John K. Shaver, M.D., F.A.C.S.
Louise N. Bacon, M.D., F.A.C.S.
Ahmad Abou Abbass, M.D., F.A.C.S.
Marla R. Anderson, M.D., F.A.C.S.
Matthew T. Brady, M.D.

Diplomates American Board of Surgery
General, Vascular, Robotic, and Oncologic Surgery

26732 Crown Valley Pkwy, Suite 351 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 and co-insurance are to be paid at the time of service.

4. OC Surgeons-SVS Surgery Division 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. 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.

Print Patient's Name	**Patient's or Authorized Representative's Signature**	**Date**

PATIENT REGISTRATION

Date: _____

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: _____

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 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.

_____
(If Representative, Print Name)

_____ _____ _____

Patient's or Authorized Representative Signature **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: ____/____/____

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
26732 Crown Valley Pkwy, Suite 351 Mission Viejo, CA 92691
Phone: (949)364-1007 Fax: (949)364-6057

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.

_____

Patient's or Authorized Representative Signature Date

OC Surgeons – SVS Surgery Division

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

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: _____

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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? _____

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: _____