CALIFORNIA SINUS CENTERS

Provider: _____ Acct: _____ Date: _____

- 3351 El Camino Real, Suite 200 Atherton, California 94027 (650) 399-4630*p* (650) 366-4930*f*
- 2123 Ygnacio Valley Rd, Bldg. K, Suite 100 Walnut Creek, CA 94598
- 371 Perkins St. Sonoma, CA 95476
- 7471 N Fresno St Fresno, CA 93720

Please print neatly and fill out every item as accurately as possible. Ask a staff member if you require assistance in filling out this form.

Name: _____
First **Middle** **Last**

Date of Birth: _____ ☐ **Male** ☐ **Female** **SSN** _____-_____-_____
mm/dd/yyyy

Address:_____
Street **City** **State** **Zip**

Home Phone: (_____) _____ **Cell Phone:** (_____)_____

Employer: _____ **Work Phone:** (_____) _____

Email: _____ **Race:**_____

Ethnicity: Hispanic_____Non-Hispanic_____Other_____ **Preferred Language:**_____

Emergency contact: _____ _____ (_____)_____
Name **Relationship** **Phone**

Primary Insurance Information	**Secondary Insurance Information**
Insurance name:	**Insurance name:**
Insurance ID :	**Insurance ID :**
Group or Policy Number:	**Group or Policy Number:**
Policy Holders Name:	**Policy Holders Name:**
Policy Holders Relationship to Patient:	**Policy Holders Relationship to Patient:**
Policy Holders Date of Birth:	**Policy Holders Date of Birth:**

Primary Care Physician (Family Doctor) _____
Name **Address/Phone**

Referring Physician_____
Name **Address/Phone**

Medicare/Medi-Cal Lifetime Signature on File*:*
I request that payment of authorized Medicare benefits be made on my behalf to Bay Area Surgical Specialists (dba California Sinus Centers) for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare/Medi-Cal Services and its agents any information to determine these benefits payable for related services.

Private Insurance Authorization for Assignment of Benefits/Information Release:
I, the undersigned, authorize payment of medical benefits to Bay Area Surgical Specialists (dba California Sinus Centers) for any services furnished me by the physician. I understand that my agreement with my insurance company is a separate agreement between myself and my insurance company and that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company, or their agent, information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. I understand that in the event I have no insurance coverage, I am responsible for all billed charges.

_____ _____
Signature **Date**

ADULT

How did you hear about our practice?(i.e. Dr, friend, web, yelp)_____

What is the reason for your visit today? _____

List all current medications, including any over the counter (OTC) medications or supplements:
☐ **Not taking any medications**

Name of Medication and Dosage

List any drug allergies or medicines you cannot take: ☐ **No known drug allergies**

Name of Medication	Type of Reaction

Pharmacy: Name:_____ Address:_____
Phone #:_____ Fax #:_____

Have you ever had allergy testing? ☐ **No** ☐ **Yes**
Have you ever taken allergy shots? ☐ **No** ☐ **Yes**

Are you allergic to any of the following?
☐ **Latex** ☐ **Tape** ☐ **Foods _____**
☐ **Other _____**

Social History

Current Occupation: _____ ☐ **Disabled** ☐ **Retired** ☐ **Student**

Marital status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Cohabitating**

Tobacco use?
☐ **Never** ☐ **Yes Amount: _____** ☐ **Quit Date_____**

Alcohol use? ☐ **No** ☐ **Yes** **1-2 Weekly** ☐ **3-4 Weekly** ☐ **5+ Weekly** ☐ **Occasionally** ☐

ADULT

Past Health History

Please indicate any diseases that you have had or been diagnosed with by a doctor

☐ **No Major Illnesses**

Childhood Diseases
- ☐ Chicken Pox
- ☐ Other_____

Cancer
- ☐ Breast
- ☐ Lung
- ☐ Other _____

Congenital (Birth) Problems
- ☐ Congenital Malformation
- ☐ Down's Syndrome
- ☐ Other_____

Ears, Nose & Throat
- ☐ Ear Infections
- ☐ Hearing Loss
- ☐ Sinus Infections
- ☐ Sleep Apnea
- ☐ TMJ Dysfunction
- ☐ Other _____

Heart
- ☐ Angina (chest pain)
- ☐ Heart Attack
- ☐ Hypertension
- ☐ Murmur
- ☐ Mitral Valve Prolapse
- ☐ Other _____

Lungs
- ☐ Asthma
- ☐ COPD
- ☐ Cystic Fibrosis
- ☐ Tuberculosis
- ☐ Other _____

Digestive
- ☐ Hepatitis – Type: A B C
- ☐ Reflux
- ☐ Other _____

Bones/Joints
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Other_____

Skin
- ☐ Psoriasis
- ☐ Eczema
- ☐ Other _____

History of any Other Condition Not Listed
- ☐ _____

Brain/Nervous System
- ☐ Headache
- ☐ Seizures
- ☐ Stroke
- ☐ Other _____

Mental/Emotional Health
- ☐ Anxiety Disorder
- ☐ Bi-Polar
- ☐ Depression
- ☐ Other _____

Glands/Hormones
- ☐ Diabetes
- ☐ Grave's Disease
- ☐ Thyroid Disease
- ☐ Other _____

Allergies/Immune System
- ☐ AIDS/HIV
- ☐ Other _____

Female Patients Only: Are you pregnant? ☐ **Yes** ☐ **No** ☐ **Possibly / Not Sure**

Please indicate any major surgeries you have had: ☐ **No Surgery**

1. _____
2. _____
3. _____

Have you ever had problems with anesthesia (being put to sleep for surgery)?

☐ **No** ☐ **Yes** _____

(Please describe)

Have you ever had a serious injury? ☐ **No** ☐ **Yes** _____

(Please describe)

Tests & Immunizations

Pneumococcal Vaccine: Date administered

Vaccine type: Prevnar 13 (PCV13) _____/_____/_____ Pneumovax 23 _____/_____/____

Influenza Vaccine: Date administered ____/_____/_____

Colonoscopy Date: _____/_____/_____

Herpes Zoster: Date Administered _____/_____/_____

Mammogram Screening: Date _____/_____/_____

Pap Smear: Date____/_____/_____

Family History

Please list any of your BLOOD RELATIVES who have a history of any of the following and give their relationship to you:

☐ **Family history unknown**

			Relationship to you and details
Problems/Complications with Anesthesia	☐ **No**	☐ **Yes**	_____
Heart Problems (Including Hypertension)	☐ **No**	☐ **Yes**	_____
Lungs	☐ **No**	☐ **Yes**	_____
Bleeding/Clotting Problems	☐ **No**	☐ **Yes**	_____
Other Major Health Problems	☐ **No**	☐ **Yes**	_____

ADULT

Please answer yes or no to any other SYMPTOMS that you have now or have had RECENTLY

		General:			**Stomach/GI Problems**
☐ **No**	☐ **Yes**	**Fever**	☐ **No**	☐ **Yes**	**Abdominal Pain**
	☐ **Yes**	**Weight loss**		☐ **Yes**	**Constipation**
		☐ **Planned** ☐ **Unintentional**		☐ **Yes**	**Diarrhea**
	☐ **Yes**	**Weight gain**		☐ **Yes**	**Excessive Gas**
	☐ **Yes**	**Sleeping Problems**		☐ **Yes**	**Heartburn**
	☐ **Yes**	**Other: _____**		☐ **Yes**	**Other:_____**
		(Please describe)			***(Please describe)***
		Eye Problems:			**Urinary or Female/Male Problems**
☐ **No**	☐ **Yes**	**Blurred vision**	☐ **No**	☐ **Yes**	**Difficulty Starting/Stopping Stream**
	☐ **Yes**	**Double vision**		☐ **Yes**	**Frequency/Urgency**
	☐ **Yes**	**Itching/Burning**		☐ **Yes**	**Incontinence**
	☐ **Yes**	**Other:_____**		☐ **Yes**	**Pain/Bleeding**
		(Please describe)		☐ **Yes**	**Other:_____**
					(Please Describe)
		Ear Problems:			**Bone/Muscle problems:**
☐ **No**	☐ **Yes**	**Dizziness**	☐ **No**	☐ **Yes**	**Painful Joints**
	☐ **Yes**	**Drainage**		☐ **Yes**	**Pain in Neck**
	☐ **Yes**	**Hearing Loss**		☐ **Yes**	**Stiffness in Neck**
	☐ **Yes**	**Infection**		☐ **Yes**	**Weakness**
	☐ **Yes**	**Itching**		☐ **Yes**	**Other:_____**
	☐ **Yes**	**Pain**			***(Please Describe)***
	☐ **Yes**	**Ringing**			**Breast or Skin problems:**
	☐ **Yes**	**Other:_____**	☐ **No**	☐ **Yes**	**Change in Moles**
		(Please describe)		☐ **Yes**	**Dry/Itchy Skin**
		Nose Problems:		☐ **Yes**	**Rash**
☐ **No**	☐ **Yes**	**Nasal Congestion**		☐ **Yes**	**Sores**
	☐ **Yes**	**Itching**		☐ **Yes**	**Other:_____**
	☐ **Yes**	**Nosebleeds**			***(Please describe)***
	☐ **Yes**	**Postnasal Drainage**			**Brain or Nerve Problems:**
	☐ **Yes**	**Other:_____**	☐ **No**	☐ **Yes**	**Change in smell**
		(Please describe)		☐ **Yes**	**Change in taste**
		Mouth Problems:		☐ **Yes**	**Change in Vision NOT Corrected with Glasses**
☐ **No**	☐ **Yes**	**Bad Breath**			
	☐ **Yes**	**Dryness**		☐ **Yes**	**Memory Loss**
	☐ **Yes**	**Hoarseness or Other Voice Change**		☐ **Yes**	**Headache**
	☐ **Yes**	**Snoring**		☐ **Yes**	**Numbness**
	☐ **Yes**	**Sore Throat**		☐ **Yes**	**Facial Pain**
	☐ **Yes**	**Swallowing Difficulty**		☐ **Yes**	**Weakness**
	☐ **Yes**	**Other:_____**		☐ **Yes**	**Other:_____**
		(Please describe)			***(Please describe)***
		Heart Problems	☐ **No**	☐ **Yes**	**Blood or lymph problems:**
☐ **No**	☐ **Yes**	**Lightheadedness**		☐ **Yes**	**Excessive Bleeding**
	☐ **Yes**	**Chest Pain**		☐ **Yes**	**Easy bruisability**
	☐ **Yes**	**Irregular Heartbeat/Palpitations**		☐ **Yes**	**Neck Mass/Swelling**
	☐ **Yes**	**Other:_____**			**Other:_____**
		(Please describe)			***(Please describe)***
		Lung Problems:			**Immune Problems:**
☐ **No**	☐ **Yes**	**Frequent Cough**	☐ **No**	☐ **Yes**	**Hives**
	☐ **Yes**	**Difficulty Breathing/Short of Breath**		☐ **Yes**	**Unusual Infections**
	☐ **Yes**	**Other:_____**		☐ **Yes**	**Other:_____**
		(Please describe)			***(Please describe)***
					Other medical problem not listed:
			☐ **No**	☐ **Yes**	_____
					_____
					(Please describe)

ADULT

OUTCOME MEASURE QUESTIONNAIRE

Name: _____ Date of Birth:_____

We would like to know more about these problems and how they impact your life. There are no "right" or "wrong" answers, and only you can provide us with this information. **Please rate your problems as they have been RECENTLY**.

Magnitude Scale

Considering how severe the problem is when you get it and how frequently it happens, please rate each item below on how "bad" it is using the following scale:

0= Not present/no problems
1= Very mild problem
2= Mild to slight problem
3= Moderate problem
4= Severe problem
5= Problem is as "bad" as it can be"

	MAGNITUDE
1. Stuffy / blocked nose……..	0 1 2 3 4 5
2. Runny nose. . . . . …….	0 1 2 3 4 5
3. Decreased sense of smell or taste. . . ……	0 1 2 3 4 5
4. Post-nasal discharge / thick nasal discharge / debris……	0 1 2 3 4 5
5. Difficulty sleeping……	0 1 2 3 4 5
6. Ear fullness / ear pain. . . . . ……. ……	0 1 2 3 4 5
7. Decreased hearing……..	0 1 2 3 4 5
8. Fatigue / worn out / decreased productivity. . . . . ……	0 1 2 3 4 5
9. Facial pain / pressure / headache . . . . . ……..	0 1 2 3 4 5
10. Cough / short of breath…….	0 1 2 3 4 5
11. Feeling depressed or sad / frustrated…….	0 1 2 3 4 5

Please feel free to add any additional comments below. Thank you for your help.

MEDICATIONS / CHANGES: _____
ALLERGIES: _____

HEIGHT:_____ **WEIGHT:**_____ **BLOOD PRESSURE:**_____/____ **PULSE:**_____

QUESTIONS FOR YOUR DOCTOR: _____

Patient / Guardian Signature_____ Date_____

THANK YOU!

ADULT

NASAL ENDOSCOPY CONSENT FORM

Patient Name:_____ DOB:_____

Nasal Endoscopy: **"How do we look into your nose / sinuses?" When you come to CSC with a nose or sinus related problem, the doctors may want to perform a nasal endoscopy. This is a surgical procedure using sterile small cameras to look through the nostrils. This may allow your doctor to:**

1. **obtain drainage for culture**
2. **evaluate previous surgery, scar tissue, openings, masses, polyps, causes of blockage**
3. **evaluate healing or complications of surgery**
4. **obtain specimens / biopsy for pathology evaluation**
5. **remove old blood, foreign material, packing, scabs/scar tissue/blockage**
6. **educate you and others: We can use video glasses / TV screens to show inside**

The nurse will have you sign this permission form first and then offer to spray your nose to make the procedure easier. The spray is a combination of Afrin (to shrink tissue) and Lidocaine (to numb). This spray does taste bad and can cause teeth/throat numbness that wears off in about 20-30 minutes. Some patients may also have a sensation that they can't swallow - do NOT panic – this will pass. Two words you need to remember during this procedure:

"Ouch": allows us to know where it is tender
"Sneeze": allows us to get outta there fast

A few (very few) patients experience significant discomfort/pressure during the procedure. We will stop if this occurs. The video glasses/ TV Screens allow you to see and can decrease the anxiety related to this. Less than 2% of patients faint/get queasy - called a vasovagal reflex - we will put these patients back and allow them to relax for a few minutes and this goes away.

YOUR CONSENT:
The procedure and description of this procedure, the more common risks associated with it and the potential complications have been described to me. This includes: a small amount of pain/pressure, a mild amount of bleeding, and a reaction to the nasal spray. I have had an opportunity to ask questions. I am satisfied with my understanding and the responses that I have received. I hereby authorize CSC personnel to perform a sinus / nasal endoscopy. I hereby authorize the doctor or his/her associates, to provide such additional services as he or they may consider to be medically advisable, including but not limited to suctioning, culturing the drainage, biopsies and packing if needed. I also consent to the use of photographs/video images to advance medical education and understand that if any photographs are used, I will not be identified by name.

Note: There may be a balance that is your responsibility if not fully paid by your insurance.
This is usually due to copay or deductible levels.

_____ _____
Date Patient's Signature / Legal Guardian

ADULT

PATIENT/RESPONSIBLE PARTY FINANCIAL AGREEMENT

I, the responsible party, certify that the above information is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges regardless of delays in insurance payment or denial of insurance coverage.

It is my responsibility to understand and have personally verified if my insurance is contracted with this practice and/or the doctor I am seeing.

I hereby authorize Bay Area Surgical Specialists, Inc. to apply for benefits and receive payments directly on my behalf for covered services rendered. They may also disclose any or all parts of my clinical record to any insurance company covering services for the purpose of satisfying charges billed.

I further agree to pay all collection costs, attorney fees and any other collection costs that may be incurred in the attempt to collect outstanding patient responsibility amounts.

I also understand, that if any insurance payments are sent directly to me, it is my responsibility to send these monies directly to Bay Area Surgical Specialists, Inc. immediately upon receipt.

I, the patient or the patient's representative, understand that all medical doctors at Bay Area Surgical Specialists, Inc. are licensed and regulated by the Medical Board of California. I can verify this by contacting the Medical Board at (800) 633-2322 or via the internet at their website: www.mbc.ca.gov.

_____	_____	_____
Signature of Patient, Parent or Legal Guardian	**Relationship to Patient**	**Date**

ADULT

HIPAA / NOTICE OF PRIVACY PRACTICES – Page 1

In accordance with HIPAA laws, this notice describes how your health information may be used or disclosed and how you, the patient, can access this information. Please review the following carefully.

The law permits us to use or disclose your health information to the following:

- Another specialist or physician who is involved in your care.
- Your insurance company, for the purpose of obtaining payment for our services.
- Our staff, for the purpose of entering your information into our computerized system.
- Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent via fax which is a permitted use allowed by law. We have on file with these sources verification for the confidentiality of the fax used and its limited access by authorized personnel.
- If this practice is sold, your health information will become the property of the new owner.
- We may release some or all of your health information when required by law. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

Federal and State law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations.

We also use a shared Electronic Medical Record that allows both our physicians and staff and certain of the participating physicians of the Muir Medical Group IPA and their staffs' access to our patients' health information. The purpose for this access is to expedite the referral of patients within the Muir Medical Group IPA systems and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the Muir Medical Group IPA system only with the patient's express authorization or as otherwise specifically permitted or required by law.

The law also establishes patient rights and our responsibility to inform you of those rights. These include:

- You have the right to request in writing any uses or disclosures we make with your health information beyond the normal uses referenced above.
- You have the right to limit the use or restrict the use disclosure of your health information. Our office will follow any restrictions notated by you on the reverse side of this form.
- You have the right to request in writing to inspect and/or receive a copy of your health information.* Our office may charge a reasonable fee to cover copying and mailing of these records to you.
- You have the right to request an alternate means or location to receive communications regarding your health information.*
- You have the right to request in writing an amendment or change to your health information. Our office may agree or disagree with your written request, but we will be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the reason for it and add it to your records.

* Conditions and limitations may apply; obtain additional information from our Privacy Officer.

ADULT

HIPAA / NOTICE OF PRIVACY PRACTICES – Page 2

- We may use your information to contact you. For example, we may mail you an appointment reminder card or call you with information regarding your care. If you are not at home, this information may be left on your answering machine or with the person who answered the phone. In an emergency, we may disclose your health information to a family member or another person designated responsible for your care. **Please designate who our offices CAN disclose your health information to by checking the boxes below:**

☐ **OK to Spouse: _____**
☐ **OK to ALL family members: <u>Please list names of family members</u>:**
_____

☐ **OK to Other: _____**
☐ **OK to leave health information on answering machine or voice mail.**

☐ **DO NOT RELEASE ANY INFORMATION to anyone other than myself (the patient).**
☐ **DO NOT RELEASE TO_____**

We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and our office will notify you of the changes in writing. You have the right to file a complaint with the Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, Washington, DC 20201. Our office will not retaliate against you for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Jenny Aivazian, at **(925) 932-6330.**

This notice goes into effect as of July 28, 2011.

ACKNOWLEDGEMENT

This acknowledges that you have received and read a copy of our Privacy Practices Notice. This document is not a contract, authorization, release, or consent form. This document will remain as part of your records.

Signed:_____ Date:_____

Patient's Name:_____ Date of Birth:_____

If person signing is not patient please provide:
Name:_____

Relationship to patient: _____

ADULT

BILLING AND FINANCIAL POLICY – Page 1

The following sets forth the policies of Bay Area Surgical Specialists, Inc. Please review this information and sign where indicated below.

- I understand that it is my responsibility to furnish Bay Area Surgical Specialists, Inc. with current, accurate insurance information at the time services are rendered and/or notify us in a timely manner of any changes in coverage, which may affect the payment of services already rendered.

- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $25.00 NSF Fee. These amounts must be cleared with our financial office prior to your next appointment.

- I understand that a cancellation fee of $25.00 may be billed directly to myself if a 48 hour cancellation notice is not provided to our office. All cancellation fees must be cleared with our financial office prior to your next appointment. Specialty Ultrasound Appointments will have a $50.00 cancellation fee per test scheduled.

- I understand that a surgery cancellation fee of $100.00 may be billed directly to myself if a surgery is cancelled. Our office will allow one cancellation with no fee charged but if a surgery is cancelled by the patient or patient's family again, this fee will be assessed. This fee must be cleared with our financial office before surgery can be rescheduled.

- I understand that Bay Area Surgical Specialists, Inc. are not providers for any **HMO** insurances unless it is through John Muir Health or Sutter Delta Medical Group, Alta Bates, Hill Physicians, &Affinity.

- We are not **Medi-Cal** providers. You will be responsible for all charges if you elect to see one of our physicians.

- It is the responsibility of each patient to verify with their insurance if this practice and the physician you are seeing is a contracted provider. BASS and/or its representatives will make every effort to assist you but BASS will not be held accountable for understanding every insurance plan.

- I understand that there is a $15.00 fee (per form) to complete disability paperwork associated with my care.

BILLING AND FINANCIAL POLICY – Page 2

- I understand that the clinic will verify my insurance eligibility for surgery, but until claims are processed deductible amounts and co-insurance amounts prior to surgery cannot be determined. I further understand that a surgery co-pay may be collected upfront and applied to those fees. I further understand that ANY FEES I AM QUOTED ARE ESTIMATED based on 1) anticipated surgery to be performed and 2) current information provided to clinic by my insurance carrier.

- I understand that I will be billed for any amounts due by me (co-payments/co-insurance amounts/deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with three (3) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the third statement being mailed, the third statement will be marked as "Final Notice" and may result in my account being sent to an outside collection service if I still do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with those collection efforts.

- I understand that the clinic will obtain the necessary authorizations prior to surgery. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for all charges not paid by my insurance carrier. This also applies if your insurance company delays payment over 90 days after billing or denial of insurance coverage. If your insurance company demands a refund of any monies paid to us, you become financially responsible for those charges.

- I understand that the clinic may also take a verbal request by me over the phone to make a credit card payment on my account. I give authorization for the clinic to bill my card for the amount specified and acknowledge that verbal requests can only be made by the responsible party since no credit card information is kept on file.

My signature below confirms that I have read these billing policies and my financial obligations as pertains to the physicians of Bay Area Surgical Specialists, Inc.

_____ _____

Legal Signature Date

_____

Print Patient's Name

_____

Relationship to Patient

ADULT

DEDUCTIBLES AND CO-PAYS

Health care is changing. That's not news, but these changes are affecting physicians, medical staff, patients and their families - on a daily basis – in their wallets and purses.

It has become increasingly important for **patients to understand how their insurance works (and often does not)** for them and what their responsibilities are related to deductibles & copays.

Many patient's **deductibles** have increased – even up to $5000 / year - so that their payment responsibilities at our centers - may be higher than the usual copays to which they are accustomed at a family or internal medicine doctor visit.

As sinus specialists at a BASS / CalSinus Center - **we perform procedures** such as nasal endoscopy, CT scans, endoscopic culture samples and flexible endoscopy - to see what others cannot see – deep inside your nose or throat.

These procedures are separately reported from an office visit. Often your explanation of benefits will show a "surgical procedure" charge (e.g.: 31231 = nasal endoscopy).

Depending on your deductible, part of the allowable **fee for these services may be your responsibility. This may be in addition to your copay**. YES – we know - this is confusing and often frustrating –and costly – but this billing format follows the correct guidelines from all agencies. The amount billed is often not the contracted amount and there are adjustments / discounts that will take effect – depending on the insurance contract. You will see such changes on insurance statement.

Another confusing issue is how **charges are billed for post-operative care.** For very FEW surgical procedures we perform, post-operative care is included in the global fee. Typically there is no charge for after surgery visits for up to 90 days after tonsillectomy, ear tubes, and septoplasty only, for example. **NOTE: Sinus surgery is an exception**.

The global period for sinus surgery is zero days = post-operative care after sinus surgery is billed as a separate encounter, beginning the day after surgery. It is not included with the surgical bundle. When you come for an office visit after sinus surgery, you will be responsible for the copay as well as any portion of the nasal endoscopy with cleaning for which your deductible has not been met.

The **rules governing global periods, copays, and deductibles** are decided by the Centers for Medicare and Medicaid (CMS) and by your insurance company and the contracts – we have with the insurance providers and you have with your carrier / employer / insurance company.

We all need to follow these rules to remain "in contract, in network and in compliance with several federal laws".

Premium:	**The monthly fee for your insurance coverage.**
Deductible:	**How much you pay first, before your insurer pays anything.**
Co-pay:	**Your cost for medical services to which your deductible does not apply.**
Co-insurance:	**The percentage you must pay for care - after you've met your deductible.**
Out-of-pocket max:	**The absolute max you'll pay annually.**

Notice to Patients:
This notice is in compliance with Section 6003 of The Patient Protection and Affordable Care Act of 2010. PPACA mandates that all facilities which provide in-office ancillary services be required to disclose to their patients' five to ten other facilities in the area providing the same service (CT-Sinus Xray). By signing this notice you are agreeing that a full list of options to receive your CT scan has been provided to you.

Alternative Radiological Facilities/Providers:
California Advanced Imaging: 3301 El Camino Real, Atherton, CA 94027, **650.364.3080**
Health Diagnostics/3T MRI: 99 El Camino Real, Menlo Park, CA, 94025, **650.327.1121**
Norcal Imaging: Fremont, Oakland, Pleasanton, Walnut Creek
114 La Casa Via, Suites 100 and 200, Walnut Creek, CA, **925.937.6100**
2201 Walnut Avenue, Suite 150, Fremont, CA, **510.713.1234**

Stanford: 300 Pasteur Drive, Stanford, CA 94305 **650.723.4527**
Stanford Medicine Imaging Center: 451 Sherman Avenue, Palo Alto, CA 94306, **650.721.4624**
Stanford Medicine Outpatient Center: 450 Broadway Pavilion B, Redwood City, CA 94043 **650.723.6855**

WRI—Palo Alto Imaging: 400 Channing Avenue, Palo Alto, CA 94301, **650.323.1343**

Please print and sign your name below.

Patient's Name:_____ Date of Birth:_____

Signature:_____ Date:_____

ADULT