Peter E. Grays, M.D., Surgical Center, PA
1909 Central Drive, Ste. 202
Bedford, TX 76021
9 Medical Pkwy, Plaza 4 Ste. 102
Dallas, TX 75234

Location:_____ Date: _____

PATIENT REGISTRATION INFORMATION

If patient cannot be billed for these services (for example, minor children), please complete RESPONSIBLE PARTY SECTION below as well as this patient registration information section.

Social Security #: _____ State: _____ Driver's License #:_____

Name:_____ ____ _____ ____/____/____ _____ S M D W O
LAST FIRST MI SEX DATE OF BIRTH AGE MARITAL STATUS

Address:_____ _____ _____ _____
STREET (NO P.O. BOX'S PLEASE) APARTMENT # CITY STATE ZIP CODE

Home Phone: (_____)_____Email Address_____

Full-Time Part-Time Retired Unemployed Student Employer's Name/School:_____
EMPLOYMENT STATUS (PLEASE CIRCLE)

Employer's Address:_____ _____ ____ _____
STREET OR P.O. BOX CITY STATE ZIP CODE

Occupation:_____ (____)_____ (_____)
WORK PHONE EXT

(____)_____ (_____)
PATIENT'S ALT. PHONE (Cell, Mobile, etc EXT

EMERGENCY CONTACT *(Please indicate a friend or relative not living at the same address.)*

_____ _____ _____
NAME PHONE RELATIONSHIP

RESPONSIBLE PARTY AND BILLING INFORMATION

Patient is responsible unless a minor child or guardian. *RESPONSBILE PARTY SECTION* must be completed.

Patient Relationship to Responsible Party: Child _____ Other _____ (Specify)

Name:_____ ____ _____ ____/____/____ _____ S M D W O
LAST FIRST MI SEX DATE OF BIRTH AGE MARITAL STATUS

Address:_____ _____ _____ _____
STREET (NO P.O. BOX'S PLEASE) APARTMENT # CITY STATE ZIP CODE

Home Phone: (_____)_____Email Address_____

Full-Time Part-Time Retired Unemployed Student Employer's Name/School:_____
EMPLOYMENT STATUS (PLEASE CIRCLE)

Employer's Address:_____ _____ ____ _____
STREET OR P.O. BOX CITY STATE ZIP CODE

Occupation:_____ (____)_____ (_____)
WORK PHONE EXT

(____)_____ (_____)
PATIENT'S ALT. PHONE (Cell, Mobile, etc EXT

OTHER PATIENT INFORMATION

Spouse Name: _____ Employer: _____

Spouse's Number_____ Work _____ Occupation _____

REFERRAL INFORMATION

Who Referred you? _____

Family Physician? _____

PRIMARY INSURANCE

Please provide copy of this card to receptionist to attach to this form.

Insurance Company: _____ Phone: (_____) _____

Address: _____ _____ _____ _____
STREET CITY STATE ZIP CODE

Co-Pay Amount (if applicable): _____ Primary Care Physician: _____

Policy Holder: _____ _____ _____ _____ / _____ / _____ _____
LAST FIRST MI SEX DATE OF BIRTH SOCIAL SECURITY

Patient Relationship to Insured Party: Self ____ Spouse ____ Child ____ Other _____(Specify)

Employer's Name _____ _____ _____
INSURED ID GROUP NAME AND/OR NUMBER

Employer's Address: _____ _____ _____ _____
STREET OR P.O. BOX CITY STATE ZIP CODE

SECONDARY INSURANCE

Please provide copy of this card to receptionist to attach to this form.

Insurance Company: _____ Phone: (_____) _____

Address: _____ _____ _____ _____
STREET CITY STATE ZIP CODE

Co-Pay Amount (if applicable): _____ Primary Care Physician: _____

Policy Holder: _____ _____ _____ _____ / _____ / _____ _____
LAST FIRST MI SEX DATE OF BIRTH SOCIAL SECURITY

Patient Relationship to Insured Party: Self ____ Spouse ____ Child ____ Other _____(Specify)

Employer's Name _____ _____ _____
INSURED ID GROUP NAME AND/OR NUMBER

Employer's Address: _____ _____ _____ _____
STREET OR P.O. BOX CITY STATE ZIP CODE

WORKER'S COMPENSATION/ACCIDENT INFORMATION

Worker's Compensation Insurance Name: _____ Adj: _____

Claim #: _____ DOI: _____

Describe injury briefly: _____

_____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

PLEASE READ:

Peter E. Grays, M.D., Surgical Center, P.A. is committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that Peter E. Grays, M.D., Surgical Center, P.A. has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to Peter E. Grays, M.D., Surgical Center, P.A. all of my rights and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid by Insurance Company, or any balance due after payments by my Insurance Company.

I appoint Peter E. Grays, M.D., Surgical Center, P.A. to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If Surgery is indicated, I am responsible for the deductible and co-insurance as indicated by my insurance plan prior to services are rendered. Disclosure: Peter E. Grays, M.D. has an ownership percentage with Texas Pediatric Surgery Center and Baylor Scott and White Medical Center -Trophy Club.

_____ _____ _____ _____
PATIENT SIGNATURE DATE WITNESS SIGNATURE DATE

HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out this information found below to the best of your ability.

Patient Name _____ Date of Birth _____ Date: _____

Local Pharmacy: _____ **Address:** _____ **Number:** _____

Chief Complaint: _____

History of Present Illness:

Location: _____ (Where is the pain/problem?)

Quality: _____ (Example: normal versus abnormal color, activity, etc)

Severity: _____ (How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Duration: _____ (How long have you had this pain/problem?, or When did it start?)

Timing: _____ (Does the pain/problem occur at a specific time?)

Context: _____ (Where were you at the onset of this pain/problem?)

Associated signs/symptoms: _____ (What other associated problems have you been having?)

Modifying factors: _____ (What makes the pain/problem worse or better?, or, Have you had previous episodes?)

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Anemia	no	yes	Back trouble	no	yes	Hepatitis	no	yes
Mumps	no	yes	Bladder infections	no	yes	High Blood Pressure	no	yes	Ulcer	no	yes
Chickenpox	no	yes	Epilepsy	no	yes	Low Blood Pressure	no	yes	Kidney Disease	no	yes
Whooping Cough	no	yes	Migraine Headaches	no	yes	Hemorrhoids	no	yes	Thyroid Disease	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	Date of last chest x-ray _____			Bleeding Tendency	no	yes
Diphtheria	no	yes	Diabetes	no	yes	Asthma	no	yes	Any other disease	no	yes
Smallpox	no	yes	Cancer	no	yes	Hives or Eczema	no	yes	(please list):		
Pneumonia	no	yes	Polio	no	yes	AIDS or HIV +	no	yes	_____		
Rheumatic Fever	no	yes	Glaucoma	no	yes	Infectious Mono	no	yes			
Heart Disease	no	yes	Hernia	no	yes	Bronchitis	no	yes	_____		
Arthritis	no	yes	Blood or Plasma			Mitral Valve Prolapse	no	yes			
Venereal Disease	no	yes	Transfusions	no	yes	Stroke	no	yes	_____		

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: (Include nonprescription) _____

_____

Have you taken Fen-Phen/Redux? no yes

Patient social history:

Marital status	Single:_____	Married:_____	Separated:_____	Divorced:_____	Widowed:_____
Use of alcohol:	Never:_____	Rarely:_____	Moderate:_____	Daily:_____	
Use of tobacco:	Never:_____	Previously, but	quit:_____	Current packs/day:_____	
Use of drugs:	Never:_____	Type/Frequency: _____			
Excessive exposure at home or work to:	Fumes:_____	Dust:_____	Solvents:_____	Air-borne Particles:_____	Noise:_____

Family medical history:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Review of Systems: Please indicate any personal history below by circling yes or no:

Constitutional Symptoms		
Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes
Eyes		
Eye disease or injury	No	Yes
Wear glasses/contact lenses	No	Yes
Blurred or double vision	No	Yes
Ears/Nose/Mouth/Throat		
Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problem or rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes
Cardiovascular		
Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath w/walking or lying flat	No	Yes
Swelling of feet, ankles or hands	No	Yes
Respiratory		
Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes
Gastrointestinal		
Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain	No	Yes

Genitourinary		
Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of strain when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Male – testicle pain	No	Yes
Female – pain with periods	No	Yes
Female – irregular periods	No	Yes
Female - # of pregnancies	_____	
Female - # of miscarriages	_____	
Female – date of last pap smear	_____	
Musculoskeletal		
Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes
Integumentary (skin, breast)		
Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes
Neurological		
Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Head injury	No	Yes
Psychiatric		
Memory Loss	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

Endocrine		
Glandular or hormone problem	No	Yes
Excessive thirst or urination	No	Yes
Endocrine continued		
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat or glove size	No	Yes
Hematologic/Lymphatic		
Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes
Allergic/Immunologic		
History of skin reaction or other adverse reaction to:		
Penicillin or other antibiotics	No	Yes
Morphine, Demerol, or other narcotics	No	Yes
Novocain or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other serums	No	Yes
Iodine, Merthiolate or other antiseptic	No	Yes

Other drugs/medications:_____

_____

_____

_____

Known food allergies:

_____

_____

Environmental allergies:

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Patient, Parent or Guardian Date

Doctor's Review

_____ _____

Signature of Doctor Date

Dr. Peter E. Grays, M.D., F.A.C.S.

Consent for Treatment

By signing this content, I am authorizing my physician (s) and /or another person to perform all exams, tests, procedures, injections, phlebotomy, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to the office of Dr. Peter E Grays, unless revoked by me in writing.

Patient or Legal Representative Signature Date

Release of Patient Information

I consent and authorize the release of any appointment information, billing information, test results, and basic care to the following persons:

( ) Myself:_____

( ) Voicemail: _____

( ) My Spouse: _____

( ) Other: _____

Please sign this page ONLY. Do not fill out the information, we will fill this out if records need to be released or are requested by our office.

Medical Records Release/Request Form

(Check One)
Release _____ Releasing information from us to you or your provider
Request _____ Requesting information from another provider to us

Date: _____
Patient Name: _____ DOB: _____
Address: _____
Phone: _____ Social Security #: _____

I authorize Peter E. Grays, M.D. Surgical Center to release/request *(circle one)* the following:

Information Requested: _____
_____
Purpose of Request: _____

To/From: *(Circle One)*
Name _____
Address _____
Phone and Fax _____

- I understand that this authorization shall be valid at all times, but that I may revoke it in writing at any time; any such revocation shall have no effect on disclosures made previously.
- I understand that I have the right to inspect the information to be released.
- I understand that if I refuse to consent to disclosure of information, the agency may be unable to serve me and/or may be unable to provide the most appropriate care for me.

Patient Signature: _____Date: _____

Peter E. Grays, M.D., F.A.C.S.
GENERAL & LAPAROSCOPIC SURGERY
Diplomate of the American Board of Surgery

Bedford Office:
1909 Central Drive, Suite 202
Bedford, TX 76021
(817) 571-4620
Fax (817) 571-4701

www.surgery-grays.com
e-mail: drgrays@surgery-grays.com

Patient Financial/Office Policy

Thank you for choosing Dr. Peter E. Grays, M.D., Surgical PA for your healthcare needs. We are committed to your treatment being successful. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, policies, or your responsibilities. Carefully review the following information and return this form to us with your signature and today's date. If you request a copy, we will be happy to assist you with one.

BASIC POLICY: All co-payments are due prior to seeing the Doctor. Payments for services rendered are due in full at the time of service. Our office accepts cash, personal checks (with valid driver's license), and credit cards. There is a $25 returned check fee due and payable from you for each check payment returned to us by your bank. **OUTSTANDING BALANCES:** Please note if there is an outstanding balance on your account, this is due and payable prior to seeing the doctor along with any necessary co-pays due that day. All accounts will need to be at a zero balance prior to your visit. If there is a misunderstanding a Patient Financial Counselor will be happy to assist you in this matter.

FOR PATIENTS WITH INSURANCE: As a service to our patients, we will bill your insurance carrier. We will also assist in billing your secondary insurance carrier, if applicable and in researching unpaid claims. Every effort will be made to closely estimate your co-payments and deductibles which are due at the time of service, but the ultimate responsibility for any unpaid balances rests on you. Please understand insurance is a contract between you and your insurance company. If an insurance carrier has not paid within 60 days of billing, any unpaid professional fees are due and payable in full from you. It will be the patients' responsibility to provide the office with current insurance information. We will ask for your insurance card at your visit to obtain copy for our records. We may occasionally request a copy at a later date to update your records. Please always have your insurance card with you at each time of visit. It is your responsibility to notify our office PRIOR to being seen if any patient information has changed. (i.e. address, name, insurance information, etc.)

FOR PATIENTS WITH WORKER'S COMPENSATION: We gladly accept all injured workers. We will verify that your claim is open prior to being seen by the doctor. If your claim is denied or being disputed during the evaluation and treatment from the Doctor, please inform the office. We will only be able to evaluate and treat and treat the related work injury condition. All other issues will be billed to your private insurance, and you will be treated as if you are a patient with commercial insurance and all responsibility occurs. If surgery is needed, our office will obtain the necessary prior authorization from your Worker's Compensation Insurance, Surgery will not be performed without Prior Authorization. If you have any questions in this matter contact your Worker's Compensation Adjustor. In addition, if your claim has been denied, or if bills are un-paid after 60 days from the date of service the all fess will become your responsibility.

MEDICARE PATIENTS: We will bill Medicare for you. We will also bill your secondary insurance, if applicable. All co-payments, deductibles, and co-insurance are due and payable at the time service is rendered.

REFERRALS: If you have an HMO plan or your insurance company requires a referral authorization from your primary care physician. You will need to obtain this or contact our office with the information so we can help you obtain this needed information from your PCP or referring doctor for you.

SURGERY FEES: All co-payments, deductibles, and co-insurance are due by 5:00 P.M. the day prior to surgery. (We do take Credit Card payments over the phone) These fees will be provided for you and explained the day of scheduling. Surgery dates are subject to cancellation if deductibles and coinsurance fees are not collected prior to surgery. Our office will obtain any Prior Authorization your insurance company requires.

NON-COVERED CHARGES: Any charges not paid by your insurance company will require payment in full the time services are provided or upon notice of insurance claim denial.

CANCELLATION OF APPOINTMENTS: Our goal is to provide the highest quality of care to our patients and fairness to other patients and the doctor; we require at least 24 hours' notice when canceling your appointment. There is a $25 fee for missed appointments without 24-hour notification, which will be due and payable from you.

MEDICAL RECORDS: There will be a $25 fee for all copies of patient medical records, please allow 7-14 business days for copying.

FMLA/DISABILITY PAPERWORK: For every disability/FMLA paperwork filled out by our office there will be a $25 fee. This will not be done until paid. Please allow 2-3 business days for paperwork to be completed.

UN-PAID BALANCES: We ask that full payment be made at the time of service unless prior arrangements have been made through the billing office. If an insurance company has determined that a patient portion is due, the patient will receive a statement. If, after 90 days, the patient has failed to pay the balance full or has not made contact with the billing office, collection activity will ensue.

REFUNDS: Occasionally it is necessary to reimburse funds to patients. In this case, a refund will only be issued after the claim has reached its final adjudication with the insurance carrier. Refunds will be issued within 30 days once appeals and claims processing are complete. In order to be considered for a refund, a formal written refund request must be filed with the Billing Department.

CALLS TO DOCTOR: In order to provide the utmost in your surgical care it is not wise to practice medicine over the telephone, therefore if you have a question or urgency we will provide you with our next available appointment. If the doctor is not available or in surgery, we recommend the Emergency Room at Plaza Medical Center Downtown, or the nearest Emergency Room.

EMERGENCY VISITS AND AFTER HOUR VISTIS: If there is an emergency and you need to be seen and you do not have a visit, we will bill your insurance for the emergency care charge. What is un-paid is your responsibility.

MEDICATION REFILLS: Our policy is for the patient to call their pharmacy and ask them to fax the request to 817-571-4701. Requests are usually handled within one business day. Processing times may vary depending on the availability of your doctor, who for your safety must review each request prior to completion.

SURVEYS In becoming a patient of Dr. Peter E. Grays, you agree to not submit an online/written survey regarding Dr. Peter E. Grays without the written consent from our office.

BILLING CONCERNS: If you have any questions regarding your account, statement, or insurance information please contact our billing office at 817-571-4620 and ask to speak to our Billing Department.

MINORS: A parent or legal guardian must accompany patients who are minors. The accompanying adult (who consents to the treatment) is responsible for payment of the account.

I have read, understood and agree to the above Financial/Office policy for Dr. Peter E. Grays, MD Surgical Center.

_____ _____

Patients Signature Date