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., F.A.C.S.

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 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

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

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., F.A.C.S.
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

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
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.

____

Patient's or Authorized Representative Signature   Date

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 <u>CIRCLE</u> 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, 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: ______________________