Temecula Valley Day Surgery

25495 Medical Center Drive STE 101, Murrieta, CA 92562

PATIENT INFORMATION

PLEASE FILL OUT ALL INFORMATION COMPLETELY

Name _____ Female ☑ Male _____ Birth Date ____/____/____ Age _____
Last First Middle Month Day Year

ADDRESS _____ _____ _____ _____
Street No. or P.O. Box City State Zip

Home Phone (____) _____ Cell Phone (____) _____ SS # _____

Email _____ Drivers License # _____

Currently Employed? Yes ☐ No ☐ Marital Status? Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Patient/Responsible Party's Employer _____ Phone _____

Employer's Address _____ _____ _____ _____
Street No. or P.O. Box City State Zip

Emergency Contact _____ Relationship _____ Phone _____

Spouse's Name _____ Employer _____ Phone _____

INSURANCE INFORMATION

Primary Insurance Co. _____

Name of Policy Holder _____

SS # _____ DOB _____

ADDRESS _____
Street No. or P.O. Box

_____
City State Zip

Phone _____

Secondary Insurance Co. _____

Name of Policy Holder _____

SS # _____ DOB _____

ADDRESS _____
Street No. or P.O. Box

_____
City State Zip

Phone _____

WORKERS COMPENSATON INFORMATION

Name of WC Ins. Co _____ Contact Person _____

ADDRESS _____ Contact Person _____
Street No. or P.O. Box

_____
City State Zip Claim/Case No _____

Verified By _____ Phone _____ Injury Date _____

Condition related to accident/ injury? Y ☐ N ☐ Date of Occurence _____ Attorney's Name (if any) _____

Consultation Requested By _____ Name of Primary Care Physician _____

TO ENSURE THE BEST QUALITY CARE, WE NEED THE NAME AND CONTACT NUMBER OF THE INDIVIDUAL TRANSPORTING YOU HOME

NAME: _____

PHONE NUMBER: _____

I certify that the above information is correct; I also understand that even though I have some type of insurance coverage, I am responsible for payment of services.

Signature of Patient or Responsible Person: _____ **Date** _____

TEMECULA VALLEY
DAY SURGERY

MEDICATION RECONCILIATION LIST
HOME MEDICATIONS

☐ **List Attached**

ALLERGIES: _____

☐ **NO KNOWN DRUG ALLERGIES** ☐ **I deny taking any home medications**

LIST OF CURRENT MEDICATIONS

Include oxygen, supplements, vitamins, and any other medications

for physician use only

Medication	Dose	Route	How often	Reason	Dose	May resume / date

_____
Patient Signature

NURSE IS TO READ BACK & VERIFY MEDICATION(S) AS STATED

_____ _____ _____
RN Signature Date Time

Discharge Medication Information

☐ **No change to your current home medications. If you have any questions, please contact your doctor.**

☐ **NEW Medication:**

Medication Name	Strength	How to Take	How Often	Reason for Medication

I have reviewed this information with the patient / family

_____ _____ _____ _____
RN Signature Patient/Representative Signature Date Time

_____ _____ _____
Physician Signature Date Time

ID / Visit: /

DOB:

Phys:

DOS:

Sex:

Age:

TEMECULA VALLEY DAY SURGERY

Name:_____

Date of Birth:_____

PATIENT PRE-OPERATIVE QUESTIONAIRE

To be completed by the patient or their representative

General Information:

Allergies: ☐ No known allergies to medication ☐ I have medication allergies, please list:

YES	NO	
☐	☐	I have had an unexpected problem during or after anesthesia or after surgery
☐	☐	I have had a family member who had an unexpected problem or died during anesthesia or surgery.
☐	☐	I have an Advance Directive. If I can't make my own decisions, my decision-maker is:
☐	☐	I have had blood transfusions
☐	☐	I will accept a blood transfusion or blood products
☐	☐	Take or treated with steroids, cortisone, prednisone
☐	☐	I wear contact lenses ☐ left eye ☐ right eye ☐ I have glaucoma
☐	☐	I have dentures, partial, bridge, caps, or loose teeth

List of Past Operations	Year	List of Past Hospitalizations	Year

YES	NO	DO YOU NOW OR HAVE YOU EVER HAD:
☐	☐	Cold, flu, or other infection within the past two (2) weeks
☐	☐	Is there any chance you could be pregnant
☐	☐	Lung Disease (TB, bronchitis, asthma, emphysema, chronic cough)
☐	☐	Smoke, if YES how many packs per day?
☐	☐	Short of breath ☐ at rest or sleeping ☐ walking/exercising
☐	☐	Sleep apnea ☐ Sleep with head up on pillows or in a chair ☐ Use CPAP machine
☐	☐	Heart Disease (heart attack, heart murmur, rheumatic fever, heart failure ☐ High BP ☐ Low BP
☐	☐	Irregular heart beat (atrial fibrillation, fast or slow heart rate)
☐	☐	Bleeding disorder or on blood thinners
☐	☐	Hepatitis, jaundice (yellow eyes/skin) or other liver problems
☐	☐	Neurological Problem: ☐ Paralysis or stroke, if YES date: ☐ Epilepsy, Seizure, Fainting Spells
☐	☐	Kidney disease, infections, or nephritis ☐ I am on dialysis
☐	☐	GI Problems such as: ☐ Heart burn ☐ Hiatal hernia ☐ Stomach Ulcers ☐ Irritable Bowel
☐	☐	Immune disease (such as Lupus, porphyria), muscle or nerve disease
☐	☐	Endocrine Problem such as: ☐ Diabetes ☐ Low Blood Sugar ☐ Thyroid
☐	☐	Back problems, herniated disc
☐	☐	History of excessive alcohol, drug, or medication use/abuse
☐	☐	History of infection ☐ MRSA ☐ HIV

Additional information I want you to know about me . . .

Completed by:	Print Name:	Signature:	Date:

If completed by someone other than the patient, please indicate your relationship:

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PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessment and physician certifications.

I have received, read and understand your N*otice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so documented below:

Reason:_____

Signature:_____ Date:_____

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FINANCIAL POLICIES

We find that communication with our patients regarding our financial policies assists us in providing you with the best service possible and helps to eliminate misunderstandings.

- INSURANCE: As a courtesy to our patients, we will bill your primary, as well as your supplemental, insurance for services rendered. You must be aware that it is your responsibility to provide us with up to date insurance information and forms necessary for us to file your claims. You are, however, ultimately responsible for any and all costs incurred.

- SELF-PAY: If you do not have insurance coverage and you need to make payment arrangements, please notify us immediately. The initial office visit fee is due, in full, at the time of service. You should also be aware that certain procedures are due and payable in full prior to the procedure.

  If there is a balance left owing, a statement will be sent notifying you of the amount due. All balances are due and payable upon receipt of the statement. If the balance is not paid in full by the next billing cycle, a $10.00, per month, re-billing fee will be added. If the balance has not been paid within 60 days of the original billing date, we will be forced to pursue legal actions to collect any outstanding balance, and you will be responsible for the collection costs and any interest that has accrued at 12% per annum.

- HMO PATIENTS: its the sole responsibility of the patient to supply the office with a valid referral at the time of each visit. If you fail to obtain necessary referral and authorization you will be responsible for any and all services rendered. It is also ***extremely*** important that you notify this office if your medical group or insurance carrier changes. If payment is denied by your insurance, you are liable for the costs of all services rendered.

- **FACILITY CHARGES vs PHYSICIANS CHARGES:** Temecula Valley Day Surgery charges are separate and not included in the physician charges. This means you may receive two statements, one from the facility and one from the physician.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICIES.

X_____ _____

Patient / Responsible Party Signature **Date**

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PATIENT'S SIGNATURE ON FILE

MEDICARE AND/OR OTHER HEALTH INSURANCE AUTHORIZATIONFOR PAYMENT

Patient Name: _____ **Date of Birth:**_____

Medicare/Health Insurance Number: _____

I request that payment of Medicare/Health Insurance benefits be paid on my behalf directly to: Temecula Valley Day Surgery, and/or Physician/Health care Provider.

These payments are for services provided to me at Temecula Valley Day Surgery and my Physician/ Health care Provider. I also authorize any holder of medical information about me to release such information to: The Health care Financing Administration and its agents, as needed to determine these benefits or the benefits payable for related services.

If item 9 of the HCFA-1500 claim for is completed, my signature authorizes the release of information to the insurer or agency shown. In Medicare assigned cases, Temecula Valley day Surgery and or the Physician/Health care Provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for only deductible, co-insurance, and/or non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

_____ _____

Patient / Responsible Party Signature **Date**

NOTICE TO ALL PATIENTS

Temecula Valley Day Surgery is a facility dedicated to the patient healthcare. Our Physicians ***are not*** Primary Care Physicians, therefore, if you are having a medical problem other than what your physician is treating you for here at the “Center”, please see your Primary Care Physician. Also, please be aware the Facility does not function as an Emergency Room. In case of an emergency you should contact your Primary Care Physician.

_____ _____

Patient / Responsible Party Signature **Date**