OLIVE SURGICAL GROUP

11605 Studt Avenue, Suite One
St. Louis, MO 63141

Office: 314 699 9818
Fax: 314 699 9868

NEW PATIENT INFORMATION

- **Please arrive 15 minutes early with COMPLETED paperwork or your appointment may be cancelled.** Please allow us to run on time by having everything completed and by being prompt. We, and the other patients, appreciate it!
- Please have a picture ID, your current insurance card(s), and your referral (if your insurance requires one).
- Olive Surgical Group does NOT accept any 3rd party billing (motor vehicle accidents, slip and falls). We do NOT perform disability appointments.
- Dr Bernardi has a **5 minute late policy** for **ALL** appointments.
- Your co-payment will be collected before seeing the physician. We accept cash, check and all major credit cards.
- Disability forms, FMLA, and short term disability will NOT be filled out until surgery has been completed. There will be a $25.00 charge for all forms after the initial form.
- There is a $50.00 fee for all **NO-SHOW** appointments. Please call to cancel or reschedule your appointment 24 hours in advance.
- Dr. Bernardi operates at Advanced Surgical Center of Sunset Hills and Mercy Jefferson in Festus, MO. Pain medication will NOT be prescribed until the completion of surgery.
- Please use blue or black ink ONLY on paperwork. Please do **NOT** use Pencil.

Thank you for your consideration!

Appointment Date & Time: _____

Please arrive by: _____

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INSURANCE INFORMATION

PLANS **NOT** ACCEPTED

- Advantra/ Advantra Complete
- Ambetter
- Assurant (if bills thru First Health or Healthlink)
- BCBS Blue Choice POS (please verify)
- BCBS HMO (all PPO plans are ok)
- BCBS PATHYWAY gold/bronze/silver
- Care Improvement Plus
- Carelink Select
- Carpenters Health and Welfare
- CMR
- Coventry
- Cox Health Systems
- Essence
- First Health
- GHP
- Health Alliance
- Healthcare USA
- Healthlink – As of Sept 2014
- Humana (any plan other than CHOICE CARE PPO- commercial and medicare)
- Medicaid (any state)
- MO HealthNet Carpenters Health and Welfare Multiplan (effective 02/01/2016)
- PHCS (effective 02/01/2016)
- Preferred Community Choice PPO
- Tricare (as primary ins)
- UMR (if bills thru First Health or Healthlink)
- United Healthcare Individual Exchange Network/Health Insurance Marketplace

Some Secure Horizons and Medicare Complete are accepted by Dr Bernardi. Some are not. Please check for Dr and facilities.

**** This may not be complete list. Every plan/ group is different. Always check your insurance to make sure that Dr. Robert Bernardi is contracted with then and/or that you have out-of-network benefits that you are comfortable using.*****

****If you have an HMO insurance, you are responsible for calling your PCP's office to have them initial a referral through your insurance. If we do not have a referral at the time of the appointment you will be financially responsible for the cost of the visit.****

****Dr Bernardi does NOT accept BCBS thru the Affordable Act.***(see below)*
Affordable Act Alpha Prefix's that are NOT accepted: YCH, JWZ, JWU, JWY, YCB, YCC, YCD, YCE

Key words that are on these cards: Gold, Silver, Bronze and "Pathway"

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DRIVING DIRECTIONS TO OLIVE SURGICAL GROUP

FROM INTERSTATE 70

- Head to Highway 270. Exit to 270 South
- South on 270 to Olive Blvd. (3 rd exit)
- Left on Olive (east) for approximately 0.3 miles
- Right on N. New Ballas Rd. (second stop light, Phillips 66 on corner)
- Left on Studt Ave. (just past the Pasta House Co. on the left)
- 11605 Studt Ave. is approximately 0.1 miles, on left (Gray Building)
- Park in the west parking lot (first that you see), enter in this door (no stairs)
- Olive Surgical Group is the first door on the right (suite 1)

FROM INTERSTATE 40/64

- Head to Highway 270. Exit to 270 North.
- North on 270 to Olive Blvd. (2 nd exit)
- Right on Olive (east) for approximately 0.3 miles
- Right on N. New Ballas Rd. (second stop light, Phillips 66 on corner)
- Left on Studt Ave. (just past the Pasta House Co. on the left)
- 11605 Studt Ave. is approximately 0.1 miles, on left (Gray Building)
- Park in the west parking lot (first that you see), enter in this door (no stairs)
- Olive Surgical Group is the first door on the right (suite 1)

FROM INTERSTATE 55

- Head to Highway 270. Exit to 270 North
- North on 270 to Olive Blvd. (8 th exit)
- Right on Olive (east) for approximately 0.3 miles
- Right on N. New Ballas Rd. (second stop light, Phillips 66 on corner)
- Left on Studt Ave. (just past the Pasta House Co. on the left)
- 11605 Studt Ave. approximately 0.1 miles, on left (Gray Building)
- Park in the west parking lot (first that you see), enter in this door (no stairs)
- Olive Surgical Group is the first door on the right (suite 1)

PATIENT INFORMATION FORM

Last Name:_____ First:_____ MI:____

Title: (circle one) Mr. Mrs. Miss Ms Dr. DOB: _____/_____/_____ Gender: (circle one) M F

Social Security Number:_____ -_____-_____ Marital Status: _____

Do you have children? _____ Number of Children: _____

Address:_____ Suite/Apt.# _____

City:_____ State:_____ Zip Code:_____

Phone Numbers: Home: (_____)_____-_____ Work: (_____)_____ Ext._____

Cell: (_____)_____-_____ Email:_____

IS THIS VISIT DUE TO A MOTOR VEHICLE ACCIDENT? YES NO A WORK COMP INJURY? YES NO

Employment Status: (circle one) Full Time Part-Time Retired Not-Employed Student

Employer:_____Occupation:_____

Employer Address:_____

City:_____ State:____ Zip:_____

Primary Care Physician:_____ Ph _____ Fax#: _____

Referring Physician:_____ Ph _____ Fax#: _____

Emergency Contact:_____ Ph:_____

Primary Insurance:_____ Ph _____

Guarantors Name_____ Relationship:_____ Date of Birth: __/__/_____

ID Number:_____ Group Number: _____

Secondary Insurance:_____ Ph _____

Guarantors Name:_____Relationship:_____ Date of Birth: __/__/_____

ID Number:_____ Group Number: _____

Unless you are a member of an insurance company that is contracted with Olive Surgical Group, Ltd (including verified workman's compensation patients) full payment isexpected on the day of the visit. All co-payments must be paid at time of service. Payment may be made by check, cash or credit card. Further, I authorize the release of any information acquired in the course of my examination or treatment to my insurance company, other physicians and/or health care facilities in order to file a claim or provide for my care. I also authorize payment directly to and assign to Olive Surgical Group, Ltd any surgical/medical benefits. I understand that there may be a balance due from me after my insurance pays their portion. I understand that if my account is not paid when due, I will be responsible for all costs incurred in the collections process of my account. I further understand that my account will be reported to a credit bureau. A copy of this release shall be as valid as the original. Olive Surgical Group, Ltd does not deny benefits or services because of race, color, national origin, age, sex, and disability, religious or political beliefs. If you feel you have been discriminated against, you may file a Complaint of Discrimination with the Administrator of this facility. You will not suffer any penalty because you file a complaint. By signing this form I acknowledge that I am giving my permission to be examined and treated by the physician.

Patient/Responsible Party Signature: _____ Date: _____

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LIST OF PHYSICIANS

Primary Care Provider/Family Doctor

Name:_____

Phone #: _____

Fax #: _____

Cardiologist

Name:_____

Phone #: _____

Fax #: _____

Pain Management

Name:_____

Phone #: _____

Fax #: _____

Other (Pulmonology, Neurology, Endocrinology, etc)

Name:_____

Phone #: _____

Fax #: _____

Other (Pulmonology, Neurology, Endocrinology, etc)

Name:_____

Phone #: _____

Fax #: _____

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OPEN AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Olive Surgical Group, LTD

Patient name:_____ DOB:_____

Address:_____City:_____State/Zip:_____

SSN#_____

I, _____, hereby authorize Olive Surigcal Gorup, LTD. to release any and all Protected Health Information maintained in my Medical Record to the following individuals, concerning my status as a patient, treatment or payment services by Olive Surgical Group, LTD.

Name/Relationship to Patient	Contact information (phone number/email)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

This authorization is given freely with the understanding that: This authorization is valid for a period of one year, unless revoked by me. I may revoke this authorization at anytime, except where information has already been released by completing the Revocation of Authorization form. Individuals listed on this form will be able to receive any and all information related to my status of a patient, treatment or payment of services provided to me by OSG, LTD during the time period in which this authorization is valid. Individuals not listed above WILL NOT be able to receive any information regarding treatment or payment for services provided to me without my prior written authorization. OSG, LTD and its workforce members are hereby released from any legal responsibility or liability for disclosure of any of my Protected Health Information as indicated and authorized herein.

1) When OSG, LTD is attempting to contact you regarding upcoming appointments or scheduling of tests would you like us to leave a message on your home or cell phone if we are unable to reach you?

Yes or No

2) When OSG, LTD receive your laboratory or other test results would you like us to leave a message on your home or cell if we are unable to reach you?

Yes or No

Printed name:_____ Date:_____

Signature (or representative):_____ Witness:_____

Relationship if not patient:_____

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HIPAA SIGNATURES

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

We are required by law to maintain the privacy of, and provide individuals notice of our legal duties and privacy respect to protected health information. If, after having read the HIPAA Notice of Privacy Practices, you have any objections to the form, please ask to speak with our HIPAA Complaince Officer in person or by phone at the office number. Your signature below is only an acknowledgement that you have received the Notice of our Privacy Practices.

Patient Signature: _____ Date: _____

MEDICARE BENEFIT AUTHORIZATION (sign only if you use Medicare as your insurance)

I request that payment of authorized Medicare benefits be made on my behalf to Olive Surgical Group for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I request payment of authorized Medigap benefits be made to the provider and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.

Patient Signature: _____ Date: _____

FINANCIAL AGREEMENT

Copayments are due at time of service. Unmet deductibles and non covered services will be due in full within 45 days of the date of service. If you are not covered by health insurance, a discounted fee is due the day of service. If you require surgery, you will need to make prior arrangements for payments with the billing office (636- 697-7553). If you are required to have a referral by your insurance plan, it is your responsibility to obtain the referral from your family care doctor. Please contact your insurance for your benefits.

Patient Signature: _____ Date: _____

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PAYMENT REQUIREMENTS (2024)

Thank you for choosing Olive Surgical Group, Dr. Robert Bernardi. We participate in most commercial insurance plans, and accept Medicare assignment. We accept payment by Cash, Check, and Credit Card.

If surgical intervention is needed, it will be necessary to **collect a portion of your deductible a week prior to surgery**. Any additional unmet deductible, coinsurance, or non covered service will be due in full within 45 days of the date of service. Copays are due at the time of service.

If you are not covered by health insurance, a discounted fee is due the day of service. If you require surgery, you need to make prior arrangements for payment with the billing office.

If you are required to have a referral by your insurance plan, it is **your responsibility** to obtain that from your primary care physician and provide the paper referral number to our office at the time of service. Please contact your insurance company directly regarding any questions you may have regarding referrals, coverage for your office visit and/or surgical procedure.

If you have any questions regarding our payment policy, you may call our billing office at **636-697-7553.**

Patient Signature: _____ Date: _____

Patient Name (printed): _____

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INITIAL HEALTH HISTORY

Date _____

Name _____

DOB _____ Age _____

Primary Care Physician _____ PCP Phone # _____

Pharmacy Name: _____ Phone Number: _____

Pharmacy Address: _____

Is this injury work-related? ☐ Yes ☐ No

Is this injury from a motor vehicle accident? ☐ Yes ☐ No

Describe what kind of work you do _____

Height _____ Weight _____

Right Handed _____ Left Handed _____ Ambidextrous _____

Do you take any prescription medications? ☐ No

☐ **Yes, please list below:**
Include Over the Counter (OTC) medications like vitamins, pain relievers, allergy, etc.

Medication	Dosage	Medication	Dosage

Have you had any **allergic reaction (bad effects) to a medication or shot?** (I.e. Latex, Penicillin, Shellfish, Eggs, Adhesive, etc.)

☐ **No, I do not have any allergies to medications.** ☐ **Yes, I do have allergies to medications:**

Medication	What happens when I take that medication

HISTORY OF MEDICAL CONDITIONS

Have you **ever** had any of the following conditions? (Check/Circle all that apply)

- ☐ **Anemia (low iron)**
- ☐ **High Blood Pressure**
- ☐ **Sleep Apnea**
- ☐ **Thyroid Disease**
- ☐ **Kidney Disease**
- ☐ **Liver Disease**
- ☐ **HIV/Hep C**
- ☐ **Pacemaker**
- ☐ **Diabetes (sugar)**
- ☐ **Gastric Reflux**
- ☐ **Seizures**
- ☐ **Osteoporosis**
- ☐ **Depression**
- ☐ **Anxiety**
- ☐ **Heart Disease** (Please Circle: A-Fib, CABG, Stents)
- ☐ **Lung Disease**
  (Please Circle: Emphysema, Asthma, COPD)
- ☐ **High Cholesterol**
- ☐ **Stroke / CVA**
- ☐ **Cancer: _____**
- ☐ **Arthritis** (Please Circle: OA, RA)
- ☐ **Other**: _____

SURGICAL HISTORY

Please list all surgeries and the year they were performed. Please be specific if it is LEFT or RIGHT and what was done.

1. _____ **Yr**_____ **5.** _____ **Yr**_____

2. _____ **Yr**_____ **6.** _____ **Yr**_____

3. _____ **Yr**_____ **7.** _____ **Yr**_____

4. _____ **Yr**_____ **8.** _____ **Yr**_____

SOCIAL HISTORY

Have you ever smoked cigarettes, cigars, used snuff, or chewed tobacco?

☐ No

☐ Yes: When did you start? _____

How much per week? _____

Have you quit? ☐ No ☐ Yes When? _____

Do you drink alcohol?

☐ No

☐ Yes: How much? _____ per ☐ day ☐ week ☐ month ☐ year

Are you: ☐ single ☐ married ☐ partnered ☐ divorced/separated ☐ widowed

FAMILY HISTORY

	Diabetes	**High Blood Pressure**	**Heart Disease**	**Cancer**	**Other**
Mother					
Father					
Sisters					
Brothers					

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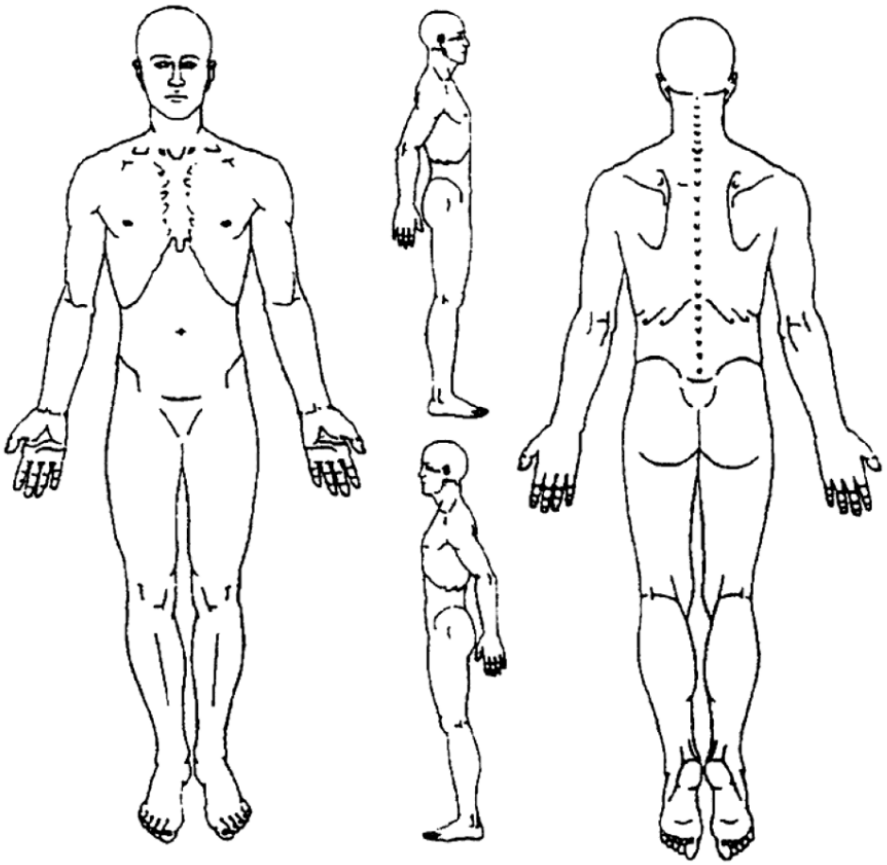
PAIN DIAGRAM AND RATING

Please choose the symbols(s) in the box that describe(s) the type of pain or sensation you are currently experiencing, and draw it on the diagram where you experience it.



A = ACHY
B = Burning
D = Dull
N = Numbness
S = Sharp
T = Tingling

Please mark the **severity** of the pain (Visual Analog Pain Severity Scale):

- **Current** pain: 0 1 2 3 4 5 6 7 8 9 10
- **Worst** pain in the last week: 0 1 2 3 4 5 6 7 8 9 10
- **Lease** pain in the last week: 0 1 2 3 4 5 6 7 8 9 10

Patient's Name (Printed): _____

Patient Signature: _____ **Date:** _____

COMPREHENSIVE REVIEW OF SYSTEMS

Name: _____

Please circle Yes or No below:

Constitutional

Weight	*Yes*	*No*
Loss of Appetite	*Yes*	*No*
Fever	*Yes*	*No*
Weakness	*Yes*	*No*
Night Sweats	*Yes*	*No*
Breastfeeding (if applicable)	*Yes*	*No*

Dermatology

Suspicious lesions	*Yes*	*No*
Suspicious moles	*Yes*	*No*
Rash	*Yes*	*No*
Itching	*Yes*	*No*
Dry or sensitive skin	*Yes*	*No*
Photosensitivity	*Yes*	*No*
Hives	*Yes*	*No*
Hair loss	*Yes*	*No*
Lumps	*Yes*	*No*
Jaundice	*Yes*	*No*

ENT

Nose bleeds	*Yes*	*No*
Change invoice	*Yes*	*No*
Sore throat	*Yes*	*No*
Difficulty swallowing	*Yes*	*No*

Respiratory

Shortness of breath	*Yes*	*No*
Chest tightness	*Yes*	*No*
Cough	*Yes*	*No*
Wheezing	*Yes*	*No*
Congestion	*Yes*	*No*

Gastroenterology

Blood in stool	*Yes*	*No*
Diarrhea	*Yes*	*No*
Vomiting	*Yes*	*No*
Constipation	*Yes*	*No*
Nausea	*Yes*	*No*
Abdominal pain	*Yes*	*No*
Change in bowel habits	*Yes*	*No*

Psychology

Depression	*Yes*	*No*
High stress	*Yes*	*No*
Mood swings	*Yes*	*No*
Suicidal ideation	*Yes*	*No*
Obsessive-compulsive tendencies	*Yes*	*No*

Neurology

Headache	*Yes*	*No*
Tingling numbness	*Yes*	*No*
Seizures	*Yes*	*No*
Dizziness	*Yes*	*No*
Focal weakness	*Yes*	*No*

Genitourinary Female

Premenstrual Syndrome	*Yes*	*No*
Infertility	*Yes*	*No*
Dysmenorrheal	*Yes*	*No*
Frequent yeast infections	*Yes*	*No*
Vaginal itching	*Yes*	*No*
Intermenstrual bleeding	*Yes*	*No*
Pelvic pain	*Yes*	*No*
Sexual activity	*Yes*	*No*
Irregular periods	*Yes*	*No*
Abnormal vaginal discharge	*Yes*	*No*

Ophthalmology

Eye irritation	*Yes*	*No*
Drainage from eyes	*Yes*	*No*
Blurring of vision	*Yes*	*No*

Hematology

Easy bruising	*Yes*	*No*
Swollen glands	*Yes*	*No*
Fatigue	*Yes*	*No*

Endocrinology

Excessive thirst	*Yes*	*No*
Excessive sweating	*Yes*	*No*
Excessive urination	*Yes*	*No*
Cold intolerance	*Yes*	*No*
Heat intolerance	*Yes*	*No*

Allergy

Runny nose	*Yes*	*No*
Scratchy nose	*Yes*	*No*
Itchy eyes	*Yes*	*No*
Sneezing	*Yes*	*No*
Ear fullness	*Yes*	*No*
Stuffy nose	*Yes*	*No*
Cough	*Yes*	*No*

Musculoskeletal

Joint stiffness	*Yes*	*No*
Leg cramps	*Yes*	*No*
Joint pain	*Yes*	*No*
Joint swelling	*Yes*	*No*
Back pain	*Yes*	*No*
Neck pain	*Yes*	*No*
Muscle aches	*Yes*	*No*

Urology

Difficulty urinating	*Yes*	*No*
Blood in urine	*Yes*	*No*
Urinary urgency	*Yes*	*No*
Frequent urination	*Yes*	*No*
Urinary incontinence	*Yes*	*No*

Cardiology

Palpitations	*Yes*	*No*
Chest pains	*Yes*	*No*
High blood pressure	*Yes*	*No*