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PATIENT INFORMATION

Patient Name:		Date of Birth:		Age:	
Address:		City:		State: Zip:	
SSN:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Divorced	
Home Phone:		Cell:		E-Mail:	
Ethnicity (<i>required by California Cancer Registry</i>): <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian <input type="checkbox"/> Other _____					
Employer:		Occupation:			
Name of Spouse/Parent:		Spouse/Parent Home Phone:			
*if patient is minor Parent Driver License#: _____ State: _____					
EMERGENCY CONTACT					
Name:		Relationship:		Phone:	
INSURANCE CARRIER/S & PAYMENT INFORMATION					
Type of Payment: <input type="checkbox"/> Insurance <input type="checkbox"/> Cash <input type="checkbox"/> Lien (<i>attach Lien document</i>)					
Insurance Carrier/s: 1. _____ 2. _____					
I understand that for this procedure/s, there will be Professional, Facility, Anesthesiology fees and Pathology fees, if biopsy is performed. I also understand that it is my responsibility to verify all medical benefits and/or reimbursement with my insurance carrier/s.					
Patient/Responsible Adult Signature:				Date:	
Patient/Responsible Adult Print Name:				Relationship to Patient	
Interpreter (If required) Signature:				Print Name	
Interpreter relationship to patient (if applicable)					
Fill out this section ONLY if you accept financial responsibility for the patient for whom you have NO legal responsibility.					
I, the undersigned person, hereby certify that I have accepted total financial responsibility for the above patient, for the care/treatments rendered to the patient by the Center and all their providers including but not limited to: surgeons, anesthesiologists, radiology, laboratories, and clinical care workers. I understand that I do not currently have any legal responsibility to provide financial support for this patient. I also understand that, by signing below, I agree to personally accept full responsibility for all financial costs associated with the care/treatments/services provided to the patient by Center. Furthermore, I certify that I have had the opportunity to ask all questions related to this matter and was given adequate answers. Please fill in all sections below and sign where indicated.					
Last Name:		First		M.I. SS#:	
Relationship to Patient:		Home phone:		Date of Birth:	
Address:		City		State Zip	
Signature of Responsible Party:					



PATIENT HISTORY

Procedure: ☐ Endoscopy ☐ Colonoscopy ☐ Flexible Sigmoidoscopy
Reason for Procedure: ☐ Dysphagia ☐ Heartburn ☐ Screening
☐ Other _____

NURSING MEDICAL HISTORY

<input type="checkbox"/> Heart Disease / Attack	<input type="checkbox"/> Stroke, TIA, ALS or MS	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Heart Murmur / MVP	<input type="checkbox"/> Anesthesia/Sedation problems	<input type="checkbox"/> Smoking Yes / No Quit _____
<input type="checkbox"/> Angioplasty	<input type="checkbox"/> Bleeding / Blood Disorder	<input type="checkbox"/> Cancer _____
<input type="checkbox"/> CHF	<input type="checkbox"/> Kidney / Liver Disease	<input type="checkbox"/> Recent Radiation Hx: _____
<input type="checkbox"/> Pacemaker/AICD	<input type="checkbox"/> Diabetes / Pancreatitis	<input type="checkbox"/> Arthritis
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Prosthesis (metal, stents, valves, joints)
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Thyroid Disorder _____	<input type="checkbox"/> GI Surgeries/Problems _____
<input type="checkbox"/> HIV	<input type="checkbox"/> Recent Cold / Flu / Infection	<input type="checkbox"/> Pregnant <input type="checkbox"/> N/A LMP _____
<input type="checkbox"/> Joint Replacement Surgery		<input type="checkbox"/> Other _____
Yes / No Type: _____	Weight _____	Height _____

SURGERIES: _____

ALLERGIES/SENSITIVITIES: ☐ No ☐ Yes (please list) _____
LATEX ALLERGY: ☐ No ☐ Yes refer to Latex Allergy Assessment: _____

COMMENTS: _____

MEDICATIONS:

Please list all medications; including inhalers, drops, vitamin supplements, herbal (Ginkgo Biloba, St. Johns Wort, Saw Palmetto, etc.) & OTC Meds:

Medications (write legibly)	Reason (dose, frequency)	Last Dose (date / time)	Medications (write legibly)	Reason (dose, frequency)	Last Dose (date / time)
Are you on blood thinning Medications? <input type="checkbox"/> Yes <input type="checkbox"/> No			6.		
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		

RN Signature _____ **Date** _____



LEGAL ASSIGNMENT OF BENEFITS- CENTER

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

I acknowledge the possibility that a check and or checks may be sent directly to me instead of you, my provider. I understand this money is not mine even though the check may be written to me. I understand you are billing my insurance company as a courtesy to me but the money paid by the insurance company belongs entirely to you. I, therefore, agree to immediately, but certainly no later than 48 hours upon receipt of any such monies, forward this money directly to you. I will make no attempt to negotiate what portion I send to you. In any event, I acknowledge and agree that any charges for service rendered to me are my responsibility and I will pay all fees including any co-pays or deductibles, if applicable.

X

Patient Signature or Financially Responsible Party Relationship to patient if not patient Date

LEGAL ASSIGNMENT OF BENEFITS- ANESTHESIA

For ANESTHESIA SERVICES rendered, I hereby authorize my Insurance Company to pay by check made payable and mailed directly to:

Anesthesiologist

for the anesthesia benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for the services rendered. I understand that as a courtesy to me, my anesthesia provider will file a claim with my insurance company on my behalf. However, I am financially responsible for, and hereby do agree to pay, in a current manner, any charges not covered by the insurance payment. If it is necessary to file a formal collection action, I agree to pay all costs, including reasonable attorney's fees incurred by the outpatient medical center in the collection of the outstanding fees. Actual Plan Benefits cannot be determined until the claim is received by your insurance company and is based upon their determination of medical necessity. The information received from the above stated is not a guarantee of payment.

X

Patient Signature or Financially Responsible Party Relationship to patient if not patient Date



NOTICE OF HIPAA PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the HIPAA Notice of Privacy Practices, Patient Rights and Responsibilities that I have read, or have had the opportunity to read, this Notice and I understand the Notice.

Patient Name (Please Print) _____

Authorized Representative (Please print if applicable) _____

Relationship to Patient _____

X

Patient's Signature or Authorized Representative's Signature _____

Date _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check ALL that apply):

☐ Home telephone: _____

Written Communication

☐ OK to speak to : _____

☐ OK to leave message with detailed information

☐ OK to mail to my home address

☐ Leave message with call back number only

☐ OK to mail my work/office address

X

Patient's Signature or Authorized Representative's Signature _____

Date _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the disclosure of, and requests for, PHI to the minimum to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to the authorization requested by the individual. Healthcare entities must keep records of PHI disclosures.

Information listed below, if completed properly, will constitute an adequate record.

Uses and disclosures for TPO (treatment, payment, operations) may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom (address or fax number)	1	Description of Disclosure Purpose of Disclosure	By Whom Disclosed	2	3

PEER REVIEW NOTICE

Peer Review sources, external to the facility, are used to evaluate delivery of medical care. I agree to waive confidentiality of my medical records for Peer Review.

Authorized Representative (Please print if applicable) _____

Relationship to Patient _____

X

Patient's Signature or Authorized Representative's Signature _____

Date _____