.**

Patients without insurance coverage. Full payment at the time of service is required

Civil Suits, Auto, Home or Business Owners Claims. If you are involved in an accident or other suit and are seeking payment from the responsible party, **we expect payment at the time of service.** We do not bill the responsible party's insurance or attorney for your services due to the time it takes to settle these claims. Please do not request that we bill your regular health insurance in these cases, as the claims will be denied.

Returned Check. A \$25.00 fee will be assessed to your account should we receive a returned check for insufficient funds or no account. You will be required to pick up the check and pay the full amount of the check plus the \$25.00 fee with cash, money order or credit card.

Insurance Form Completion. We will be happy to complete relevant portions of insurance, FMLA, and social service forms, etc...for disability claims. Our standard fee for this is \$10.00 per form.

Missed appointments. We allocate office time and staff for your scheduled appointment, and if you do not show then the time is wasted and could have been used for someone else. We therefore reserve the right to charge for missed appointments. We require advanced notice of at least one business day if you cannot make your scheduled appointment. If you fail to provide the required notice, we may charge a fee of \$25.00 for each missed appointment.

By my signature below, I agree that I have read and understand the financial policy of CFV-Ferncreek General Surgery and further agree to hold harmless the physician's and staff of CFV-Ferncreek General Surgery for refusal to render further services in the event that I do not honor this agreement. I authorize CFV-Ferncreek General Surgery to submit medical claims for payment to my insurance carrier and other healthcare benefit associations. I assign all insurance and other healthcare benefits payable to CFV-Ferncreek General Surgery directly.

Responsible party _____

Date: _____



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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT NAME: _____ DOB: _____

TREATMENT DATES: _____ SSN: _____

PURPOSE FOR RELEASE: CONTINUATION OF CARE OTHER: _____

I hereby consent to and authorize _____

NAME PHONE #

ADDRESS CITY ST ZIP CODE

To release to _____

NAME PHONE #

ADDRESS CITY ST ZIP CODE

OR:

- FERNCREEK GENERAL SURGERY**
4140 Ferncreek Dr., Ste. 601
Fayetteville NC 28314-2569
(910) 485-3880 fax (910) 485-5341

The specific type of information to be released:

Information relating to the following treatment, condition, or dates

All healthcare information Other as listed below

I DO DO NOT authorize the release of information that may be present in my record relating to drugs or alcohol, mental health conditions/treatment; and/or testing/treatment for communicable diseases including hepatitis, STDs, AIDS, ARC (AIDS-related complex), or HIV.

This Consent will automatically expire one year from date of signature, unless another date is specified below.

Authorization not valid beyond _____ (Date cannot exceed one year from signature date)

Signature of patient/Legal Representative

Date

Relationship to patient

Print Name

Signature of Witness

Date