ALL INFORMATION ON THIS FORM MUST BE COMPLETED FOR THE OFFICE OF STEPHEN V. HAMN, M.D., F.A.C.S.

Patient information

Last name	First name		MI
Date of birth	Age	Home phone	
Address	City	State	Zip
Social Security number	Driver's license #	Sex: Male ☐ Female ☐	
Marital status		Other contact number	
Employer	Occupation	Work phone	
Employer address	City	State	Zip code

If insurance is carried by someone other than the patient, please complete this section.

Last name	First name		MI
Date of birth	Age	Home phone	
Address	City	State	Zip
Social Security number	Driver's license #	Relationship to patient	
Employer		Employer address	
Work phone	Occupation		

Emergency contact information

Full name	Relationship to patient	Phone number

Primary insurance information

Insurance company name	Insurance phone number
Policy/certification number	Group/account number

Secondary insurance information

Secondary insurance company name	Insurance phone number
Policy/certification number	Group/account number

Primary care physician information

Primary care physician name	Primary care physician phone number

Who may we thank for referring you to our office?

Full name	Phone number

As the responsible party, I agree that all charges that are not directly paid by my insurance will be my responsibility

Responsible party signature: ⌦ ______________________________ ***Date:*** ______________________

Stephen V. Hamn, M.D., F.A.C.S.
3108 Midway Rd., Suite 204
Plano, Texas 75093
(972) 845-4567

Medical history

The following information is very important to your health. Please take time to fully and completely fill out this important information.

Full name	Age	Height	Weight

What brought you to the office today?

Please list all allergies to medications

Office Use Only

Primary care physician information

Name:

Telephone number:

Medications: Please list all medications that you are currently taking.

Medication name	Dosage	Frequency taken	Indication

Past medical history: Please list all medical conditions or illnesses

Medical conditions	Illnesses

List all non-surgical hospitalizations you have experienced as an adult.

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Patient's name	**Date of birth**

Past surgical history: Please list all surgical procedures or operations

Year	Operations

Social history

Do you use tobacco? Yes ☐ No ☐	If yes, how many packs do you smoke per day?	Years of using tobacco?
Do you drink alcohol? Yes ☐ No ☐	If yes, what is the amount and frequency?	
Have you ever been treated for depression? Yes ☐ No ☐	If yes, are you currently in treatment? Yes ☐ No ☐	
If currently in treatment, please provide the name of your physician or therapist.	Have you ever been hospitalized for mental illness?	

Family history: Please indicate family members having any of the following illness.

	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Siblings	Children
Obesity								
Diabetes								
High blood pressure								
Heart disease								
Cancer								
Seizures								
Breathing problems								
Kidney disease								
Arthritis								
Early death & cause								
Other								

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Patient's name

Date of birth

System review: Please place an X in the box next to each item that applies to you.

Constitutional

- ☐ Fatigue
- ☐ Tiredness
- ☐ Recent weight loss
- ☐ Fever
- ☐ Night sweats
- ☐ Abnormal bleeding

Respiratory

- ☐ Shortness of breath
- ☐ Asthma
- ☐ Wheezing
- ☐ Cough
- ☐ Bloody sputum
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Difficulty sleeping flat
- ☐ Waking up short of breath

Cardiovascular

- ☐ Chest pain
- ☐ Pain in arms and neck
- ☐ Heart attack
- ☐ Palpitations
- ☐ Heart pounding
- ☐ Abnormal heart beats
- ☐ Heart murmur
- ☐ Stroke
- ☐ High/low blood pressure
- ☐ Pain in legs
- ☐ Cold feet
- ☐ Loss of pulses

Endocrine

- ☐ Hyper/hypothyroid
- ☐ Goiter
- ☐ Previous radiation
- ☐ Diabetes
- ☐ Adrenal gland tumor
- ☐ Previous steroid use
- ☐ Swollen glands

Musculoskeletal

- ☐ Pain in joints
- ☐ Muscular aches
- ☐ Swelling in joints
- ☐ Arthritis
- ☐ Pain in hips, knees, ankles or feet
- ☐ Low back pain
- ☐ Herniated disk
- ☐ Sciatica
- ☐ Numbness in feet or legs
- ☐ Abnormal lumps or masses

Genitourinary

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Leakage of urine
- ☐ Pain with urination
- ☐ Trouble starting urine
- ☐ Kidney stone
- ☐ Bladder infection

Men

- ☐ Discharge from penis
- ☐ Loss of erection

Neurological

- ☐ Seizures
- ☐ Convulsions
- ☐ Fainting
- ☐ Dizziness
- ☐ Light headedness
- ☐ Falling
- ☐ Muscle weakness
- ☐ Numbness
- ☐ Tremors
- ☐ Loss of consciousness
- ☐ Strokes

Psychological

- ☐ Depression
- ☐ Nervousness
- ☐ Anxiety
- ☐ Suicidal thoughts
- ☐ Suicide attempts
- ☐ Schizophrenia
- ☐ Anorexia
- ☐ Bulimia
- ☐ Binge eating
- ☐ Hospitalization for emotional problems
- ☐ Psychiatric or psychological counseling

Head and Neck

- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Dizziness
- ☐ Vertigo
- ☐ Sinus congestion
- ☐ Runny nose
- ☐ Sneezing
- ☐ Loss of smell
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Difficulty swallowing
- ☐ Pain when swallowing
- ☐ Hoarseness
- ☐ Lump in neck

Gastrointestinal

- ☐ Jaundice
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Vomiting
- ☐ Nausea
- ☐ Heartburn
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Pain with bowels
- ☐ Blood in stool
- ☐ Hemorrhoids
- ☐ Change in stool size
- ☐ Colitis

Women

- ☐ Vaginal discharge
- ☐ Abnormal vaginal bleeding
- ☐ Irregular periods
- ☐ Pelvic/pap exam within the last year
- ☐ Hysterectomy

Skin/Breast

- ☐ Skin cancer
- ☐ Abnormal moles
- ☐ Burns
- ☐ Rash
- ☐ Breast mass
- ☐ Nipple discharge
- ☐ Mammogram with in the last year
- ☐ MRSA

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Patient's name	**Date of birth**

Any other important medical information, please list below.

The above is true, correct and complete to the best of my belief.

Patient's signature ***Date***

(Required)

Medical information has been reviewed by:

Physician's signature Date

ALL INFORMATION ON THIS FORM MUST BE COMPLETED FOR THE OFFICE OF STEPHEN V. HAMN, M.D., F.A.C.S.

In our efforts to comply with the health information privacy act, HIPAA, we need to be certain that we guard your privacy according to you wishes when it comes to your family, friends and co-works.

Please place an X in the box next to the best response to the following questions.

May we leave messages concerning your appointments/treatments with a co-worker, receptionist or secretary that regularly answers your calls?	Yes ☐	No ☐
May we leave messages on an answering machine at home?	Yes ☐	No ☐
May we leave information with a spouse or significant other?	Yes ☐	No ☐
Is there anyone that is not listed above that we can give information to? If yes, please specify here.	Yes ☐	No ☐
For any children above 18, still living at home, may we discuss your appointments/treatments with your parent(s) or guardian?	Yes ☐	No ☐
I would like to receive regular email updates and/or newsletters? If so, please provide your email address:	Yes ☐	No ☐

You must inform us in writing of any changes in your directives. This record takes effect March 1, 2019 and will be kept in your file with your acknowledgment of receipt of our Notice of Privacy Practices.

Patient's signature ***Date***

(Required)

Print name

Notice of physician ownership

Stephen Hamn, M.D., F.A.C.S. has ownership interest in the following facilities: Baylor Medical Center at Frisco and Presbyterian Plano Center for Diagnostics and Surgery. I understand that my physician may refer me to one of the facilities for service. I also understand that I may speak with my physician about his financial relationship with the facility and to provide my treatment at a facility where he has no ownership interest.

Patient's signature ***Date***

(Required)

ALL INFORMATION ON THIS FORM MUST BE COMPLETED FOR THE OFFICE OF STEPHEN V. HAMN, M.D., F.A.C.S.

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 read the below information completely and carefully.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with aid in or facilitate collection of data for purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payers, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.

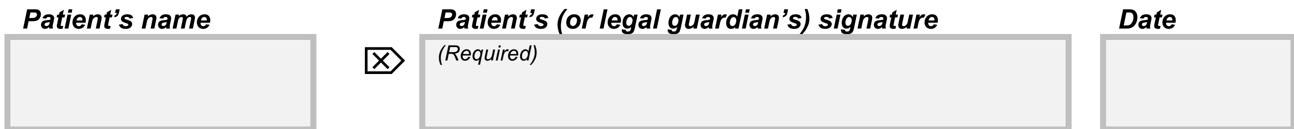
This office will not sue or disclose any of you medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information, to provide you with this Notice of Privacy Practices, and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a compliant with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak with the office Manager or Privacy Officer to obtain additional information regarding any questions you may have concerning this notice or to receive a printed copy of this notice. This Notice of Privacy Practices is effective as of April 14, 2013.


Patient's name
Patient's (or legal guardian's) signature
(Required)
Date

Stephen V. Hamn, M.D., F.A.C.S.
3108 Midway Rd., Suite 204
Plano, Texas 75093
(972) 845-4567

We would like to thank you for making an appointment with our office. It is important that you understand the procedures of our office regarding **General Surgery.**

- You are responsible for getting referrals and keeping them updated with our office
- You must pay any copays, deductibles or deposits **two days prior to the day of your surgery** at our office. **We do not offer payment arrangements**

Important: please read carefully and sign and acknowledgement.

- I hereby authorize Stephen V. Hamn, M.D., F.A.C.S. to furnish medical records and/or test results including HIV status, via fax or mail, to my referring doctor, insurance companies and to the doctor to whom I am referred concerning my illness or treatment. I will not hold the physicians or the employees responsible for any misdirected records or correspondence, authorize payment of all medical benefits to Stephen V. Hamn, M.D., F.A.C.S.

- An assistant surgeon, PA or CRNFA (certified registered nurse first assist) may be assisting with your surgery. The assistant surgeon is out of network with all insurance companies

- The office staff will notify you if there will be a deposit due for the assistant. If your insurance company pays the assistant surgeon's fee, the deposit will be refunded back to you. If your insurance company does not pay, we will keep the deposit and accept that as payment in full for the assistant surgeon. Refunds are given according to office policy and after all deductible, copays, co-insurance and claims have been paid. This amount is not included in out of pocket maximums

- Please note there is a $15.00 fee for completing Family Medical Leave or disability papers each time they are requested

- I hereby certify that I have provided Stephen V. Hamn, M.D., F.A.C.S. my current insurance, address, phone numbers and any other pertinent information. I also understand that failing to disclose this information could result in my insurance carrier not providing benefits for this service

TO ALL PATIENTS: If for any reason you decide to cancel your surgery, please inform us at least 48 hours in advance to avoid a $250.00 cancellation fee.

Patient's signature ***Date***

(Required)

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Member Authorization Form for a
Designated Representative to Appeal Adverse Determination

To: ____________________________________

____

____

Date: ____________________________________

Member name: *(Required)*

Member #: ____________________________________

I hereby authorize ____ to appeal my insurance carrier's determination concerning any denials of claims or incorrect payment of claims (including delayed payment of claims), on my behalf, as my Designated Representative, and, as part of the appeal, I hereby authorize my insurance carrier in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative in all aspects of the appeal. I understand that they communications may contain the following:

- All medical and financial information contained in my insurance file, including but not limited to treatment for venereal disease, alcoholism and drug abuse, abortion, mention disorder and HIV status relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed

I understand this information is privileged and confidential and will not be released as specified in this authorization, or as required or permitted by law. This authorization is valid for a period of one year.

Signature of Member or Legal Guardian/Representative

(Required)

Signature of Witness ***OR*** ***Signature of Designated Representative***

Name of Witness or Designated Representative (that matches above signature) – Please print

Title (if on provider's staff) or relationship to member