CHRIAS
Christiana Institute of Advanced Surgery
CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA

Name:_____ DOB:_____

Office Registration Form

Name:			**Date of Birth:**
Address:		**City:**	**Zip:**
Home Phone #:	**Work Phone #:**	**Cell Phone #:**	**Gender (circle):** Male Female
Soc. Security #:	**Race (Circle):** American Indian | Asian Native |Hawaiian | Black or African American | White | Hispanic | Other		**Ethnicity (circle):** Hispanic | Non-Hispanic
Marital Status *(S-Single, M-Married, D-Divorced, W-Widowed*):	**Email Address:**		
Employer:	**Employer Phone#:**	**Occupation:**	

Chief Complaint/Reason for Visit: _____

Name of Primary Care Physician:_____ **Phone #:**_____

Who Referred You to Us? *(Check all that apply & specify)*

□**Physician (Name)** _____ □**Internet/Website** _____

□**Friend/Relative (Name)** _____ □**Advertising** _____

□Other _____

Participating Pharmacy: _____Phone #:_____
Emergency Contact: _____Relation:_____
Phone#:_____

Primary Insurance: _____ Policy ID #:_____
Policy Holder's Name: _____
Date of Birth:_____
Secondary Insurance:_____ Policy ID #:_____
Policy Holder's Name: _____
Date of Birth:_____

Initial: **_____ I agree to bring my insurance card and co-pay (if applicable) to *every* appointment. I am aware that if I do not, my appointment may need to be cancelled and rescheduled.**

Please initial:

_____I request that payment of authorized benefits Medicare, Medicaid, and/or any Insurance carrier listed, be made to me or on my behalf to the provider listed on this form, for any services furnished to me by my physician. I understand and agree I will be responsible for any charges, i.e. co-payments, deductibles, or non-covered services not paid forby my insurance carrier. I authorize any holder of medical information about me to release it to the Division of Family Services, the Health Care Financing Administration, listed insurer(s), and/or agents of these companies, and/or the listed responsible person(s), any information needed to determine these benefits or the benefits for other related services rendered.

Name:_____ DOB:_____

Patient Consent for Use and Disclosure of Protected Health Information

The individual whose signature appears below hereby attests to the following statements:
With my consent, CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Please refer to CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA's Notice of Privacy Practices for a more complete description of such uses and disclosures.)

With my consent, CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA may disclose my PHI to the following individuals (family, relatives, or friends) who may assist in my care:

Name	Relationship	Home #:	Work #:	Cell #:

I have the right to review the Notice of Privacy Practices prior to signing this consent. CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA reserves the right to revise its Notice of Privacy Practices at any time. A written copy of our Notice of Privacy Practices may be obtained by forwarding a written request to our office.

CONSENT FOR CALLS TO HOME
With my consent, CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA may call my home or other designated location and leave message on my voice mail or with a person listed above in reference to any item that may assist CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

CONSENT FOR MAIL
With my consent, CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA may mail to my home or other designated location any item that may assist CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA in carrying out TPO such as appointment reminder cards and patient statement as long as they are marked CONFIDENTIAL.

CONSENT FOR E-MAIL
With my consent, CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA may e-mail to my designated e-mail address any message in reference to any item that may assist in my care.

CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA may contact me for TPO use, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

I have the right to request that CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA restricts how it uses or discloses my PHI to carry out the TPO, However, CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA is not required to agree to my requested restrictions, but, if it does, it is bound by this agreement.

By signing this form, I am consenting to CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA's use and disclosure of my PHI to carry out TPO.
I may revoke my consent in writing except to the extent that CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA has already made disclosure in reliance upon my prior consent. If I do not sign this consent, CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA may decline to provide services to me.

Signed by: _____ _____
Signature of Patient Date

_____
Patient's Name

(PATIENT WILL BE PROVIDED WITH A SIGNED COPY OF THIS AUTHORIZATION)

Name:_____ DOB:_____

Patient Health History

Name:_____ Today's Date:_____
Social Security Number:_____ Date of Birth: _____
Reason for visit:_____ Referred by:_____

List all medications (use back if you need extra space):
Drug_____ dose_____ How often_____
Drug_____ dose_____ How often_____
Drug_____ dose_____ How often_____
Drug_____ dose_____ How often_____
Do you take aspirin routinely? _____Yes _____No How often?_____

Allergies to medications: 1._____ 2._____ 3._____

Do you have a latex allergy? _____Yes _____No

Please check if you have had any of the following surgeries:
_____Appendectomy _____Gallbladder removed _____Hernia repair
_____Heart surgery _____Hysterectomy _____Colon surgery
_____Breast surgery _____Kidney transplant
_____Others (please list)_____

Please check if you have had any of the following medical problems:
_____Mitral valve prolapse _____Cancer _____Emphysema
_____Abnormal EKG _____High blood pressure _____Arthritis
_____Angina _____Hearth attack _____Lung disease
_____Diabetes _____Heart failure _____Liver disease
_____Bleeding problems _____HIV _____Kidney disease
_____Other (please list)_____

If you are a dialysis patient, what days are you dialyzed?_____
Dialysis unit?_____
List any problems with anesthesia in past:_____

Last chest x-ray:_____Last EKG:_____
Where did you have them done?_____

Do you smoke?_____ Packs per day?_____ Drink alcohol?_____How often?_____

Any family history of:
_____Cancer _____Diabetes _____High blood pressure_____Stroke _____Heart attack _____Bleeding disorder

Date of last menstrual period:_____

Name:_____ DOB:_____

Disability Form/FMLA Request

Name: _____ **Date:** _____

Dear Patient,

If you require disability forms to be completed prior to your scheduled surgery, our office needs a signed release and processing fee of $20.00. A minimum of **seven to ten** business days are required for completion. There is no charge to complete and FMLA form.

Thank you in advance for following these simple directions. It will enable our office to process your request more efficiently. Completed forms may be picked up or faxed. If you have any questions, please call our office at (302) 892-9900.

Sincerely,

Natalia Co

Natalia Co
Practice Administrator

_____ _____
Patient Signature Date

CHRIAS
Christiana Institute of Advanced Surgery
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Name:_____ DOB:_____

No Show/ Cancellation Policy

Attention CHRIAS Patients:

We understand that there are times when you must miss an appointment due to emergencies, unforeseen events or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from receiving much needed treatment. Conversely, a situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment schedule.

Patients who No Show two or more times within a 12-month period will receive a No Show letter emphasizing the importance keeping scheduled visits and the ramifications of failing to keep future appointments. Patients who continue to No Show after receiving the No Show letter are subject to be discharged from the practice and will not be eligible to schedule future visits.

We ask that you are mindful of other patients' time by providing us 48 hours' notice when cancelling an office appointment.

Appointment Type	Minimum Timeframe to Cancel	Charge
New Patient	48 hours	$100.00
Established Patient	48 hours	$25.00
Surgical Procedures	2 weeks	$100.00

Patients with Medicaid are excluded from the aforementioned; however the "No Show" will be documented with their insurance company. ***Both the Cancellation and No Show fees are the patient's sole responsibility and must be paid in full before the next appointment.***

Please sign below acknowledging that you have read, understand and agree to the Cancellation and No Show terms above.

Patient Name **Date of Birth**

Patient Signature **Date**

Name:_____ DOB:_____

Welcome to Your Secure Patient Portal – IQ HEALTH!

Dear Patient,

In order to effectively communicate with your physician and the CHRIAS staff, **you must** sign up for our secure patient portal called **IQHealth!**

This system allows web based interactions between patients and our office. You will be able to:

- ✓ Review your test results
- ✓ Access your medical records
- ✓ Request an appointment
- ✓ Request medication refills
- ✓ Update demographic information
- ✓ Communicate electronically and securely with your doctor
- ✓ Receive paperless billing and track your payments

In order to take advantage of this new feature, you will need an online invitation. To set up your account, you will receive a one-time secure email invitation from **IQHealth.com** with the subject "**United Medical Physicians invites you to join IQ Health"**.

Please check your email Inbox and/or Spam folder and expect to see the invitation within 1-2 business days. Simply click on the link in your email and follow the prompts to activate your account. This link will expire in 30 days. For any questions or concerns please contact the office for assistance at (302) 892-9900.

We hope this new system will make communication with our office easier and more convenient.

Sincerely,

Christiana Institute of Advanced Surgery

Website: IQHealth.com **Smartphone App: HealtheLife**

"I wish to participate" (**please print clearly**)

Name: _____ **Date of Birth:** _____

Email Address: _____ **Last 4 digits of SSN:** _____

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Name:_____ DOB:_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please send a copy of this release with their requested records.

PATIENT INFORMATION (Please Print)

✓ Patient Name		✓ Date of Birth / /		Social Security Number _____ - _____ - _____
✓ Address	City	State	Zip	✓Phone

RELEASE FROM (Name of Physician or Facility)

I authorize release of my medical records from:

Address	*City*	*State*	*Zip*	*Phone* / *Fax*

RELEASE TO (Name of Physician or Facility Receiving Information)

Please send my medical records to: Christiana Institute of Advanced Surgery
Physician / Facility

537 STANTON-CHRISTIANA RD, SUITE 102 Address	NEWARK City	DE State	19713 Zip	✓Phone 302-892-9900 ✓Fax 302-892-9980

RELEASE INFORMATION

✓Reason: ☐ Change of Insurance ☐ Moving Out-Of-Area ☐ Transfer of Care ☐ Specialist Consultation ☐ Personal File ☐ Legal

✓Please release the following (check all that apply)

☐ Recent H & P ☐ Hospital Reports ☐ X-Ray Reports
☐ Lab Reports ☐ Last Three (3) Visits ☐ Others:

Please allow 15 days for processing. Incomplete information will delay processing.
Use of this information for any other than the stated purpose is prohibited.
This information is for the use of designated recipient only and cannot be provided to any other agency.

CONSENT

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse.

I authorize the release of HIV/HTLV/AIDS test result ☐ YES ☐ NO
I understand that I may be charged for copies provided ☐ YES ☐ NO

✓_____ ✓_____
Signature of patient, parent, guardian, conservator, or patient representative (circle one) Date

✓_____ _____
Witnessed by: Date

Note: *This consent is valid for 90 days. It may be revoked by the signer at any time.*

For Office Use:

Released/ Mailed/Faxed:	Received By:
Initial/Date:	Signature/Date:

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CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA

Name:_____ DOB:_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please send a copy of this release with their requested records.

PATIENT INFORMATION (Please Print)				
✓ Patient Name		✓ Date of Birth / /		Social Security Number _____ - _____ - _____
✓ Address	City	State	Zip	✓Phone
RELEASE FROM (Name of Physician or Facility)				
I authorize release of my medical records from: **Christiana Institute of Advanced Surgery**				
537 STANTON-CHRISTIANA RD, SUITE 102 Address	NEWARK *City*	DE *State*	19713 *Zip*	*Phone* 302-892-9900 *Fax* 302-892-9980
RELEASE TO (Name of Physician or Facility Receiving Information)				
Please send my medical records to: Physician / Facility				
Address	City	State	Zip	✓Phone ✓Fax
RELEASE INFORMATION				
✓Reason: ☐ Change of Insurance ☐ Moving Out-Of-Area	☐ Transfer of Care ☐ Specialist Consultation	☐ Personal File ☐ Legal		
✓Please release the following (check all that apply) ☐ Recent H & P ☐ Hospital Reports ☐ X-Ray Reports ☐ Lab Reports ☐ Last Three (3) Visits ☐ Others:				
Please allow 15 days for processing. Incomplete information will delay processing. *Use of this information for any other than the stated purpose is prohibited.* *This information is for the use of designated recipient only and cannot be provided to any other agency.*				
CONSENT				
I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse.				
I authorize the release of HIV/HTLV/AIDS test result ☐ YES ☐ NO I understand that I may be charged for copies provided ☐ YES ☐ NO				

✓_____ ✓_____

Signature of patient, parent, guardian, conservator, or patient representative (circle one) Date

✓_____ _____

Witnessed by: Date

Note: *This consent is valid for 90 days. It may be revoked by the signer at any time.*

For Office Use:

Released/ Mailed/Faxed: Initial/Date:	Received By: Signature/Date: