BASS Medical Group

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: _____

BASS
MEDICAL GROUP

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 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: _____

BASS
MEDICAL GROUP

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. 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.

BASS
MEDICAL GROUP

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 Name: _____ Date of Birth: ¡MASTER! Today's Date: _____
First *Middle Initial* *Last*

Reason for your visit today? Be precise.

Physician that referred you for care at Bay Area Surgical : _____

PAST MEDICAL HISTORY

Do you have or have you had any of the following conditions?	YES	NO	Type / Year Diagnosed
Cancer (kidney, bladder)	❑	❑	
Heart (chest pain, heart attack, murmur)	❑	❑	
Have you had an EKG?	❑	❑	When/Where?
High Blood Pressure	❑	❑	
Pacemaker	❑	❑	
Blood or clotting problems	❑	❑	
Breast- cancer	❑	❑	
Stomach/Liver (reflux, bleeding, hepatitis, etc)	❑	❑	
Bowels (change in bowel habits, constipation, diarrhea)	❑	❑	
Glands (Diabetes, thyroid, gout)	❑	❑	
Gynecologic System (female organs)	❑	❑	
Musculoskeletal (arthritis, disc disease)	❑	❑	
Eyes/Ears/Nose/Throat	❑	❑	
Stroke	❑	❑	
Lungs (Asthma, Emphysema, Pneumonia, shortness of breath, TB)	❑	❑	
Bladder Disease	❑	❑	
Brain/Nervous System (seizure, "blackout spells")	❑	❑	
Mental Illness (Nervous condition/Depression)	❑	❑	
Skin (rash, psoriasis, hives)	❑	❑	
Constitutional (unexplained weight loss, fevers, chills, night sweats)	❑	❑	
Any other illnesses?	❑	❑	
Have you had any accidents/injuries within the last 24 months?	❑	❑	
Have you ever received the Shingles Vaccine?	❑	❑	

PAST SURGICAL HISTORY

Type of Operation	Surgeon	Date(s)
Do you have any artificial joints and/or heart valves? ❑ Yes ❑ No	If yes, give which & date:	
Have you ever had a blood transfusion? ❑ Yes ❑ No	If yes, when?	

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

CURRENT MEDICATION LIST

DRUG NAME	DOSE	FREQUENCY	PRESCRIBING PHYSICIAN

ALLERGIES

☐ **No Known Allergies** ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Cipro ☐ Macrobid

MEDICATION	SPECIFIC TYPE OF REACTION

CONSENT TO ACCESS MEDICATION HISTORY

In order to provide you with the best possible care, your prescriptions will be written electronically whenever possible. Electronic prescribing is now a common practice due to healthcare initiatives requiring the use of electronic medical records. With your permission, e-prescribing will provide us access your medication history electronically, enabling us to see critically important information on your current and past prescriptions, better assess potential medication issues, and improve safety and quality of care.

By signing below I give my consent to Bay Area Surgical to access my medication history electronically and to the best of my knowledge, I verify that the above medical information is complete and correct. I understand that it is my responsibility to inform my physician if I ever have a change in my health.

*** **SIGNATURE**: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient

PREFERRED OUTSIDE PHARMACY

Name & Address (Location) of Preferred <u>OUTSIDE</u> Pharmacy: Is this is a MAIL ORDER PHARMACY? ☐ Yes ☐ No

Please list a local pharmacy for urgent prescriptions if primary is a mail order.
Name & Address of LOCAL pharmacy:

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First *Middle Initial* *Last*

Names of ALL Physicians			
Name	**Phone**	**Address**	**Specialty**

GYNECOLOGICAL HISTORY	**YES**	**NO**	
Is there any chance you could be pregnant?	❑	❑	
Have you ever taken birth control pills?	❑	❑	
Have you ever taken hormone replacement therapy?	❑	❑	If yes, when:
Do you have a family history of breast cancer?	❑	❑	
Have you had a hysterectomy?	❑	❑	If yes, What type? ❑ Vaginal or ❑ Abdominal
			If yes, Reason:
If yes, were tubes and ovaries removed?	❑	❑	
Are you sexually active?	❑	❑	
Do you frequently have pain with intercourse?	❑	❑	

Number of pregnancies		Number of live births		Number of Cesarean Sections	
Age at first pregnancy		Did you breastfeed?		Date of last mammogram	
Date of last pap smear		Onset of menstruation (age)		Age at menopause	
Date of last menstrual period					

FAMILY HISTORY

RELATION	**AGE(S)**	**STATE OF HEALTH**	**IF DECEASED, CAUSE/AGE OF DEATH**
Mother			
Father			
Siblings			
Spouse			
Children			
Are you of Ashkenazi Jewish descent?	**YES** ❑	**NO** ❑	

Please list any diseases that run in your family, such as cancer, kidney stones, diabetes, etc.

Disease	Family member

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

REVIEW OF SYSTEMS

Have you experienced any of these problems during the past month?

	YES	NO		YES	NO
Weight loss	☐	☐	Chest Pain/Palpitations	☐	☐
Fevers	☐	☐	Mood changes or Depression	☐	☐
Chills	☐	☐	Trouble sleeping	☐	☐
Skin rash or itching	☐	☐	Frequent indigestion	☐	☐
Headaches	☐	☐	Nausea or vomiting	☐	☐
Loss of balance or coordination	☐	☐	Diarrhea or constipation	☐	☐
Hearing loss	☐	☐	Jaundice	☐	☐
Vision trouble	☐	☐	Rectal bleeding	☐	☐
Do you wear contacts or glasses?	☐	☐	Foul-smelling urine	☐	☐
Arm or leg weakness	☐	☐	Blood in urine	☐	☐
Sinus drainage	☐	☐			
Difficulty swallowing	☐	☐			
Hoarseness or change in voice	☐	☐			
Sores in mouth or lip	☐	☐			
Cough	☐	☐			
Coughed up or spit up blood	☐	☐			

URINARY SYMPTOMS	YES	NO
Check appropriate box:	☐	☐
Burning with urination	☐	☐
Urinating frequent, small amounts	☐	☐
Feeling like you need to urinate urgently! "or else....."	☐	☐
Lower abdominal pressure	☐	☐
Do you awaken at night to urinate?	☐	☐
If yes, how many times? _____	☐	☐
Do you pass air or "gas" in the urine?	☐	☐

URINARY TRACT INFECTIONS	YES	NO
1. Have you ever had any previous urinary infections (cystitis)? **If NO, go on to question 6.**	☐	☐
a) How many? _____		
b) Last infection _____		
c) At what age did they start? _____		
d) Related to sexual activity?	☐	☐
2. Did you ever have a high fever (102) with a urinary infection?	☐	☐
3. Did you ever have pain in the flank or kidneys with urinary infection?	☐	☐
4. Have you ever had X-rays of the kidneys (IVP) or bladder (Voiding Cystogram)?	☐	☐
5. Were you ever hospitalized to treat a urinary infection?	☐	☐
6. Have you ever had a sexually transmitted disease?	☐	☐
Check: ☐ Gonorrhea ☐ Chlamydia ☐ Herpes ☐ Genital Warts ☐ PID ☐ Other _____		

INCONTINENCE	YES	NO
Do you have leakage of urine (wetting of pants) with:		
a) Sneezing, coughing, straining	☐	☐
b) Laughing, walking	☐	☐
c) Upon arising from a sitting position	☐	☐
d) Sudden urge to urinate/cannot hold it until you get to the bathroom	☐	☐
e) During sexual intercourse	☐	☐
Do you use any pads for protection?	☐	☐
How many per day? _____		
Do you have to push or strain to empty the bladder?	☐	☐
Have you ever had a bladder suspension surgery?	☐	☐
If YES, through the Abdomen? ☐ Through the Vagina? ☐		

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First *Middle Initial* *Last*

KIDNEY STONES	YES	NO
1. Do you have pain in the flank or kidney area?	❑	❑
If YES: ❑ Left ❑ Right		
2. Have you ever had a kidney stone?	❑	❑
3. If NO, skip to next section		
If YES,		
a) Date(s)? _____		
b) How many? _____		
c) Passed spontaneously? ❑ YES ❑ NO		
d) How was the stone removed? ❑ Surgically ❑ Basket		
e) Lithotripsy (shock waves)? ❑ YES ❑ NO		
4. What was the stone made of? ❑ Calcium ❑ Uric Acid ❑ Other: _____		
5. Were you placed on stone prevention therapy?	❑	❑
6. What type? _____		

HEMATURIA	YES	NO
1. Have you seen blood in your urine?	❑	❑
2. If NO, skip to question 5		
If YES,		
a) Was the blood only at the beginning of the stream?	❑	❑
b) Throughout the stream?	❑	❑
c) At the end of the stream?	❑	❑
3. Was the bloody urine *(check all that apply)* ❑ Tea colored ❑ Rose wine/ cranberry colored ❑ Burgundy wine colored ❑ Clots		
4. Was there any pain or burning with the bloody urine?	❑	❑
5. Has a doctor found blood in your urine under a microscope?	❑	❑

SOCIAL HISTORY

(✓)	SUBSTANCE:	APPROXIMATE YEAR STARTED / FREQUENCY:
❑	ALCOHOL	Year: ☐ Never ☐ Rarely ☐ Occasional/Social ☐ Drinks/Day: _____
❑	SMOKING STATUS	❑ Current/Every Day ❑ Current/Some Days ❑ Former Smoker ❑ Never Smoker ❑ Unknown
❑	TOBACCO	Year: Pack(s) A Day: Quit: ☐ NO ☐ YES *If YES*, Date Quit:
❑	STREET DRUGS/OTHER	Year: Type: Do you use needles?
❑	HIV positive or AIDS	☐ YES ☐ NO