GENERAL AND LAPAROSCOPIC SURGICAL ASSOCIATES, P.C.

STEFANO F. AGOLINI, M.D

4660 Kenmore Avenue, Suite 608
Alexandria, VA 22304

Phone: (703)823-4066
Fax: (703)823-4067

PATIENT INFORMATION

Name: _____ ***DOB:*** _____ ***Date:*** _____

Address: _____ City_____State_____Zip_____

Phone (_____)_____ Email Address_____

Marital Status: Married _____ Single _____ Divorced _____ Widow _____

Emergency Contact _____ Relationship:_____

Emergency Contact Phone: (_____)_____

Insurance Company: _____ ID: _____ Group:_____

Policy Holder _____ DOB: _____

Primary Care Doctor _____ Referring Doctor _____

Pharmacy Name :_____ Phone: _____

MEDICAL HISTORY

What brings you here today: _____

Location(please specify if right or left) _____

Duration of symptoms _____

Any medical conditions such as:

Hypertension YES ____ NO_____ Diabetes YES ____ NO_____

Heart Attack YES ____ NO_____ Stroke YES ____ NO_____

History of blood clot or pulmonary embolism YES ____ NO_____ High cholesterol YES ____ NO_____

Any other medical conditions:

List any surgeries(especially important any abdominal or pelvic surgeries)

_____

_____

_____

MEDICAL HISTORY CONTINUED

List of all medications you take with dose and frequency:

_____
_____
_____
_____

Do you take any blood thinners YES ____ NO_____

Are you taking any GLP-1 Medication YES____ NO____

List any allergies:

_____
_____

Are you at risk of falling: YES_____ NO_____

Do you smoke cigarettes YES ____ NO_____
If so when did you start and how much _____

Do you drink alcohol YES ____ NO_____
If so on average how many drinks a week _____

What kind of work do you do: _____

If over age of 65, do you have a living will: YES ____ NO_____
Do you have a Medical Power of attorney: YES_____ NO_____
Do you have any food insecurities: YES _____ NO_____
Are you in need of shelter: YES_____NO_____
Do you feel safe at home: YES_____NO_____
Do you have any transportations needs YES_____ NO_____

Any family history:

_____
_____

List any imaging studies you have related to current problem

_____
_____

Anything else that you think Dr Agolini should know:

_____
_____
_____

Cancellation Policy/ For Surgery

- **Cancellation/ No Show Policy for Surgery**
  Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office. If surgery is not canceled at least **15 DAYS** in advance you will be charged a **$250.00** fee; this will be added as a charge to your account and will not be covered by your insurance company.
  This fee must be paid to General and Laparoscopic Surgical Associates

- **Account balances**
  We will require that patients with self pay balances or insurance copays do pay their account balances to zero (0). Patients who have questions about their bills may call our billing office representative at 888-665-8898 with whom they can review their account and concerns.

_____	_____	____/____/____
Print Patient Name	Signature Patient/Guardian	Date

Surgical Billing Policy

1. We will bill the insurance that you provide us at the time of check in. Unless you are a self pay patient we do not collect any money before your surgery. The hospital might call you to let you know if you have any copays or deductible to pay before the surgery.
2. After we perform your surgery, we will bill your insurance with all the charges from your surgery and if you received a bill please send your payment as soon as possible to avoid late fees or possibly being sent to collections. Unfortunately some insurance companies only pay a portion of the bill and they bill the patient a deductible or copay.
3. If you have any questions, please call pir billing department at 888-665-8898. They will be able to go over any information you need about your bill.

_____	_____	____/____/____
Print Patient Name	Signature Patient/Guardian	Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form you acknowledge that Dr. Agolini's office has given you a chance to review its Privacy Notice, which explains how health information will be handled in various situations. We must try to have you sign this form on your first date of service with us after April 14, 2003.

If your first date of service with us was due to an emergency, we must try to give you notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Check all that are true:

[ ] I have had a chance to review Dr. Agolini's Privacy Notice.
[ ] Dr. Agolini or his staff has given me the chance to discuss my concerns and questions about the privacy of my health information.

_____ _____

Patient's Signature Date

Does the patient have a copy of Privacy Notice?
[ ]Yes [ ]No

Dr. Agolini's staff should complete if Acknowledgement Form is not signed:
Please explain why the patient was unable to sign an acknowledgement form and Dr. Agolini's staff efforts in trying to obtain the patient's signature.

AI use in healthcare documentation

At **GENERAL & LAPAROSCOPIC SURGICAL ASSOCIATES** we use Athena's AI scribe to support medical documentation. This tool helps transcribe conversations, summarize clinical notes, and assist with administrative tasks. It is designed to enhance efficiency and accuracy while allowing healthcare providers to focus on patient care. However, Athena's AI scribe does not replace human medical expertise or clinical judgment. All AI-generated notes are reviewed by a licensed healthcare provider before being added to your medical record. Athena's AI tools are intended solely for documentation and administrative support and are not used to diagnose, treat, or make medical decisions.

_____ _____

Patient's Signature Date