



www.bassmedicalgroup.com

IMPORTANT!!

It is critical that we know all medications that you are taking.

Please bring a complete list of your current medications (including strength and how many you take a day) to your appointment.

If you are unable to bring a list, then bring all of your medications in a bag and our staff will make a list for the doctor.

DO WE HAVE YOUR CURRENT BILLING INFORMATION?

Please make sure you have your current insurance cards with you at the time of check in.

BARIATRIC FORMS



NEW PATIENT REGISTRATION

Date: _____ Social Security Number _____ - _____ - _____
Email Address _____ Pharmacy _____
Patient's Name: _____
Last Name First MI
Date of Birth: _____ Male Female Marital Status: S M W D Age _____
Race: _____ Are you Hispanic? Yes No
Language: _____ Religion _____ /or Declines to specify
Street Address: _____ City: _____
State/zip code: _____ Home Phone #: (_____) _____ -- _____
Cell Phone #: (_____) _____ -- _____ Driver's License#: _____
Patient's Employer: _____ Work Phone #: (_____) _____ -- _____
Is this work-related? Yes No If yes, date of injury: _____ Claim #: _____
Spouse's Name: _____ SS# _____

PATIENT'S INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____
Insurance is through: Patient Spouse Parent Other DOB of Insured: _____
SECONDARY INSURANCE CARRIER: _____
Insurance is through: Patient Spouse Parent Other DOB of Insured: _____
If patient is a Minor, are parents Married, Divorced? Custodial Parent _____
Custodial Parent's Home Phone: (_____) _____ -- _____ Work Phone: (_____) _____ -- _____
Custodial Parent's SS #: _____ Date of Birth: _____

PHYSICIAN INFORMATION

Referring Physician's Name: _____ City: _____
Primary Care Physician: _____ City: _____

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact: _____
Phone #: (_____) _____ -- _____ Relationship to Patient: _____



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



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.



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: Please list names of family members:

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 office, 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: _____



BILLING AND FINANCIAL POLICY – pg 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 \$250.00 may be billed directly to myself if a surgery is cancelled. This fee will also be assessed if cancellation has not been made 7 days prior to scheduled surgery date. 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.

Updated 1/31/18



BILLING AND FINANCIAL POLICY – pg 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

PATIENT HISTORY FORM

DATE ____/____/____

REFERRING DOCTOR _____

NAME _____ PRIMARY CARE DOCTOR _____

DOB _____ REASON FOR VISIT _____

MEDICATIONS		
Please list all current medications, including vitamins:		
Name of medication	Dose	Frequency

ALLERGIES	
Please list all drug allergies:	
Drug	Reaction

PAST MEDICAL HISTORY			
Please check whether you have or have had any of the following conditions:			
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High cholesterol
High blood pressure/Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	COPD/emphysema
Coronary artery disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma
Congestive heart failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke
Chronic renal failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dementia (e.g., Alzheimer's)
Atrial fibrillation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parkinson's Disease
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis B
Type _____			Hepatitis C
Type _____			HIV
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
Others:			

PAST SURGICAL HISTORY			
Please list all prior surgeries:			
Surgery	Year	Surgery	Year

NAME _____

DOB _____

FAMILY HISTORY			
Please answer the following questions about your family members:			
Father	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	Age (or age at death):	Cause of death:
	Medical problems:		
Mother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	Age (or age at death):	Cause of death:
	Please list any significant medical problems:		
Sister	Please list any significant medical problems (if any):		
Brother	Please list any significant medical problems (if any):		
Family h/o	Please list any significant medical problems of other relatives (e.g., grandparents, uncles, aunts, etc.)		
Additional Space for Family History:			

SOCIAL HISTORY	
Drinks Alcohol	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes how often? Daily - Weekly – Monthly – Socially - Rarely
	<input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor Amount? When was your last drink?
Tobacco Use	Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many packs per day?
	How many years did you smoke? What year did you quit?
Drug Use	Do you currently use recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever used intravenous drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No
Caffeine Use	If yes, what kind? Please circle: Coffee – Soda – Chocolate – Tea – Other? How many cups? How many sodas?
Employment	Occupation (past or present):
Social History	Marital Status, please circle one: Single , Married , Widowed , Divorced Who Lives in your home with you? _____ Do you have children? _____ If so how many _____
Miscellaneous	Have you ever received a blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No

NAME _____ DOB _____

REVIEW OF SYSTEMS	
Please check whether you have any of the following problems, either CURRENTLY OR REPEATEDLY:	
<p>Constitutional</p> <p>Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Headache <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Unexplained weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p>	<p>HEENT</p> <p>Runny nose <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty hearing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p>
<p>Neurologic/Psychiatric</p> <p>Numbness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tingling <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Weakness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Memory loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Spinal cord injury <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Headache <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty Sleeping <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p>	<p>Metabolic/Endocrine</p> <p>Excessive thirst <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Too hot <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Too cold <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p> <p>Immunologic</p> <p>Hay fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Food allergies <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p>
<p>Respiratory</p> <p>Shortness of breath <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Wheezing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cough <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p>	<p>Musculoskeletal</p> <p>Joint pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Back pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Artificial joints <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p>
<p>Cardiovascular</p> <p>Chest pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Irregular pulse <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart valve problem <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p>	<p>Hematologic</p> <p>Easy bruising or bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blood clots in arms or legs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p>
<p>Gastrointestinal</p> <p>Abdominal pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Nausea/vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Indigestion/heartburn <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Constipation <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p>	<p>Genitourinary</p> <p>Back Pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cloudy Urine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Nausea <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p>
<p>Vascular</p> <p>Cool Extremity <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain in limb <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Varicose Veins <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p>	<p>Dermatologic</p> <p>Rash <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Boils/infections <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p>



Name _____ DOB _____

Bariatric Surgery New Patient Questions

Weight History:

You have been obese since what age? _____

Most weight you have lost in a single attempt? _____ lbs.

How did you first learn of having surgery for weight loss? _____

What program(s) or method(s) did you use to lose this weight?

___ Weight Watchers

___ Nutrisystem

___ Jenny Craig

___ Liquid Diet

___ Atkins

___ South Beach

Other _____

In the past, did you try prescription weight loss drugs? ___ Yes ___ No

If yes, which one(s)? _____

What resource(s) have you used to learn about weight loss surgery?

___ **Bay Area Surgical Specialists website (bayareasurgical.com)**

___ **John Muir Health website**

___ **obesityhelp.com**

___ **speaking with family/friends who have undergone weight loss surgery**

Other (please list) _____

Please list any concerns or questions that you would like to discuss with the bariatric surgeon.