

Saddleback Valley Surgical Medical Group, Inc.

26732 Crown Valley Pkwy, Ste. 351

Mission Viejo, CA 92691

Phone (949) 364-1007 Fax (949) 364-0317

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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.
3. 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 guaranty of payment. Any expenses deemed not covered by you insurance company will be your financial responsibility. Any yearly deductible amount not met will be collected prior to your surgery date.
4. Patients who carry medical insurance should remember that the professional services are rendered and charge to the patient, not the insurance company. To avoid misunderstanding, **it is best to learn beforehand exactly what you policy will cover.** In most cases, your insurance card shows a customer service phone number that you can use to obtain answers to your questions. We encourage you to discuss fees with us prior to any medical or surgical procedure. We do not render services on the assumption that all charges will be paid by insurance company. Furthermore, authorization of treatment by your insurance company does not guarantee payment by the insurance company for services rendered.
5. I agree that payment will not be delayed or withheld because of any insurance coverage, or the processing of claims. All proceeds of insurance will be assigned to this office.
6. I have been notified that my insurance company may deny payment for services. Should this occur, I agree to personally and fully be responsible for payment for services.
7. All accounts are to be paid in full within 90days. Substantial monthly payments are expected. Payment plans should be arranged in writing. In the event that it becomes necessary to institute collection measures, I agree to pay all collection expenses and attorney fees.
8. ****There may be possible denial of payment by your insurance carrier and that you will be liable for the cost of Registered Nurse First Assistants / Physician Assistant / Family Nurse Practitioner. We can provide you with the cost of the assistant fee for your particular operation. ****
9. Saddleback Valley Surgical Medical Group is **NOT contracted with Medi-Cal or Cal-Optima Plans** therefore medical services will be patients' responsibility.

Print Patient's Name

Patient's or Authorized Representative's Signature

Date

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been notified 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.

Print Patient's Name

Patient's or Authorized Representative Signature

Date

(If Representative, Print's Name and Relationship to Patient)

AUTHORIZATION TO REQUEST HEALTH INFORMATION

This portion below is to authorize Saddleback Valley Surgical Medical to request medical records from your provider(s)

I voluntarily authorize and direct the health care provider Saddleback Valley Surgical Medical Group to use my health information during the term of this authorization.

Information to be disclosed: This authorization permits the Saddleback Valley Surgical Medical Group to 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:

_____ Only the following records or types of health information: (insert dates of treatment, types of treatment or other designation.)

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

Date of Birth

(If Representative, Print Name and Relationship to Patient)

Authorized Facility Signature

Date

PATIENT REGISTRATION

Date: _____

First Name: _____ Birth Date: _____ Age: _____

Middle Name: _____ Circle: 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

Referred By? _____ Reason? _____

PHARMACY

Name: _____

Phone: _____ Fax: _____

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.

(If Representative, Print Name)

Patient's or Authorized Representative Signature

Date

Relationship to Patient

**Saddleback Valley Surgical Medical Group
Health Questionnaire**

Name: _____

Age: _____ Birth date: _____

Marital status: _____ Sex: **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 to medicines?
 No known drug allergies
Describe reactions: (Example hives, rash, anaphylaxis, trouble breathing)

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:

**Saddleback Valley Surgical Medical Group
Health Questionnaire**

Patient Name: _____

Please review the comprehensive list of diseases, symptoms, and medical issues down below and CIRCLE any that pertains 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: _____

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: _____

Hematologic Disease:

_____ **None**

Circle: bleeding disorder, easy bruising, hemophilia, anemia
leukemia, bleeding problem after surgery
Other, please list: _____

Have you ever had a blood transfusion? YES NO

Gastrointestinal Disease:

_____ **None**

Circle: Ulcer disease, gallstones, GERD, pancreatitis, hepatitis, liver disease, 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, diverticulitis, 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: _____

**Saddleback Valley Surgical Medical Group
Health Questionnaire**

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, rectocoele, cystocoele
Other, please list: _____

When did you have your last...?

Mammogram? _____

Pap smear? _____

Breast exam? _____

Rectal exam? _____

Menstrual Period? _____

What was your age at your first menstrual period? _____

What was your age at your first live birth? _____

Number of mother/sister(s) daughter(s) with breast cancer?

Number of previous breast biopsies? _____

If positive biopsy, with atypical hyperplasia? **YES NO**

Smoking History:

Never smoked

Yes, I smoke

How many years have you smoked? _____

How many packs per day do you usually smoke?

I quit _____ Yr _____ Mo _____ Wks _____ Days ago

How many years did you smoke? _____

How many packs per day did you usually smoke? _____

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

x

Date: _____