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Diplomates American Board of Surgery
General, Robotic, and Oncologic Surgery
27799 Medical Center Rd, Suite 440 Mission Viejo, CA 92691
(949) 364-1007 Fax (949) 364-0317

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 OC Surgeons-SVS Surgery Division 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, co-insurance, deductibles, and prior balances are to be paid at the time of service.
4. OC Surgeons-SVS Surgery Division will submit to your insurance company for 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 for 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. 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. OC Surgeons-SVS Surgery Division is **NOT contracted with Medi-Cal or Cal-Optima Plans** therefore medical services will be the patient's responsibility.
10. Out of respect for our staff and other patients, we ask that you give us at least 48-hour notice for a cancellation. Missed appointments or **cancellations without 48-hour notice will incur a fee of \$75.**

Print Patient's Name

Patient's or Authorized Representative's Signature

Date

PATIENT REGISTRATION

First Name: _____ Birth Date: _____ Age: _____

Middle Name: _____ Gender: Male or Female

Last Name: _____ Marital Status: _____

Home Phone: _____ Social Security: _____
(Memorial care patients please provide last 4 social security)

Cell: _____ Driver's License: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Your Email Address: _____

Best way to reach you? Home phone Work phone Cell Email

Race: _____ Ethnicity: _____ Language: _____

PHARMACY

Name: _____

Phone: _____ Fax: _____

Address: _____

EMPLOYER INFORMATION

Employer's Name: _____ Occupation: _____

Work Number: _____ Address: _____

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____

Home Number: _____ Cell: _____

INSURANCE INFORMATION

DO YOU HAVE MEDICAL INSURANCE? YES or NO

(Person financially responsible for the patient)

GUARANTOR Name: _____ D.O.B.: _____

Relationship: _____ Social Security #: _____

Address: _____

Home Number: _____ Cell: _____

Employer's Name: _____

PRIMARY INSURANCE: _____

SECONDARY INSURANCE: _____

I hereby authorize the OC Surgeons-SVS Surgery Division to furnish information to the above-named insurance carriers concerning this illness, and I hereby irrevocably assign to the OC Surgeons-SVS Surgery Division all payments for medical services rendered. A Photostat copy of this assignment shall be considered as valid as the original.

Name of Representative

Patient's Signature or Authorized Representative

Date

Relationship to Patient



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HIPAA Privacy Authorization Form
 Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____	Date of Birth: ____/____/____
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I hereby authorize and request the health care provider to release my health information to:

OC Surgeons – SVS Surgery Division
C/O: Medical Records Department
27799 Medical Center Rd., Suite 440 Mission Viejo,
CA 92691
Phone: (949)364-1007 Fax: (949)364-0317

In addition to the authorization for release of my Protected Health Information (PHI) described above this Authorization, I furthermore acknowledge that I have the right to authorize access and disclosure of my Protected Health Information (PHI) to anyone of my choosing for billing, condition, treatment and prognosis to the following individual(s):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I request the following restriction (s) to releasing my PHI:

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand that I am entitled to a copy of OC Surgeons- SVS Surgery Division’s Notice of Privacy Practices. I can access a copy of the Notice of Privacy Practices from the website www.saddlebackvalleysurgery.com or from the office directly. This Notice describes how OC Surgeons-SVS Surgery Division 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 OC Surgeons-SVS Surgery Division 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.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Unless otherwise revoked this authorization shall be in force and effect one year from today’s date at which time this authorization expires.

How to access the Open Payments Database

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars (\$10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public. It can be found at <https://openpaymentsdata.cms.gov>.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>

x

Patient’s or Authorized Representative Signature

Date

Print Patient’s Name

Patient Representative’s Name & Relationship

**OC Surgeons – SVS Surgery Division
Health Questionnaire**

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. Kushner Dr. Shaver Dr. Bacon
 Dr. Abbass Dr. Anderson Dr. Brady

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:

**OC Surgeons – SVS Surgery Division
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, 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: _____

**OC Surgeons – SVS Surgery Division
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, rectocele, cystocele
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? _____

How many pregnancies have you had? _____

How many child births have you had? _____

Do you have relatives with breast cancer?

Number of previous breast biopsies? _____

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

Birth Control use: _____

Post menopause hormone use: _____

Ashkenazi heritage: _____

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

I am a sober alcoholic

Less than 1 drink a week

1-5 drinks per week

1 drink per day

2 drinks per day

3 drinks per day

more than 3 drinks per day

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 _____

Print Patient Name

Reviewed By:

Date: _____