Patient Financial Responsibility & Acknowledgement

I hereby acknowledge my understanding and intentions to comply with the following:

1. I authorize treatment of the person named below and understand that I am ultimately responsible for the charges, regardless of available insurance benefits.

2. It is your responsibility to provide Saddleback Valley Surgical Medical Group with proof of insurance and an authorization number or referral when applicable. If these items are not provided, we ask that you pay in full at the time of service or reschedule your appointment.

3. All insurance co-pays and co-insurance are to be paid at the time of service.

4. Saddleback Valley Surgical Medical Group will submit to your insurance company for all medical services rendered. We will attempt to verify eligibility and benefits with your insurance company; however, this verification is not a guarantee of payment. Any expenses deemed not covered by your insurance company will be your financial responsibility. Any yearly deductible amount not met will be collected prior to your surgery date.

5. To facilitate understanding of your individual insurance policy, it is best to learn about your policy prior to using your coverage. Your insurance card identifies a customer service phone number that can be used to obtain answers about your specific benefits. With most insurance coverage’s, the beneficiary will have some financial out-of-pocket payment. Our office staff is available for discussions about fee disclosures for both office and surgical interventions. While the office will obtain an authorization of treatment from your insurance company, this does not guarantee payment for services rendered.

6. I agree that payment will not be delayed or withheld because of any insurance coverage, or the processing of claims. All insurance proceeds will be assigned to this office.

7. If my insurance company denies payment for services, I agree to be fully responsible for payment of said services provided in my care. Denials can affect your procedure costs, the surgeon, and the designated assistant, a Registered Nurse First Assistant/Physician Assistant/Family Nurse Practitioner. Our office can provide a fee schedule for surgical costs associated with your operation.

8. All accounts are to be paid in full within 90 days. If you are financially unable to comply, a written payment plan will be arranged for you. You will be required to make these payments on time per written agreement. In the event of payment default and it becomes necessary to institute collection measures, you will be responsible to pay all collection expenses and attorney fees.

9. Saddleback Valley Surgical Medical Group is NOT contracted with Medi-Cal or Cal-Optima Plans therefore medical services will be the patient’s responsibility.

Print Patient’s Name ___________________________ Patient’s or Authorized Representative’s Signature ___________________________ Date ___________________________
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Saddleback Valley Surgical Medical Group's Notice of Privacy Practices. This Notice describes how Saddleback Valley Surgical Medical Group may use and disclose my Protected Health Information, certain restrictions on the use and disclosure of my health care information, and rights I may have regarding my protected health information by way of my signature, I provide Saddleback Valley Surgical Medical Group with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

______________________________                        ______________________________________________________
Patient’s Name                                              Patient’s or Authorized Representative Signature

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

I voluntarily authorize and direct the health care provider Saddleback Valley Surgical Medical Group to obtain/use my health information during the term of this authorization. **Information to be disclosed:** This authorization permits the Saddleback Valley Surgical Medical Group to obtain/use the following medical records:

- All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that the above-named health care provider may hold.

- All of my health information described above except for the following: ______________________________________

  I __________________________________________________________ authorize the following individual(s) to receive access to any and all information regarding my medical care. I understand that this authorization will be in effect until revoked by me in writing.

  ______________________________________________    ___________________________________________
  Name                                             Relationship

**Term:** This Authorization will remain in effect for (1) year from the date this authorization is signed. **Redisclosure:** I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclose of my health information. **Refusal to sign/right to revoke:** I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider. **Revocation:** I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider at my health care provider's regular office address. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation. **Questions:** I may contact my health care provider for answers to my questions about the privacy of my health information at my health care provider's regular office telephone number. I understand that I have the right to receive a copy this authorization from my health care provider. **Photocopy:** A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid as the original.

______________________________                        ______________________________
Print Patient’s Name                                              Patient’s or Authorized Representative Signature

______________________________                        ______________________________
Date of Birth                                                  (If Representative, Print Name and Relationship to Patient)

______________________________                        ______________________________
Authorized Facility Signature                                    Date
PATIENT REGISTRATION

First Name: ______________________________       Birth Date: ___________ Age: _____
Middle Name: ____________________________       Gender: Male or Female
Last Name: _______________________________       Marital Status: _________________
Home Phone: _______________________________       Social Security: _________________
Cell: ______________________________________       Driver’s License: ________________
Home Address: ______________________________________________________________________
City: ___________________________ State: ______ Zip Code: __________________________
Your Email Address: _________________________________________________________________

Please circle best way to reach you regarding healthcare information? Home # / Work # / Cell / Email / Patient portal
Race: ___________________________ Ethnicity: ___________________________ Language: ___________________________

PHARMACY
Name: __________________________________________       Fax: _____________________________
Phone: __________________________________________       Address: ______________________________________

EMPLOYER INFORMATION
Employer’s Name: ______________________________________________________________________
Work Number: ___________________________ Occupation: _____________________________
Address: _____________________________________________________________________________

EMERGENCY CONTACT
Name: ___________________________ Relationship to patient: _____________________________
Home Number: ___________________________ Cell: _____________________________

INSURANCE INFORMATION
DO YOU HAVE MEDICAL INSURANCE?  YES or NO
GUARANTOR (Person financially responsible for the patient)
Name: __________________________________________       D.O.B.: _____________
Relationship: ___________________________ Social Security #: _____________________________
Address: _____________________________________________________________________________
Home Number: ___________________________ Cell: _____________________________
Employer’s Name: ______________________________________________________________________

PRIMARY INSURANCE: __________________________________________________________________
SECONDARY INSURANCE: __________________________________________________________________

I hereby authorize the Saddleback Valley Surgical Medical Group to furnish information to the above named insurance carriers concerning this illness, and I hereby irrevocably assign to the Saddleback Valley Surgical Medical Group all payments for medical services rendered. A Photostat copy of this assignment shall be considered as valid as the original.

__________________________________________       _____________________________
Patient’s or Authorized Representative Signature       Date         Relationship to Patient

(If Representative, Print Name)
Name: ____________________________________________
Age: ______________ Birth date: _______________________

PLEASE FILL OUT
Marital status: ______________ Gender:  Male   Female
Height: __________  Weight: __________
Occupation: _______________________________________

Were you referred by a physician?  YES  NO
Referring physician: ______________________________________

Primary physician: ______________________________________

Other physicians you see: (i.e. Cardiologist)
________________________________________________________

Which surgeon are you here to see?
__Dr. De Santis   __Dr. Maeda   __Dr. Shaver
__Dr. Kushner   __Dr. Atchison   __Dr. Sanampudi

What problem do you have that we will address in this office, and how long have you had this problem?
Please describe:
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Allergies?
__ No known drug allergies
Describe reactions: (Example hives, rash, anaphylaxis, trouble breathing)
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

*Circle if allergic to these items:
 Latex   Shellfish   Iodine   Tape

Do you have SLEEP APNEA?  YES  NO

Is your condition WORK - RELATED?  YES  NO
If so, please state date of injury or approximate date of onset?
_________________________________________________________________

Medications:
____No Medications
Medication  Dose  Frequency  Indication
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Medical History:
__No past medical problem
Please list all medical problems you have:
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Surgical History:
__No prior operations
Please list all of your prior operations and dates:
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Endoscopic History:
__No prior endoscopic procedures
Please note prior colonoscopies or upper endoscopies:
_________________________________________________________________
_________________________________________________________________

Cardiac catheterization procedures:
__No prior cardiac catheterization procedures
Note most recent procedure and date:
_________________________________________________________________
Patient Name: ______________________________________

Please review the comprehensive list of diseases, symptoms, and medical issues down below and **circle** any that pertain to your medical condition. It is very important for us to know as much as possible about your underlying medical condition so that we can specifically direct your surgical care according to your individual medical condition and needs.

**General Symptoms:**
____ No general symptoms
Circle: Fever, Fatigue, loss of appetite, weight loss, weight gain, malaise, night sweats, obesity

**Nervous system Disease:**
____ None
Circle: Headache, depression, stroke, TIA, memory deficits, Alzheimer’s disease, peripheral neuropathy, Psychiatric illness, sciatica, migraine headache, seizure disorder,
Other please list: ______________________________________

**Cardiovascular Disease:**
____ None
Circle: Hypertension, heart attack, murmur, chest pain, or angina, congestive heart failure, elevated cholesterol, history of rheumatic heart fever, ankle swelling or edema, shortness of breath when lying flat
Other, please list: ______________________________________

**Hematologic Disease:**
____ None
Circle: bleeding disorder, easy bruising, hemophilia, anemia leukemia, bleeding problem after surgery
Other, please list: ______________________________________

**Gastrointestinal Disease:**
____ None
Circle: Ulcer disease, gallstones, GERD, pancreatitis, hepatitis, liver disease, diverticulitis, abdominal pain, chronic diarrhea, chronic constipation, black stools, blood in stools, irritable bowel disease, ulcerative colitis, Crohn’s disease, peri-anal abscess, anal fissure, hemorrhoid disease, rectal prolapse, stomach cancer, colon cancer, pancreatic cancer
Other, please list: ______________________________________

**Urinary Disease:**
____ None
Circle: Urinary tract infection, blood in urine, burning with urination, frequent urination, difficulty with urination, urinary incontinence, renal insufficiency, kidney failure, kidney cancer
Other, please list: ______________________________________

**Muscular or Skeletal Disease:**
____ None
Circle: Osteoporosis, numerous or frequent fractures, osteoarthritis, rheumatoid arthritis, artificial joints, muscle cramps, muscle weakness, back pain, scoliosis
Other, please list: ______________________________________

**Infectious Diseases:**
____ None
Circle: Hepatitis, A, B, or C, HIV, rheumatic Heart fever, tuberculosis
Other, please list: ______________________________________

**Endocrine Disease:**
____ None
Circle: Juvenile diabetes mellitus, adult onset diabetes mellitus, thyroid disease, goiter, graves’ disease, parathyroid disease, pancreatic disease, adrenal disease, osteoporosis
Other, please list: ______________________________________

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Name of Defibrillator? ______________________________________
Date:__________________ Doctor:_________________
Make:________________ Model #:____________________

Name of Pacemaker?_______________________________________
Date:__________________ Doctor:_________________
Make:________________ Model #:____________________

Respiratory Illness:
____ None
Circle: Recent pneumonia, asthma, COPD, shortness of breath at rest or with minimal exercise, tuberculosis, cough, voice hoarseness, sinus disease, pulmonary embolus
Other, please list: ______________________________________
Vascular Disease:
_____ None
Circle: carotid artery disease, abdominal aortic aneurysm, calf pain when walking, thigh or buttock pain when walking, forefoot or toe pain, non-healing foot ulcer or sores, black toes, varicose vein disease
Other, please list: ____________________________________________

Male specific diseases and medical issues:
_____ None
Circle: prostate problems, prostate cancer, testicular cancer, epididymitis, impotence, STD, breast mass, hair loss
Other, please list: ____________________________________________

When was your last rectal/prostate exam?
________________________________________________________

Female specific diseases and medical issues:
_____ None
Circle: breast disease, breast cancer, endometriosis, ovarian disease, ovarian cyst, ovarian cancer, uterine fibroids, uterine cancer, cervical cancer, STD, rectocele, cystocele
Other, please list: ____________________________________________

When did you have your last…?
Mammogram? _______________________
Pap smear? _______________________
Breast exam? ______________________
Rectal exam? ______________________
Menstrual Period? __________________

Smoking History:
Do you smoke?  Yes  No
Have you ever smoked?  Yes  No
How long did you smoke for? ______________________
How many pack(s) per day? ______________________
When did you quit? ______________________

Alcohol Use:
_____ Never drink alcohol
_____ Seldom drink alcohol
_____ Drink alcohol more than 4 times a week
_____ I am a sober alcoholic

Family Medical History:
Please describe any medical problems that run in your family:
(Example: Heart disease, diabetes, cancer, gallbladder disease)
________________________________________________________
________________________________________________________
________________________________________________________

When was your last complete physical exam? __________
Physician name: ________________________________________

Have you ever had problems with anesthesia?
_____ NO
_____ YES, please explain: ______________________

For children: Are all immunizations up to date?  YES  NO

Signature of patient or legal guardian  
________________________________________________________

Print Patient Name  
________________________________________________________

Reviewed By:  
________________________________________________________

Date: ______________________