



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: _____



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"



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 is expected 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: _____



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 #: _____



OPEN AUTHORIZATION TO RELEASE
PROTECTED HEALTH INFORMATION

Olive Surgical Group, LTD

Patient name: _____ DOB: _____
Address: _____ City: _____ State/Zip: _____
SSN# _____

I, _____, hereby authorize Olive Surgical Group, 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: _____



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 Compliance 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: _____



PAYMENT REQUIREMENTS (2026)

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): _____



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)	☐ Pacemaker	☐ Heart Disease (Please Circle: A-Fib, CABG, Stents)
☐ High Blood Pressure	☐ Diabetes (sugar)	☐ Lung Disease
☐ Sleep Apnea	☐ Gastric Reflux	(Please Circle: Emphysema, Asthma, COPD)
☐ Thyroid Disease	☐ Seizures	☐ High Cholesterol
☐ Kidney Disease	☐ Osteoporosis	☐ Stroke / CVA
☐ Liver Disease	☐ Depression	☐ Cancer: _____
☐ HIV/Hep C	☐ Anxiety	☐ 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 _____	4. _____	Yr _____
2. _____	Yr _____	5. _____	Yr _____
3. _____	Yr _____	6. _____	Yr _____

SOCIAL & FAMILY HISTORY

Have you ever smoked cigarettes, cigars, ☐ No
used snuff, or chewed tobacco?

☐ 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

Do you use recreational drugs? ☐ No ☐ Yes: What Kind? _____ How often? _____

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

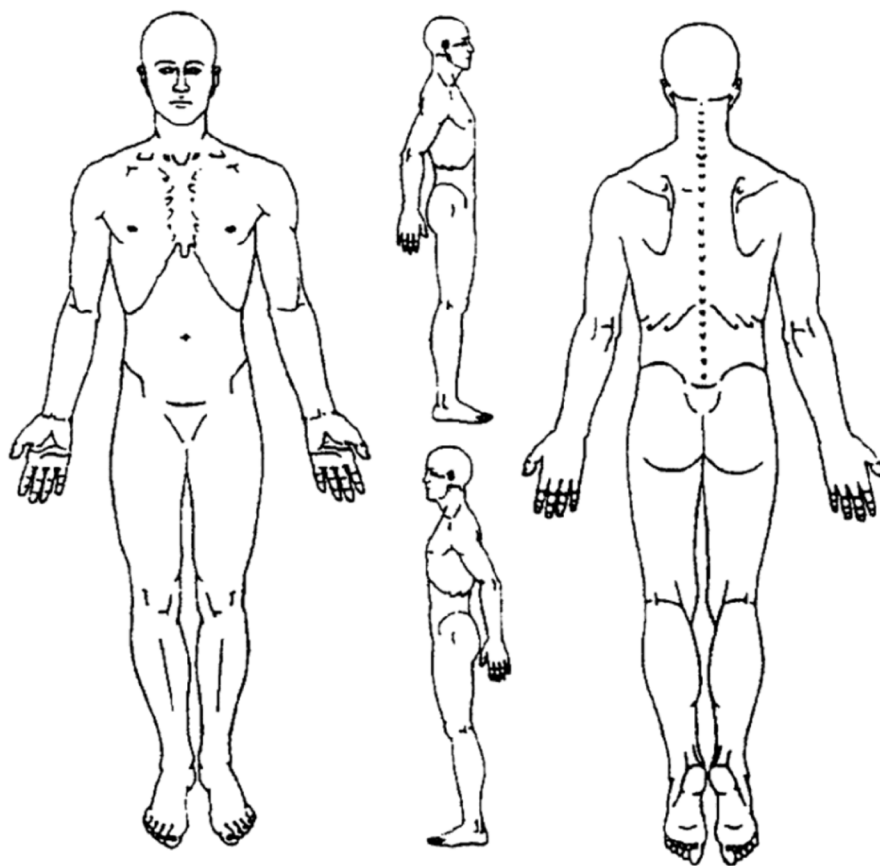
Do you have any children? ☐ No ☐ Yes: How Many? _____

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



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
- **Least 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 in voice	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
Dysmenorrhea	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