DSA DALLAS SARCOMA ASSOCIATES

PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please print)

Patient's Name: (Last) _____ (First) _____ (MI) _____

Address: _____

City, State, Zip: _____

Home: _____ Cell: _____ Work: _____

E-Mail Address: _____ DOB: _____

Sex: ☐ Female ☐ Male ☐ Transgender

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Language: ☐ English ☐ Spanish ☐ Indian: Hindi, etc. ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Social Security Number: _____ - _____ - _____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐

Responsible party name: (Last) _____ (First) _____ (MI) _____

Date of birth: MM _____/DD _____/YYYY_____ Sex: ☐ Female ☐ Male

Social Security Number: _____-_____-_____ Phone number: _____

Address: _____

City, State: _____ ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last) _____ (First) _____

Phone number: _____ Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient: _____ ☐ Guardian

Address _____

City, State: _____ ZIP: _____

Home phone: _____ Work hone: _____ Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: _____ Date: _____

Printed name of patient or personal representative: _____ Relationship to patient: _____

DSA DALLAS SARCOMA ASSOCIATES

NEW PATIENT ASSESSMENT – Please circle your answers and explain as needed.

Name: _____ Age: _____ DOB: _____

Height: _____ Weight: _____

Pharmacy Name: _____ Pharmacy Address: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

Referring Provider: _____ Primary Care Provider: _____

Infectious Disease Provider: _____ Orthopedic Provider: _____

Any Other Providers: _____

Chief Complaint: Why have you come to see us today?

Pain Mass/Tumor Infection Wound Doctor's Order Other: _____

In which body part? _____ **Left Right**

When did you notice the problem? _____

How did you first notice it? (Injury, Illness, etc.) _____

Do you have other symptoms? **Drainage Redness Swelling Stiffness Weakness Fever Numb**

How does it feel? **Aching Throbbing Sharp Dull Stabbing Burning Tingling** _____

Rate your pain (1-10), with 10 being a trip to the ER: _____

Are you symptoms getting: **Better Worse Same**?

When does it hurt? **Day Night Standing Walking Stairs In/Out of Chairs Constant Occasional**

Other: _____

Medications
(Please also include over the counter and herbal medications.)

Medication	Dose	Frequency	Date When Medication Began

DSA DALLAS SARCOMA ASSOCIATES

Patient Name: _____ Date of Birth: _____

Past Medical History: Please circle conditions you have/had:

Anemia	Heart Attack	Poor Circulation
Anxiety	Heart Problem	Pulmonary Embolism
Arthritis	Hepatitis	Rheumatoid Arthritis
Bleeding Disorder	Hernia	Seizures/Epilepsy
Blood Clots	High Blood Pressure	Stroke
Cancer	Kidney Disease	Thyroid Problems
Diabetes	Leg or Foot Ulcer	Tuberculosis
Endocarditis	Liver Disease	Ulcers
Fibromyalgia	Lung Disease	Urinary Tract Infections
GERD (Acid Reflux)	Osteoporosis	Other: _____
Gout	Pacemaker	_____

Childhood Diseases: **Measles** **Mumps** **Scarlet Fever** **Other:** _____

Have you ever been diagnosed with Hepatitis C, and if so, when? _____

(If yes, then you should not drink alcohol as it is associated with varying degrees of risk to your health.)

Females: Are you now, or do you think you could be pregnant? **Yes** **No**

ALLERGIES

SURGERY/HOSPITALIZATIONS	**DATE**

DSA DALLAS SARCOMA ASSOCIATES

Patient Name: _____ Date of Birth: _____

Family: What illnesses have there been in your family?

	Major Illnesses, or had the same problem as you do now	Living?	Age of Death
Father			
Mother			
Sibling (M F)			
Sibling (M F)			
Child (M F)			
Child (M F)			
Grandparent (M F)			
Grandparent (M F)			

Siblings: Brothers: _____ Sisters: _____ Healthy? _____

Children: Sons: _____ Daughters: _____ Healthy? _____

Social:

Alcohol: How often do you drink? **Daily** **Weekly** **Monthly** **Occasionally** **Never**

Unhealthy alcohol use covers a spectrum that is associated with varying degrees of risk to health. This may include risky use, problem drinking, harmful use, and alcohol abuse, and the less common but more severe alcoholism and alcohol dependence. Risky use is defined as >7 standard drinks per week (or >3 drinks per occasion) for women and seniors and >14 standard drinks per week (or >4 drinks per occasion) for men <65 years old.

Tobacco: Do you smoke now? **Yes** **No** How many packs per day? _____ How many years? _____

Have you quit? **Yes** **No** If yes, when? _____

The U.S. Surgeon General has said, "Smoking cessation (Stopping smoking) represents the single most important step that smokers can take to enhance the length and quality of their lives."

Exercise: **Never** **Sometimes** **Often**

Are you: **Single** **Married** **Widowed** **Divorced** **Other:** _____

Where do you live now? **Home Alone** **With Family** **Nursing Home** **Assisted Living** **Rehab/LTAC**

Drugs: Have you, or do you currently, use illegal drugs? **Yes** **No** **Quit (when):** _____

Diet: **Diabetic** **Low Salt** **Low Carb** **Other:** _____

Occupation: _____ **Working** **Retired** **Temp. Disability** **Perm. Disability**

DSA DALLAS SARCOMA ASSOCIATES

Patient Name: _____ Date of Birth: _____

ROS: What else is troubling you TODAY?

General:	**Fever Chills Weight Loss/Gain Fatigue Malaise (Feel Sick) Night Sweats**
Skin:	**Multiple Birthmarks Rashes Wounds Itching**
Head:	**Cavities Vision Changes Ulcers**
Chest:	**Shortness of Breath Wheezing Cough Chest Pain Palpitations**
Digestion:	**Nausea Vomiting Constipation Diarrhea**
Urine:	**Infections Bloody Frequency Urgency**
Reproduction:	**Discharge VD/STD Irregular Periods**
Nerves:	**Fainting Shooting Pains Numbness Tingling Weakness**
Body:	**Cramps Soreness Fractures Swollen Joints**
Mind:	**Depression Anxiety Mood Swings**
Glands:	**Swollen Glands Chills Sweats Hyperactive Constant Hunger/Thirst**
Blood:	**Bruises Transfusions Blood Thinners**

Immunizations

Have you had the flu shot this flu season? _____ Yes _____ No If Yes, when? _____

Have you had the Pneumococcal vaccine? _____ Yes _____ No If Yes, when? _____

"I attest that the above information is true and correct, to the best of my knowledge."

Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

Thank you for taking the time to tell us about you! Did you know that all this information can point to bone and muscle conditions? Everything you answer here can help us find the real problem.

Authorization For Use or Disclosure of Medical Record Information
Dallas Sarcoma Associates

DSA DALLAS SARCOMA ASSOCIATES

sharecare

TX22025

Patient Information

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

Email Address: _____

City: _____ State _____ Zip: _____ Work Phone: _____

Release Information To

I hereby authorize Dallas Sarcoma Associates to release my medical record information to:

☐ Mail Copies To: ☐ Discuss Medical Information With:

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ◯ Personal ◯ Continuing Care ◯ Insurance ◯ Legal ◯ Transfer (*Explain*) ◯ Other (*Explain*)

Comments/ Authorization Specifications: _____

NOTICE: The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to federal and/or state privacy laws. Dallas Sarcoma Associates will not condition treatment on the signing of this Authorization or payment of associated fees.

Information to be Released

◯ Please provide a 2-year abstract (includes 5 years of labs, radiology, and diagnostics)

◯ Please provide my entire medical record for dates: From_____To_____

◯ Please provide my entire billing record for dates: From_____To_____

◯ Please provide *only* the following records within the date range listed below:

___ Progress Notes/Consults ___ Labs ___ Radiology Reports
___ Pathology ___ Billing ___ Other (*Explain Below*)

From _____ To _____

Comments/ Authorization Specifications: _____

NOTICE: This Authorization is valid for 365 days (30 days for alcohol/drug abuse treatment) unless you specify otherwise. You may revoke this Authorization at any time by providing a written statement to the Health Information Management Department at Dallas Sarcoma Associates, except to the extent that Dallas Sarcoma Associates has already completed action on it.

POTENTIAL FEES: See the "Fee and Process Explanation Letter" for more information regarding associated costs.

Authorization to Release Protected Information

Required: Please complete the check boxes below indicating how protected information should be handled, even if the categories do not necessarily apply to the patient's medical records.

Release Records? Check one — *Initial each line below to confirm your choices*

I ☐ DO ☐ **DO NOT** want ***Psychotherapy Notes** released _____

I ☐ DO ☐ **DO NOT** want information about ***Mental Health** released _____

I ☐ DO ☐ **DO NOT** want information about ***HIV Tests** & **Related Information** released _____

I ☐ DO ☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released _____

STOP AND REVIEW: Please confirm that you have put a checkmark and initialed **ALL** the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

NOTICE TO RECIPIENT: Federal rules prohibit further disclosure, by the recipient, of any alcohol or substance abuse records released under this Authorization, unless the recipient has received written consent from the person to whom It pertains or as otherwi se permitted by 42 CFR Part 2.

Sign Here _____ Date Here _____

Patient's Signature **Date**

_____

Parent/Legally Recognized Representative Signature **Date**

_____

Description and Proof of Authority to Act on Patient's Behalf

Know Your Privacy Rights
Refer to the HIPAA

Document Updated: 12/11/2017

DSA DALLAS SARCOMA ASSOCIATES

Dallas Sarcoma Associates Patient HIPAA Acknowledgment and Consent Form

Patient Name (Printed): _____ **Date of Birth:** _____

Notice of Privacy Practice/clinics.

_____ (Patient/Representative initials) I acknowledge that I have received the practice/clinic's Notice of Privacy, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic's Notice of Privacy.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent ____ (Patient/Representative Initials) to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

-OR-

I do not consent ____ (Patient/Representative Initials) to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic's health care operations purposes (e.g., quality improvement activities).

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications:

We want to stay connected with our patients. Patients in our practice/clinic may be contacted via email, calls to your cellular telephone (including prerecorded/artificial voice messages and/or calls from an automatic dialing device), and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email, cellular telephone number, address or text number below, you understand that you may get these communications from the Practice/clinic. You may opt out of these communications at any time (see next page).The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

I authorize to receive text messages and/or cellular telephone calls for appointment reminders, feedback, and general health reminders/information and **the cell phone number is** _____.
I authorize to receive email messages for appointment reminders and general health reminders/feedback/information and **the email that i**s_____.

-OR-

I **decline** _____ (Patient/ Representative Initials) to receive communication via text.
I **decline** _____ (Patient/ Representative Initials) to receive communication via cellular telephone call.
I **decline** _____ (Patient/ Representative Initials) to receive communication via email.

DSA DALLAS SARCOMA ASSOCIATES

Note: *This clinic uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.*

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ____ ***I do want*** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:
  - Name: _____ Date: _____
  - Name: _____ Date: _____
- ____ ***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

Patient/Parent/Guardian/Patient Representative Signature _____ **Date:** _____

Patient/Parent/Guardian/Patient Representative Name (Printed) _____

Patient Name (Printed): _____ **Date of Birth:** _____

Only If you have previously consented to receive communication via text/cellular telephone call/email and wish to remove the consent/Opt Out/Revocation of communications via email and/or text or cellular telephone call. In other words, I do not want my email address or cell number to be used any longer for the above mentioned communications.

*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **text**.*
*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **cellular telephone call**.*
*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **email**.*

Patient Name: _____

Patient/Patient Representative Signature: _____
Date: _____ *Time:* _____

DSA DALLAS SARCOMA ASSOCIATES

Patient Name: _____ Date of Birth: _____

Financial and Office Policies

Use of Physician Assistant (PA). Our office employs certified physician assistant, Jennifer Reed, PA-C. She has worked with our practice for many years and assists our physicians in the operating room. She also sees patients in the office for follow up appointments and any of your follow up appointments may be with her.

FMLA, Short Term Disability, Leave of Absence Paperwork. All leave related documents to be filled out by our office is free for the patient the first time only. All subsequent documents requiring revisions or for family members leave of absence will incur a $25 service fee.

Insurance. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company who makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. Our verification staff is dedicated to ensuring your visit is covered by your insurance or advising you otherwise prior to your appointment. In some instances, we might not be able to obtain this information. It is always good practice for you to check with your insurance carrier to verify your specific benefits so there are no unexpected financial surprises at the time of your visit. Payment for services is ultimately your responsibility.

Self-Pay Patients. All self-pay patients are required to pay at the time the services are rendered. We offer a self-pay discount if the balance is paid in full at the time of service.

Returned Checks. There is a fee (currently $25.00) for any checks returned by the bank.

Past Due Account. Your account becomes past due 30 days following receipt of your first statement. We will take necessary steps to collect this debt. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Waiver of Confidentiality. Please understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you're past due status is reported to a credit reporting agency, the fact you received treatment at our office may become a matter of public record.

Appointments. It is our goal to provide services to you in the most comfortable and timely manner as possible. In order to achieve this, we must require you to be on time for your appointments. If you must cancel an appointment, we ask you give us 24 hours notice whenever possible. Patients who are more than 15 minutes late will have to be reschedule their appointment. In order to ensure accurate records and rue identity of all patients you will need to present your Driver's License or Identification Card and Insurance Card at the time of your appointment.

I have read this document and understand the practice policies and my responsibilities.

Patient/patient representative signature: _____ Date: _____

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify) _____

DSA DALLAS SARCOMA ASSOCIATES

Patient Name: _____ Date of Birth: _____

Falls Risk Assessment (Age 65 and older)
Please Note: This screening is required by federal mandate to be completed annually.

Date: _____

Increased Fall Risk Factors (check all that apply):

___ Diagnoses (Do you have 3 or more existing Medical Conditions?)
___ Do you have a prior history of falls within 3 months?
___ Incontinence (Do you have an uncontrolled bladder?)
___ Visual Impairment (Do you have trouble seeing?)
___ Impaired functional mobility (Do you use a cane or walker?)
___ Environmental Hazard (Do you have stairs or loose rugs at home?)
___ Polypharmacy (Do you take more than 3 medications?)
___ Pain affecting level of function (Does pain keep you from performing your daily activities?)
___ Cognitive Impairment (Do you have trouble remembering things, concentrating or making decisions that affect daily life?)
___ None of the above

History of falls in the past year: NO YES If yes, how many: _____
If yes, were you injured: NO YES

Medicare Secondary Payor Development Form

Facility Name	COID	Patient's Retirement Date	Spouse's Retirement Date	Spouse's Deceased Date
DALLAS SARCOMA ASSOCIATES	**23151**			

Patient's Name	Account No.	Medicare No.

You must ask the patient each question in sequence and comply with any instructions which follow an answer. Failure to obtain information regarding Medicare as a secondary payor is a violation of your Provider agreement with Medicare.

Does the patient have an HMO policy? ☐ No ☐ Yes

If Yes, name, address and phone of HMO:

_____

_____

~~**Does the HMO replace Medicare?** ☐ No ☐ Yes~~

~~*If Yes, the HMO will be primary. If No, it will be secondary.*~~

~~**Is this patient an inpatient?** ☐ No ☐ Yes~~

~~**Was the patient given Important Message?** ☐ No ☐ Yes~~

~~*If No, why not?*~~ _____

Has patient been an Inpatient in a health care facility within the last 60 days? ☐ No ☐ Yes

If Yes, name, address and phone of facility:

_____

_____

Has the patient had any outpatient medical services in the last 72 hours? ☐ No ☐ Yes

If Yes, name, address and phone of facility:

_____

_____

1. Are you receiving Black Lung (BL) Benefits?
   - ☐ No
   - ☐ Yes; Date benefits began: _____

   If Yes, BL is Primary only for claims related to BL.

2. Are the services to be paid by a government program such as a research grant?
   - ☐ No
   - ☐ Yes; *Government program will pay primary benefits for these services.*

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?
   - ☐ No
   - ☐ Yes; *DVA is primary for these services.*

4. Was the illness/injury due to work related accident or condition?
   - ☐ No; **Go to Question 5.**
   - ☐ Yes; Date of injury/illness: _____

   Name, address and phone of Workers Compensation Plan:

   _____

   _____

   _____

   Policy or ID Number: _____

   Name, address and phone number of your employer:

   _____

   _____

   If Yes, Workers Compensation is Primary Payor only for claims related to work related injury or illness. **Go to Question 8.**

5. Was the illness/injury due to a non-work related accident?
   - ☐ No; **Go to Question 8.**
   - ☐ Yes; Date of accident:

6. What type of accident caused the illness/injury?
   - ☐ Automobile ☐ Non-Automobile

   Name, address and phone of no-fault or liability insurer:

   _____

   _____

   _____

   Insurance Claim Number: _____

   No-Fault insurer is Primary payor only for those claims related to the accident. **Go to Question 8.**
   - ☐ Other (explain) _____

7. Was another party responsible for this accident?
   - ☐ No; **Go to Question 8.**
   - ☐ Yes; Provide name, address and phone of any liability insurer:

   _____

   _____

   _____

   Insurance claim number: _____

   If yes, liability insurer is Primary only for those claims related to the accident. **Go to Question 8.**

8. Are you entitled to Medicare based on:
   - ☐ Age; **Go to Questions 9 – 12.**
   - ☐ Disability; **Go to Questions 13 – 16.**
   - ☐ ESRD; **Go to Questions 17 – 23.**

9. Are you currently employed?
   - ☐ No; Date of retirement: _____
   - ☐ Yes; Provide name, address and phone of your employer:

   _____

   _____

10. Is your spouse currently employed?
    - ☐ No; Date of retirement: _____
    - ☐ Yes; Provide name, address and phone of spouse's employer:

    _____

    _____

    If the patient answered No to both questions 9 and 10, Medicare is primary. If the patient answered "Yes" to questions 1 – 4 or 5 – 7 then Medicare is NOT primary payer.

    Do not proceed any further.

    If yes to questions 9 or 10, go to questions 11 and 12.

11. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment?
    - ☐ No; **Stop.** *Medicare is primary payer unless the patient answered Yes to questions 1 – 4 or 5 – 7.*
    - ☐ Yes

Medicare requires this form to be completed for every Medicare patient. The information is used to determine if other payors are primary to Medicare. Medicare requires the patient to sign the MSP form.

Medicare Secondary Payor Development Form

Patient's Name	Account No.	Medicare No.

12. Does the employer that sponsors your GHP employ 20 or more employees?
- ☐ No; **Stop.** *Medicare is Primary payer unless the patient answered "Yes" to questions 1-4 or 5 – 7.*
- ☐ Yes; **Stop.** *Group Health Plan is Primary. Obtain the following information.*

Name, address and phone of GHP:

Policy ID Number:

Group ID Number:

Name of Policy Holder Relationship to Patient

13. Are you currently employed?
- ☐ No; Date of Retirement
- ☐ Yes; Provide name, address and phone of your employer:

14. Is a family member currently employed?
- ☐ No
- ☐ Yes; Provide name, address and phone of employer:

If patient answers "No" to both questions 13 and 14, Medicare is Primary unless the patient answered "Yes" to questions 1–4 or 5–7. **Do not proceed any further.**
If Yes to questions 13 or 14, go to question 15 and 16.

15. Do you have your group health plan (GHP) coverage based on your own, or a family member's current employment?
- ☐ No; **Stop.** *Medicare is Primary unless the patient answered "Yes" to questions 1 – 4 or 5 – 7.*
- ☐ Yes

16. Does the employer that sponsors your GHP, employ 100 or more employees?
- ☐ No; **Stop.** *Medicare is Primary unless the patient answered "Yes" to questions 1 – 4 or 5 – 7.*
- ☐ Yes; **Stop.** *Group Health Plan is Primary. Obtain the following information:*

Name, address and phone of GHP:

Policy ID Number:

Group ID Number:

Name of Policy Holder Relationship to Patient

17. Do you have group health plan (GHP) coverage?
- ☐ No: Stop. *Medicare is Primary.*
- ☐ Yes; Provide name, address and phone of GHP:

Policy ID Number

Group ID Number:

Name of Policy Holder Relationship to Patient

Name, address and phone of employer, if any from which you received GHP coverage:

18. Have you received a kidney transplant?
- ☐ No
- ☐ Yes; Date of Transplant:

19. Have you received maintenance dialysis treatments?
- ☐ No
- ☐ Yes; Date dialysis began:

If you participated in self dialysis training program, provide date training started:

20. Are you within the 30 month coordination period?
- ☐ No; **Stop.** *Medicare is Primary.*
- ☐ Yes

21. Are you entitled to Medicare on the basis of either ESRD and age, or ESRD and disability?
- ☐ No; **Stop.** *GHP is Primary during the 30 month coordination period.*
- ☐ Yes

22. Was your initial entitlement to Medicare (including simultaneous Entitlement) based on ESRD?
- ☐ No; *Initial entitlement based on age or disability.*
- ☐ Yes; **Stop.** *GHP continues to pay Primary during the 30th month coordination period.*

23. Does the working aged or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)?
- ☐ No; *Medicare continues to pay Primary.*
- ☐ Yes; *GHP continues to pay Primary during the 30 month coordination period.*

I understand that I am responsible for charges not covered by the Medicare program, and that such services include, but are not limited to the following: Cosmetic surgery, dental care, take-home drugs, private duty nurses, custodial care, television, telephone, private room (unless medically necessary), personal convenience items, non-FDA approved medical devices.

X _____ X _____

Patient or Representative / Relationship Witness Date