Bay Area Colon & Rectal Surgeons
A Division of BASS Medical Group

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NEW PATIENT REGISTRATION

Date 06/23/2020 First Name _____ Last Name _____ Date of Birth _____

Age _____ Gender _____ Marital Status _____ Drivers License _____

SSN _____ Preferred Language _____ Pharmacy _____

Email _____ Home Phone _____ Cell Phone _____

Address _____
Street City State Zip

Patient's Employer _____ Work Phone _____

Is this work related? _____ If yes, date of injury _____ Claim # _____

Spouse's Name _____

PATIENT INSURANCE INFORMATION

Primary Insurance Carrier _____ Insurance ID # _____

DOB of Insured _____ Secondary Insurance Carrier _____

Secondary Insurance ID _____ DOB of Insured _____

If patient is a Minor, parents are _____ Custodial Parent _____

Custodial Parent's Home Phone _____ Work Phone _____

Custodial Parent' SSN _____ Date of Birth _____

REFERRING PHYSICIAN INFORMATION

Referring Physician's Name _____ City _____

Primary Care Physician _____ City _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship to Patient _____

Phone _____

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Reason for visit: _____

Tobacco use

Are you a current smoker: YES ☐ NO ☐ **Former smoker:** YES ☐ NO ☐

Types: Cigarettes Vaping Cigar Pipe

Number of years smoked: _____ **Packs per day:** _____

Smokeless tobacco: YES ☐ NO ☐ **Types:** Chew Snuff

Allergies

Medication allergies: _____

_____

Medication List

Medication name	Dosage	Frequency

(if medication list is extensive please attach to this sheet)

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Medical History

PLEASE CIRCLE ANY PROBLEM YOU HAVE HAD OR ARE BEING TREATED FOR.

Blood Problems
- Anemia
- Blood clots (DVT/ Embolism)
- Bleeding disorder
- Clotting disorder
- HIV positive

Cardiac Vascular
- Angina (chest pain)
- Arrhythmia (heart rhythm problems)
- Atrial fibrillation
- Heart failure
- Hyperlipidemia: (high cholesterol)
- Hypertension: (high blood pressure)
- Malignant hyperthermia
- Past heart attack
- Peripheral vascular disease: (Blood vessel problems in legs)

Cancer
- Anal cancer
- Bladder cancer
- Breast Cancer
- Cervical cancer
- Colon cancer
- Kidney cancer
- Ovarian cancer
- Penile cancer
- Prostate cancer
- Rectal cancer
- Small bowel cancer
- Stomach cancer
- Other Cancer: _____

Respiratory
Asthma
Other: _____

Eyes
- Glaucoma
- Vision loss

Endocrine
- Diabetes
- Hyperthyroidism (high thyroid disease)
- Hypothyroidism low thyroid disease

Gastrointestinal
- Accidental bowel leakage
- Anal/Rectal trauma/injury
- Celiac disease (gluten sensitivity)
- Colon/Rectal polyps
- Crohn's disease
- IBS (Irritable bowel syndrome)
- Ulcerative colitis

Infections
- Hepatitis

Kidney/Urinary
- Poor kidney function
- Renal failure
- Urinary incontinence (leakage of urine)

Mental Health
- Anxiety
- Depression

Musculoskeletal
- Arthritis
- Back problems
- Gout
- Pelvic fracture

Neurological
- Multiple sclerosis
- Neuropathy
- Spinal cord injury
- Sleep apnea
- Stroke (Cerebrovascular accident)

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Surgical History
Please list all prior surgeries and the year preformed: **Previous colonoscopies:**_____ **Previous endoscopies:** _____

Alcohol Use

Do you drink alcohol? YES ☐ NO ☐

If yes how often? Daily ☐ Weekly ☐ Monthly ☐ Socially ☐ Rarely ☐

Amount consumed: 1-3 ☐ 3-5 ☐ 5 or more☐

Drug use

Do you use recreational drugs? Yes ☐ NO ☐

Have you in the past? YES ☐ NO ☐

Have you ever used intravenous drugs? YES ☐ NO ☐

Caffeine use

Please circle all that apply: Coffee Soda Tea Chocolate Other

Number of cups:_____ **Number of sodas:**_____

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Family History

Item	Family member (i.e. Mother, father)	Comments
Allergies		
Anxiety/Depression		
Arthritis		
Asthma		
Breast cancer		
Clotting disorder		
Colon/Rectal cancer		
COPD		
Crohns/Ulcerative Colitis		
Dementia		
Glaucoma		
Heart disease		
Hyperlipidemia		
Hypertension		
Kidney disease		
Learning disabilities		
Lung cancer		
Macular degeneration		
Migraines		
Osteoporosis		
Ovarian cancer		
Prostate cancer		
Other:		
Other:		
Diabetes		

PROVIDER FINANCIAL POLICY

1. A copy of your photo ID and insurance card is requested upon check-in.
2. Copayments and balances are due at the time of service.
3. Procedures done in the office including Anoscope's may be subject to annual deductible and will be billed separately once the claim is processed.
4. This office accept credit cards (VISA/MASTERCARD AND DISCOVER).
5. This office accepts checks with the proper identification.
6. There will be a fee of $25.00 for returned checks.
7. A 24-hour notice is required to cancel office appointments or there will be a fee of $50.00 charged to you. This charge is not billed to your insurance.
8. A 72- hour (business hours) notice is required to cancel/reschedule any surgery or procedure to be done in the hospital/ surgery center or there will be a fee of $200.00 charged to you.
9. There is a fee of $25.00 for the completion of forms such as EDD (state disability), FMLA, etc.
10. Any bills or balances are due within 30 days of final payment by insurance company.
11. Supplemental/ secondary insurance claims will be filed when appropriate.
12. For large balances payment arrangements can be made.
13. If you do not have insurance (CASH PAY PATIENTS) total payment is due at time of service.
14. Changes to insurance, home address, or phone number should be reported immediately to the office for billing and other purposes.
15. Telephone number to call with account questions is 925-627-3424.

THANK YOU FOR CHOOSING OUR TEAM FOR YOUR HEALTHCARE NEEDS

Name: _____

Signature: _____

Date: _____

ASSIGNMENT OF BENEFITS

Patient Name: _____

Assignment of Insurance Benefits:

I hereby authorize BACRS a Division of Bass Medical Group to apply for benefits and receive payments on my behalf for covered services rendered. I agree that I am financially responsible to BACRS a Division of Bass Medical Group for charges not paid under my insurance policy. I agree that a photocopy of this form may be used in lieu of the original.

Release of Information:

I hereby authorize BACRS a Division of Bass Medical Group to disclose and all parts of my clinical records to any insurance company covering services for the purpose of satisfying charges billed.

Medicare Patients:

I request that payments of authorized Medicare benefits be made payable to BACRS a Division of Bass Medical Group on my behalf on any services furnished to me. I authorize any holder of medical information to release to the Health Care Financing Administration and its agent any information needed determined benefits of the payable of related services.

I understand that my signature request that payment be made and authorizes the release of medical information necessary to pay claims. My signature authorizes the release of information to the insurance agency covering services provided my BACRS a Division of Bass Medical Group. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as a full coverage, and I am responsible only for deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND DOES UNDERSTAND THE ABOVE TERMS AND CONDITIONS.

_____ _____

Signature of Patient or Patient's Agent, **Date**

Representative of Guarantor

Assignment of Benefits

Patients Name _____

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 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, 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	**Relationship to Patient**	**Date**

HIPAA/NOTICE OF PRIVACY PRACTICE

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 permitted use allowed by law. We have on file with these sources' verification of confidentiality of the fax use and its limited access by authorized personnel.**
- **If this practice is sold your healthcare information will become 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 healthcare operations.

We also use a shared Electronic Medical Records system that allows both our physicians and staff and certain participating physicians of the Muir Medical Group IPA and their staff access to our patients' health information. The purpose of the access is to expediate the referral of patients within the Muir Medical Group IPA and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Records System can be released outside the Muir Medical Group IPA system only when the patient 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 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.**
- **You have the right to request an alternative 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 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 record.**

HIPAA/NOTICE OF PRIVACY PRACTICE

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 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.

☐ **Ok to speak with Spouse:** _____

☐ **Ok to speak with family member listed here:**

_____

☐ **Ok to leave health information on answering machine or voicemail.**

☐ **DO NOT RELEASE ANY INFORMATION TO ANYONE OTHER THAN MYSELF (PATIENT)**

☐ **DO NOT RELEASE TO:** _____

We reserve the right to change our privacy practices and 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, 220 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, Lisa McGuinness, at (925) 274-9000.

This notice goes into effect as of January 10, 2017.

ACKNOWLEDGEMENT

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

Signature: _____ **Date:** _____

Patients name: _____ **Date of Birth:** _____

If person signing is not patient, please provide name and identify the relationship to the patient and in what capacity you/they are signing (E.g., parent, guardian, conservator):

Name: _____

Capacity and/or relationship to patient: _____

TELEHEALTH DISCLAIMER

1. **Please be advised that communicating via telehealth/telehealth video is not secure communication. By receipt of this telehealth/telehealth video disclaimer you understand the potential risk inherent with telehealth/telehealth video communication and agree to accept the possible risk and use telehealth/telehealth video communication as a way for you and this office to communicate.**

2. **I understand that BACRS a Division of Bass Medical Group does not and cannot guarantee the confidentiality of any telehealth/ telehealth video communications and will not be liable for improper disclosure of confidential information and/or breaches of confidentiality caused by me or a third party. I understand that BACRS a Division of Bass Medical Group has no control over the security or management of my individual internet service provider and cannot guarantee that information will not be intercepted, altered, or read by an unintended recipient.**

Signature: _____

Printed name: _____

Date: _____