Swapna Ghanta, M.D.

Breast Surgery

Welcome to our practice! The relationship with our patients is viewed with a deep sense of responsibility. When patients entrust their care to our professional expertise, they are expressing respect for, and have faith in our clinical judgment and technical proficiency. We strive to be perceptive and sensitive to the feelings of our patients at all times; to empathize and be sympathetic to their physical and emotional discomforts. Above all, we strive to give each patient the best quality of care in every possible aspect by constantly updating our knowledge and methodology. Please feel free to contact us at any time if you have questions about any aspect of your care.

Due to unforeseen circumstances, your appointment time could be delayed. This could result in a prolonged waiting time. Our office will call to reschedule appointments when this waiting time could be excessive. Please also be aware that appointments may need to be completely rescheduled in Emergency Surgery situations. We strongly recommend you check your answering machine, home phone, cell phones, etc., prior to your visit to make sure our office has not left you a message. Please allow enough time for your scheduled appointment, with or without a waiting period.

Please bring the following to your appointment:

- **Your photo ID and current insurance card(s) (not copies)**
- **The enclosed forms, <u>completely filled out</u> (please bring all 12 pages to your appointment)**

Your appointment is with: **Swapna Ghanta, M.D.**

At the following location:
(Be sure to confirm the location when you make your appointment)

☐**112 La Casa Via, Suite 340** **Walnut Creek, CA 94598**	☐**2350 Country Hills Drive, Suite A** **Antioch, CA 94509**	☐**2637 Shadelands Drive** **Walnut Creek, CA 94598**
Phone (925) 945-7600 **Fax (925) 945-7664**	**Phone (925) 757-0800** **Fax (925) 757-2160**	**Phone (925) 932-6330** **Fax (925) 932-0139**

Your appointment date & time: _____

Please arrive at: _____ for your: _____ appointment

*****Please make note of your appointment on your calendar*****

<u>48 hour notice for all cancellations is required</u>
<u>Cancellation Fee of $25.00 per missed appointment</u>

BASS MEDICAL GROUP

PATIENT HISTORY FORM

DATE _____/_____/_____ **AGE**_____ **REFERRING DOCTOR** _____

NAME _____ **PRIMARY CARE DOCTOR** _____

DATE OF BIRTH _____/_____/_____ **REASON FOR VISIT** _____

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

ALLERGIES (If no known allergies, please write "NONE")	
Please list all drug, latex, tape etc allergies:	
Drug	**Reaction**

PAST MEDICAL HISTORY

Please check whether you have or have had any of the following conditions:

Diabetes	☐ Yes ☐ No	High cholesterol	☐ Yes ☐ No
High blood pressure/Hypertension	☐ Yes ☐ No	COPD/emphysema	☐ Yes ☐ No
Coronary artery disease	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Congestive heart failure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Chronic renal failure	☐ Yes ☐ No	Dementia (e.g., Alzheimer's)	☐ Yes ☐ No
Atrial fibrillation	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No
		DVT (Blood Clot)	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hepatitis B	☐ Yes ☐ No
Type _____		Hepatitis C	☐ Yes ☐ No
Type _____		HIV	☐ Yes ☐ No

Others:

PAST SURGICAL HISTORY

Please list all prior surgeries:

Surgery	**Year**	**Surgery**	**Year**

SEE ATTACHED ☐

BASS MEDICAL GROUP

FAMILY HISTORY			
Please answer the following questions about your family members:			
Mother	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Please list any significant medical problems:		
Father	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Please list any significant medical problems (if any):		
Sister	Please list any significant medical problems (if any):		
Brother	Please list any significant medical problems (if any):		
Family	Please list any significant medical problems of other relatives (e.g., grandparents, uncles, aunts, etc.)		

Has anyone in your family ever had **breast cancer**?
☐ Yes ☐ No If Yes, What is their relationship(s) to you? _____

What was the diagnosis? _____ Their age(s) _____

Has anyone in your family ever had **ovarian cancer**?
☐ Yes ☐ No If Yes, What is their relationship(s) to you? _____

FOR WOMEN ONLY			
Menstrual Period Information (Estimate)	Age when your first period started? ____Age when your period stopped? ____ Last Menstrual Period? _____		
Pregnancies **Deliveries** **Miscarriages / Abortions**	# of Pregnancies ____# of Deliveries ____# of Miscarriages/Abortions ____		
Age when first child was born? _____ Have you had a hysterectomy? ☐Yes ☐No	Did you breast feed? ☐Yes ☐No If yes how long? _____ Are you breast feeding at this time? ☐Yes ☐No	Have you taken birth control pills? ☐Yes ☐No If yes From _____ To _____ Have you had your ovaries removed? ☐Yes ☐No	Have you taken estrogen? ☐Yes ☐No If yes From _____ To _____

Have you had any prior breast biopsies? ☐Yes ☐No If yes: Date: ☐Right _____ ☐Left _____ ☐Both _____	**Do you currently have or have ever had any of these symptoms?**	(Check all that apply) ☐Breast Lumps ☐Breast Pain ☐Nipple Discharge ☐Endometriosis ☐Abnormal Pap Smear ☐Abnormal Vaginal Bleeding

Genetic Testing	Have you ever had genetic testing? ☐Yes ☐No If yes, When? _____ If yes, Were there any gene mutations noted and which ones?_____ _____ Have your parents ever had genetic testing? ☐Yes ☐No If yes, Which parent? _____ When? _____ If yes, Were there any gene mutations noted and which ones?_____ _____

SOCIAL HISTORY		
Drinks Alcohol	Do you drink alcohol? ☐Yes ☐No If yes how often? Daily - Weekly – Monthly – Socially - Rarely	
	☐Beer ☐Wine ☐Liquor Amount? When was your last drink?	
Tobacco Use	Do you smoke? ☐Yes ☐No If yes, how many packs per day?	
	How many years did you smoke? _____ What year did you quit? _____	Passive Smoke Exposure ☐Yes ☐No
Drug Use	Do you currently use recreational drugs? ☐Yes ☐No Have you in the past? ☐Yes ☐No	
	Have you ever used intravenous drugs? ☐Yes ☐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):	
Hobbies and Recreational Activities		
Miscellaneous	Have you ever received a blood transfusion? ☐Yes ☐No	

BASS MEDICAL GROUP

REVIEW OF SYSTEMS

Please check whether you have any of the following problems, either CURRENTLY OR REPEATEDLY:

Constitutional
- Fever ☐ Yes ☐ No
- Headache ☐ Yes ☐ No
- Unexplained weight loss ☐ Yes ☐ No
- Other: _____

HEENT
- Runny nose ☐ Yes ☐ No
- Difficulty hearing ☐ Yes ☐ No
- Other: _____

Neurologic/Psychiatric
- Numbness ☐ Yes ☐ No
- Tingling ☐ Yes ☐ No
- Weakness ☐ Yes ☐ No
- Dizziness ☐ Yes ☐ No
- Memory loss ☐ Yes ☐ No
- Seizures ☐ Yes ☐ No
- Anxiety ☐ Yes ☐ No
- Spinal cord injury ☐ Yes ☐ No
- Headache ☐ Yes ☐ No
- Difficulty Sleeping ☐ Yes ☐ No
- Other: _____

Metabolic/Endocrine
- Excessive thirst ☐ Yes ☐ No
- Too hot ☐ Yes ☐ No
- Too cold ☐ Yes ☐ No
- Other: _____

Immunologic
- Hay fever ☐ Yes ☐ No
- Food allergies ☐ Yes ☐ No
- Other: _____

Respiratory
- Shortness of breath ☐ Yes ☐ No
- Wheezing ☐ Yes ☐ No
- Cough ☐ Yes ☐ No
- Other: _____

Musculoskeletal
- Joint pain ☐ Yes ☐ No
- Back pain ☐ Yes ☐ No
- Artificial joints ☐ Yes ☐ No
- Other: _____

Cardiovascular
- Chest pain ☐ Yes ☐ No
- Irregular pulse ☐ Yes ☐ No
- Heart attack ☐ Yes ☐ No
- Heart valve problem ☐ Yes ☐ No
- Other: _____

Hematologic
- Easy bruising or bleeding ☐ Yes ☐ No
- Blood clots in arms or legs ☐ Yes ☐ No
- Anemia ☐ Yes ☐ No
- Other: _____

Gastrointestinal
- Abdominal pain ☐ Yes ☐ No
- Nausea/vomiting ☐ Yes ☐ No
- Indigestion/heartburn ☐ Yes ☐ No
- Diarrhea ☐ Yes ☐ No
- Constipation ☐ Yes ☐ No
- Other: _____

Genitourinary
- Back Pain ☐ Yes ☐ No
- Cloudy Urine ☐ Yes ☐ No
- Nausea ☐ Yes ☐ No
- Other: _____

Dermatologic
- Rash ☐ Yes ☐ No
- Boils/infections ☐ Yes ☐ No
- Other: _____

Vascular
- Cool Extremity ☐ Yes ☐ No
- Pain in limb ☐ Yes ☐ No
- Other: _____

IMPORTANT!!

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

This includes Advil, Aspirin, Ibuprofen and Motrin, as well as all herbal supplements.

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.

Patient's Name: _____

Patient's Date of Birth: _____

MY PREFERRED PHARMACY:

Name: _____

Address: _____ **City**_____

State: _____ **Phone: (_____)** _____**-** _____

BASS MEDICAL GROUP

NEW PATIENT REGISTRATION

Date: _____ **Social Security Number:** _____ - _____ - _____

Patient's Name: _____
Last Name **First** **MI**

Date of Birth: _____ ☐ Male ☐ Female **Marital Status:** S M W D **Age:** _____

Please check one: **Do you speak English?** ☐ Yes ☐ No, other_____
☐ Black/African American ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander
☐ Caucasian/White ☐ Unknown ☐ Prefer not to state ☐ Other: _____

Street Address: _____ **City:**_____

State/Zip code: _____ **Driver's License#:**_____

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

Patient's Employer: _____ **Work Phone #:** (_____) _____ -- _____
Patient's Employment: ☐ Full time ☐ Part time ☐ Student ☐ Retired

Is it ok to leave messages on: Cell Phone ☐ Yes ☐ No Home Phone ☐ Yes ☐ No Work Phone ☐ Yes ☐ No
Please indicate with a 1, 2, 3 or N/A which telephone number to call first: Cell _____ **Home** _____ **Work**_____

Spouse's Name: _____ **DOB** _____**SS#** _____

Spouse's Employer: _____ ☐ Full time ☐ Part time ☐ Student ☐ Retired

PATIENT'S INSURANCE INFORMATION

Primary Insurance Coverage is through:
PRIMARY INSURANCE: _____ ☐ Patient, ☐ Spouse, ☐ Parent, ☐ Other_____

Insured's Name: _____ **Insured's DOB:** _____

Secondary Insurance Coverage is through:
SECONDARY INSURANCE: _____☐ Patient, ☐ Spouse, ☐ Parent, ☐ Other_____

Insured's Name: _____ **Insured's DOB:** _____

If patient is a Minor, are parents ☐ Married ☐ Divorced? **Custodial Parent** _____
Custodial Parent's Home Phone: (_____) _____ -- _____**Custodial Parent's Work Phone:** (_____) _____ -- _____
Custodial Parent's SS #: _____ **Custodial Parent's 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 BASS Medical Group and their billing department 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 BASS Medical Group immediately upon receipt.

I understand that if Dr. Ghanta is unavailable, whether she is in surgery, on nights or weekends, or unavailable for some other reason, that I may receive a call from a covering physician or be asked to go to urgent care or the emergency room if I experience an urgent or emergent issue. I also understand that I may be offered care or treatment from a covering physician in the event that Dr. Ghanta is unavailable.

I, the patient or the patient's representative, understand that all medical doctors at BASS Medical Group 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 **Date**

_____ _____

Print Name of Person Signing **Relationship to Patient**

Swapna Ghanta, M.D.

Breast Surgery

BILLING AND FINANCIAL POLICY – PAGE 1

The following sets forth the policies of BASS Medical Group. Please review this information and sign where indicated below.

- I understand that it is my responsibility to furnish Bass Medical Group 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 billing office prior to your next appointment.

- **I understand that a surgery cancellation fee of $100.00 maybe 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 billing office before surgery can be rescheduled.

- I understand that Swapna Ghanta, M.D. is only a contracting provider with Blue Shield and Health Net through Covered California and the Health Care Exchange. If your coverage is through any other plan through Covered California or the Health Care Exchange please inform the office PRIOR TO YOUR VISIT WITH DR. GHANTA. Dr. Ghanta is not a contracting provider with Anthem Blue Cross through Covered California and the Health Care Exchange.

- I understand that Dr. Swapna Ghanta is not a provider for any HMO insurances other than thru John Muir Physician Network, Alta Bates/Brown & Toland, CCHP and Hill Physicians Medical Group.

- 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. It is also the responsibility of each patient to know which facilities their insurance is contracting with.

- 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 & Financial Policy,1)

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, and/or 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 BASS Medical Group.

_____ _____

Legal Signature Date

_____

Print Patient's Name

_____

Relationship to Patient

(Billing & Financial Policy,2)

BASS MEDICAL GROUP

Swapna Ghanta, M.D.

Breast Surgery

Notice of Privacy Practices

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 and their staff access to our patients' health information. The purpose for this access is to expedite the referral of patients within the system and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the 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 page 2 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

- 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, Spouse's name: _____**
☐ **OK to ALL family members**
☐ **OK to Other, Name & Relationship: _____**

☐ **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 at our main 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: _____

Preferred telephone number to call first (_____) _____-_____

Additional telephone number to call (_____) _____-_____

If person signing is not patient please provide the following:

Name: _____

Relationship to patient: _____ Contact Telephone Number:_____

(HIPAA-Notice of Privacy Practices,2)

PHOTOGRAPHIC CONSENT:

I hereby grant permission for the use of any of my photographic medical records including illustrations, images, and/or other imaging records to Dr. Ghanta / BASS Medical Group for the following uses:

My medical care and treatment (or for the patient I am authorized to sign for)	☐ **Yes**	☐ **No**
Educational presentations/lectures to other physicians	☐ **Yes**	☐ **No**
Discussions with other patients about potential surgery	☐ **Yes**	☐ **No**
Inclusion on practice website to show surgery outcomes	☐ **Yes**	☐ **No**

*****All identifiable characteristics will be omitted to protect patient privacy unless written consent is obtained from the patient in advance*****

I also understand that I may withdraw this permission or limit it at any time by giving Dr. Ghanta written notice specifying the images I no longer want her to use (or that I do not want any of my images used). Dr. Ghanta will discontinue use of the designated images within 15 business days of receiving the written notice.

Signed: _____ Date: _____

Patient's Name: _____ Date of Birth: _____

If person signing is not patient please provide the following:

Name: _____

Relationship to patient: _____ Contact Telephone Number:_____

(Photographic Consent)