USA
University Surgical Associates
A Team Approach to Treatment

Complete all forms and bring them with you on your scheduled appointment date.

Thank you!

University Surgical Associates, PSC

General Surgery
Robert N. Cacchione, M.D.
William G. Cheadle, M.D.
Glen A. Franklin, M.D.
Richard N. Garrison, M.D.
Brian G. Harbrecht, M.D.
Farid J. Kehdy, M.D.
Gerald M. Larson, M.D.
Frank B. Miller, M.D.
J. David Richardson, M.D.
Jorge L. Rodriguez, M.D.
Christopher R. Schneider, M.D.
Jason W. Smith, M.D.
Gary C. Vitale, M.D.

Surgical Oncology
Michael B. Flynn, M.D.
Richard E. Goldstein, M.D., Ph.D.
Robert C. G. Martin, M.D.
Kelly M. McMasters, M.D., Ph.D
Hiram C. Polk, Jr., M.D.
Amy R. Quillo, M.D.
Charles R. Scoggins, M.D.

Transplant
Mary Eng, M.D.
Christopher M. Jones, M.D.
Michael R. Marvin, M.D.

Colorectal Surgery
Susan Galandiuk, M.D.
Jeffrey R. Jorden, M.D.
Michael H. McCafferty, M.D.

Vascular Surgery
Amit J. Dwivedi, M.D.
Marvin E. Morris, M.D.
Charles B. Ross, M.D.
Andrea E. Yancey, M.D.

Plastic and Reconstructive
Larry D. Florman, M.D.
Jarrod A. Little, M.D.
Terry M. McCurry, M.D.
Gordon R. Tobin, M.D.
Bradon J. Wilhelmi, M.D.

Otolaryngology, Head and Neck Surgery
Jeffrey M. Bumpous, M.D.
Swapna K. Chandran, M.D.
Arun K. Gadre, M.D.
Toni M. Ganzel, M.D.
Kevin L. Potts, M.D.
Welby Winstead, M.D.

Dear Patient:

Enclosed is information regarding your appointment with:

_____ Dr. Susan Galandiuk
_____ Dr. Michael McCafferty
_____ Dr. Jeffrey Jorden

1. Please be sure to have your medical records with you, including (if you have had) any surgery, colonoscopy, and/or pathology reports. You may have them sent to our office to the attention of the doctor you are scheduled to see, by fax, prior to your office visit. Our fax number is 502-584-0302.

2. Bring X-rays, MRIs and any scan films (if you have had them done) with you. You can pick these up at the facility where you had them done. Call the facility ahead of time to arrange this pickup.

3. You will need to have a Fleet enema prior to your visit. This will ensure that your rectal area is empty for the doctor to examine you if he/she needs to. You may purchase the Fleet enema or other generic sodium phosphosoda enema at any pharmacy without a prescription, he directions for using the enema is printed on the box. Take the enema two hours before you leave for your appointment or the evening before if your appointment is early in the morning. FAILURE TO DO THIS MAY DELAY YOUR VISIT OR PREVENT AN ADEQUATE EXAM… CAUSING YOU TO HAVE TO RESCHEDULE YOUR APPOINTMENT.

4. Colostomy / Iliostomy patients do not need to do the Fleet enema, but do need to bring ostomy supplies for a change of their appliance.

Should you have additional questions, please call our office between 9:00 a.m. and 4:00 p.m. at 502-583-8303 or toll free at 1-800-872-8033.

Looking forward to seeing you.

Dr. Susan Galandiuk
Dr. Michael McCafferty
Dr. Jeffrey Jorden

Welcome to our practice.

It is very important that you fill out the enclosed patient registration form, medical history form, and financial policy form completely, prior to your appointment. Please be sure to bring these forms and your current insurance card or cards with you to your appointment. We **must** get copies of your insurance cards to enable us to bill claims properly. ***Please do not mail paperwork to our office, bring it with you!***

The anticipated cost of your initial visit can range in cost. It is difficult for us to provide you with a precise cost estimate for your visit, however, you must pay your copay prior to being seen by the doctor.

Some insurance plans require that you obtain a referral from your Primary Care Physician in order to see a Specialist. Please remember it is the **patient's responsibility** to know their individual insurance plans, each plan has different coverages and networks. If your insurance company requires you obtain a referral we **must have this prior to your appointment or you may bring it with you to your appointment. If you do not have your referral we cannot see you and your appointment will be rescheduled to our next available appointment date. There will be no exceptions!**

Insurance plans that may require a referral include:

- **Aetna HMO/Aetna MC/Aetna QPOS**
- **Cigna HMO/Cigna MC**
- **Humana HMO/Humana HMO-MBP**
- **Indiana Medicaid/Hoosier Healthwise**
- **Kentucky Medicaid/KENPAC**
- **Passport**
- **Tricare**

This is not an inclusive list; please check with your benefits administrator if you have any questions concerning referrals.

Thank you for choosing our practice! We are here to help you in any way possible. Our office hours are Monday – Friday; 8:30 am to 5:00 pm. The clinical and business staff will be happy to help you with any appointment, please call to cancel well in advance so that we may offer this appointment space to someone else in need.

How did you hear about University Surgical Associates and/or your doctor?

☐ Internet ☐ Radio ☐ Direct Mail ☐ Today's Woman ☐ Louisville Magazine ☐ Newspaper
☐ Audience Playbill ☐ Your physician ☐ TV ☐ Friend or word of mouth ☐ Other ________________________

Referring Doctor: ____________________ Family Doctor / PCP: ____________________

Address ____________________ Address: ____________________

Phone: ____________________ Phone: ____________________

Patient Information

Patient's Last Name:	First Name:	M.I.	Patient's Social Security #:
Street Address:			Age: / Date of Birth:
City: / State: / Zip:	Email Address:		Patient's Home Phone:
Race: / Language:	Religion:		Patient's Cell Phone:
Employment or Student Status (if not a minor): Full Time ☐ Part Time ☐ Self Employed ☐ Active Military ☐ Name of School:		Gender: (circle one) Male Female	Marital Status: S M D W
Employment / Retirement Eff.Date:	Patient's Employer:		Patient's Occupation:
Patient's Work Phone & Ext#:	Employer's Address:		Date Employment Started:
Spouse's Date of Birth:	Spouse's Name:		Spouse's Social Security #:
Spouse's Work Phone:	Spouse's Employer		Spouse's Occupation:

[NOT NEEDED IF A CHILD]

Responsible Party / Child's Parent Information

Responsible Party or Father's Name:			Responsible Party or Mother's Name:		
Social Security #:	Date of Birth:	Relationship to Patient:	Social Security #:	Date of Birth:	Relationship to Patient:
Employer:		Work Phone & Ext:	Employer:		Work Phone & Ext:
Home Address if different from Patient's:			Home Address if different from Patient's:		
City, State & Zip:		Phone:	City, State & Zip:		Phone:

Primary Insurance

PLEASE NOTE: We MUST Make A Copy of Your Insurance Card.

Insurance Company Name:		Effective Date:	Subscriber's Date of Birth
Subscriber's Full Name:	Subscriber's Social Sec #:		Relationship to Patient:

Secondary Insurance

PLEASE NOTE: We MUST Make A Copy of Your Insurance Card.

Insurance Company Name:		Effective Date:	Subscriber's Date of Birth:
Subscriber's Full Name:	Subscriber's Social Sec #:		Relationship to Patient:

Emergency Contact

SOMEONE WITH A DIFFERENT PHONE NUMBER

Name:	Phone Number:	Relationship to Patient:

RELEASE OF INFORMATION: I hereby authorize the release of medical information or other information acquired during the course of examination and treatment to insurance carriers, physicians, or my legal representatives. I hereby request payment of benefits from all insurance carriers to University Surgical Associates P.S.C. I understand I am responsible for and will pay any amount not covered by insurance including collection costs and reasonable attorney fees if referred for collection.

____________________ Signature – Responsible Party ____________________ Date

____________________ USA Doctor ____________________ Registrar

UNIVERSITY SURGICAL ASSOCIATES, PSC   PATIENT HISTORY FORM
(see also dictated note/letter from today's date)

Patient's Name:_______________________________________**Today's Date**____________________

Age:____ **Birth Date:** _____________ **Race:**______________________**SSN:**___________________

Family Physician: Dr. _________________________ **Referred by: Dr.** _________________________

Other Physicians you see: ____

Reason for Visit:____

THIS BOX FOR MD USE ONLY

Location
Quality
Severity
Duration
Timing
Context
Modifying Factors
Associated Signs and Symptoms

Past Medical Problems: (check boxes that apply, describe below and list dates if possible)
☐High Blood Pressure ☐ Diabetes ☐ Heart Disease/Heart Attack ☐ Kidney Disease ☐ Lung Disease/COPD ☐ Seizures ☐ Stroke ☐ Cancer ☐ Emotional/Psychiatric Problems ☐ Hepatitis

____

____

____

List all Previous Operations/Procedures (for example, colonoscopy, cardiac stent, etc.) List reason,date, & MD

____

____

____

____

____

Cancer Treatments: Have you ever had Chemotherapy or Radiation Therapy? If so when and by whom:

____

____

Medications: (List name, dose, & how often taken)

____

____

____

____

Do you take aspirin/ aspirin-containing products / any blood thinners? ☐YES ☐NO (if yes, please list)

____

Are you allergic to any medications? ☐YES ☐NO (if yes, please list) **ALLERGIC to LATEX?** ☐YES ☐NO

____

Social History

☐ Single ☐ Married ☐Separated ☐ Divorced ☐ Widowed Occupation______________

Do you use alcohol? ☐YES ☐NO How much and how often?________________________________

Do you use tobacco now? ☐YES ☐NO Did you ever use tobacco? ☐YES ☐NO

Describe tobacco use (for example, packs per day) ____

Heavy Sun Exposure in past? ☐YES ☐NO Blistering Sunburns in past? ☐YES ☐NO

Tanning Bed Use? ☐YES ☐NO

Family History List diseases (including specific types of cancer) that run in the family, which relative was affected, and at what approximate age.

____

____

____

ROS: List all symptoms that you are experiencing currently

General	Yes	No
Weakness	_____	_____
Weight loss	_____	_____
Fever/chills	_____	_____
Night sweats	_____	_____
Eyes	**Yes**	**No**
Vision changes	_____	_____
Double vision	_____	_____
Head/Neck	**Yes**	**No**
Headache	_____	_____
Blackout spells	_____	_____
Changes in hearing	_____	_____
Changes in taste/smell	_____	_____
Thyroid Problems	_____	_____
Neck lumps	_____	_____
Ear pain	_____	_____
Hematologic	**Yes**	**No**
Anemia	_____	_____
Easy Bruising	_____	_____
Clotting Problem	_____	_____
Lung	**Yes**	**No**
Lung problems	_____	_____
Shortness of breath	_____	_____
Cough up blood	_____	_____
Wheezing/Asthma	_____	_____
Pneumonia	_____	_____
Tuberculosis	_____	_____
Musculoskeletal	**Yes**	**No**
New aches/pains in Bones/joints	_____	_____
Arthritis	_____	_____

Heart	Yes	No
Chest Pain	_____	_____
Heart Attack	_____	_____
Irregular Heart Beat	_____	_____
Heart Failure	_____	_____
Swelling in Ankles	_____	_____
Palpitations	_____	_____
Gastrointestinal	**Yes**	**No**
Abdominal pain	_____	_____
Nausea/Vomiting	_____	_____
Vomit Blood	_____	_____
Difficulty Swallowing	_____	_____
Heartburn /Indigestion	_____	_____
Blood in Stool	_____	_____
Black/Tarry Stool	_____	_____
Change in stool size/color	_____	_____
Constipation	_____	_____
Yellow Jaundice	_____	_____
Kidney	**Yes**	**No**
Blood in Urine	_____	_____
Kidney/bladder infection	_____	_____
Kidney stones	_____	_____
Painful urination	_____	_____
Difficulty urinating	_____	_____
Breast	**Yes**	**No**
Lump	_____	_____
Nipple discharge	_____	_____
Pain	_____	_____
Date Last Mammogram	____________	

Reproductive History	Yes	No
Age at 1st period	____________yrs	
Age at menopause	____________yrs	
# Pregnancies	____________	
# Live births	____________	
Age at 1st pregnancy	____________yrs	
Breast Fed	_____	_____
If yes, your age at the time	____________yrs	
Last Menstrual period	____________	
Last Pap Smear	____________	
Currently use Hormone Replacement Therapy	_____	_____
If yes, how long	____________	
Previously used Hormone Replacement Therapy	_____	_____
If yes, when stopped	____________	
Neurologic	**Yes**	**No**
Tingling	_____	_____
Numbness	_____	_____
Weakness	_____	_____
Psychiatric	**Yes**	**No**
Depression	_____	_____
Anxiety	_____	_____
Mood swings	_____	_____
Skin	**Yes**	**No**
Rash	_____	_____
Skin cancer	_____	_____
Change in mole	_____	_____

FOR BARIATRIC PATIENTS ONLY:

Diets used and weight lost: ____

Sustained weight loss: ______________ How long was weight lost? _____________________

How long over 100 lbs. overweight? _________________ How many times have you lost over 25 lbs? __________

How long have you been overweight? _______________years.

Are you currently under a physician's care for weight loss? YES NO Physician's Name:__________________

PHYSICIAN COMMENTS:

____

Physician Signature: ____ Date________________

(History Form Reviewed with Patient)

University Surgical Associates, PSC
401 East Chestnut Street Suite 710
Louisville, Ky 40202

Dear Patient,

In order to help us stay within the guidelines of HIPAA, please list below any person /persons that you authorize us to disclose information to regarding your Protected Health Information. (**You do not need to list any of your doctors.)**

Name	Relationship
1. ________________________	________________________
2. ________________________	________________________
3. ________________________	________________________
4. ________________________	________________________
5. ________________________	________________________

Do we have your permission to leave information on your **answering machine** when you are not at home?

Yes ________ **No** __________

____________________________________ ______________________
Patient's Name (Please Print) Date of Birth

____________________________________ ______________________
Patient's (or Guardian's) Signature Date

USA
University Surgical Associates
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Financial Policy

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. Please read the following policy. If you have any questions, please feel free to discuss them with our staff.

YOUR INSURANCE

We have made prior arrangements with many insurers and other health plans. We will bill those plans with whom we have an agreement and will collect any required copayment at the time of service. The copayment will be collected when you arrive for your appointment. For elective surgery you will be contacted to arrange for payment of the coinsurance and deductible. In the event your health plan determines a service to be "not covered" or you have "no insurance coverage", you will be responsible for the complete charge. We will also bill your health plan for all services we provide in the hospital. We will be glad to establish a payment plan to meet your needs.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

CANCELLATION/NO SHOW POLICY

An appointment must be cancelled 24 hours in advance. A patient that does not cancel their appointment at least 24 hours in advance or is a NO SHOW will be charged $25.00.

SUPPLIES POLICY

If we know there are supplies involved we will try to alert you of our charges before you come for your scheduled appointment. Your insurance may deny payment for this ________________________ service/supply. The patient/responsible party understand that this charge may be non covered and will be responsible for these charges at the time of service.

MEDICAL RECORD POLICY

When requesting disability forms to be completed we will require a $25.00 payment for the initial form and a $10.00 payment for follow-up forms in advance of their completion.

PRESCRIPTION POLICY

We ask that you call in your refill request for prescriptions during the hours of 9:00 am – 3:00 pm Monday thru Friday only. Prescription refills from 3:00 pm Friday – 9:00 am Monday are not available.

I have read and understand the financial policies of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

____ ____________________

Signature of Patient or Responsible Party if a Minor Date

____

Signature of Co-responsible Party

____

Please Print the Name of the Patient

University Surgical Associates
401 East Chestnut St. Suite 710
Louisville, KY 40202

AUTHORIZATION TO OBTAIN RECORDS FROM ANOTHER DOCTOR
(DISCLOSURE OF PROTECTED HEALTH INFORMATION)

This authorization, if signed, will authorize University Surgical Associates to obtain certain protected health information that is in the below mentioned entity's possession for the patient named below.

Patient Name: ______________________________ Date of Birth: ______________

Patient Address: ______________________________ City, State & Zip ______________

I, ______________________________ (patient's name) hereby authorize the following entity ______________________________ (practice or doctor records to be acquired FROM) located at ______________________________ to release or disclose my protected health information described below to Dr. ______________________ with **University Surgical Associates, PSC** located at **401 East Chestnut St., Suite 710, Louisville, Kentucky 40202**.

_____ Entire Medical Record

Or the specified records as indicated:

		Date(s) of service
_____	History and physical examination	______________
_____	Consultation reports	______________
_____	X-ray reports	______________
_____	Laboratory tests	______________
_____	Operative report	______________
_____	Discharge summary	______________
_____	Progress notes	______________
_____	Photos, videotapes, or digital or other images	______________
_____	Other (please list)	______________

____

____

I understand that this information may include information relating to Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, or mental or behavioral health or psychiatric care.

______________________________ ______________________
Signature (Patient or Patient's Representative) Date

______________________________ ______________________
Printed Name of Patient's Representative given authority to act for patient Phone Number

____
Relationship to Patient

USA
University Surgical Associates
A Team Approach to Treatment.

UofL HealthCare Outpatient Center
401 East Chestnut Street, Suite 710
Louisville, Kentucky 40202

Phone: 502.583.8303
Toll Free: 1.800.872.8033
Fax: 502.584.0302
www.usapsc.com

Did you know that your surgeon not only takes care of patients, but:

- Is a Professor of Surgery at the University of Louisville School of Medicine?
- Performs basic, translational, and clinical research to improve patient care?
- Teaches students, residents and fellows who come from around the world to learn the latest surgical procedures and participate in groundbreaking research?

We want to tell you about some of the exciting research and educational programs that are underway in the Department of Surgery at the University of Louisville School of Medicine. We are proud to be nationally recognized for groundbreaking advances in: **Cancer Detection and Treatment, Trauma and Critical Care, Minimally Invasive Surgery, Bariatric Surgery, Digestive Diseases, Endocrine Surgery, Vascular Surgery, Head and Neck Surgery, Plastic and Reconstructive Surgery, Hearing and Speech Disorders, Organ Transplantation, and Surgical Infections.**

A small sampling of our research includes:

1. The Sunbelt Melanoma Trial, a multicenter study that is the largest ever conducted in melanoma with more than 3,600 patients registered. It was conceived, written and directed from the Department of Surgery.

2. Genetic research relating to colorectal cancer and inflammatory bowel disease, which together affect hundreds of thousands of Americans every year. We have been using the latest technology such as gene chips to try to identify the cause of these disorders.

3. Minimally Invasive Parathyroid and Thyroid Surgery. We are one of the first centers to develop and test the procedure of Minimally Invasive Radioguided Parathyroidectomy, which allows patients with parathyroid tumors to undergo a much less invasive yet curative procedure through a small incision. We have also developed techniques for minimally invasive endoscopic thyroid surgery.

4. Studies of sound perception and speech production in children and adults that have undergone cochlear implant surgery

5. The University of Louisville Breast Cancer Sentinel Lymph Node Study, which involves more than 4,000 patients from 79 institutions across the US and Canada. It is the largest study of its kind and is largely responsible for the acceptance of this minimally invasive procedure for patients with breast cancer around the world.

6. Basic research into the molecular basis for the response to trauma, shock, inflammation, and infection.

7. New technologies for the treatment of liver tumors. Over the past decade, we have helped develop and test new minimally invasive techniques for treatment of liver tumors. This allows many patients who previously were not candidates for surgery to eliminate cancer in the liver.

8. New gene therapy approaches to cancer as an alternative to chemotherapy. In the past decade, we have developed several new treatments of liver tumors, colon cancer, pancreatic and stomach cancer, melanoma, breast cancer, and cervical cancer.

9. Studies to evaluate rare endocrine tumors using artificial intelligence.

10. We were one of the first U.S. centers to pioneer the use of the Lap Band System™ and other minimally invasive surgical treatments for obesity. We were the first center in America to perform an intragastric balloon and this was done in the setting of a clinical trial.

This is where you can help.

Research is responsible for the development of new approaches to surgery and the treatment of a variety of conditions and diseases. We have made much progress, yet our work is far from done. With additional funding support, we feel confident we can bring some of these exciting results to our patients more quickly.

Your investment in our research will bear dividends for years to come, helping others facing a diagnosis such as yours. Any amount helps, and you can specify where you would like your money to be used.

If you are interested in investing in our research by making a donation or want to learn more, please contact Lukas C. Dwelly, MPA, MA by email at lukas.dwelly@.louisville.edu or **502-235-1002.** He also may contact you following your treatment to gauge your interest and to discuss your experience with our office. In addition, you can discuss your interest with your surgeon or our office staff any time. You can also visit our Web site at louisvillesurgery.com. Thank you again for your confidence in our program.

If you wish to have your name removed from the list to receive fundraising requests supporting the Department of Surgery, please make your wishes known in writing to: Department of Surgery, Development Office, 530 South Jackson Street; Louisville, KY 40202, and all reasonable efforts will be taken to ensure you will not receive any such communications from us in the future.