COASTAL SURGEONS

Appointment No-Show / Surgery Cancellation Agreement

Same Day Cancellations or No-Show for Office Visits

$50.00 Fee

(Please contact our office 24 hours prior to avoid fees)

Surgery Cancellations less than 48 Hours

$150.00 Fee

(If surgery is cancelled 48 hours prior to scheduled surgery date, NO FEE will be charged)

I acknowledge that I have read and understand the above information.

Patient Name: _____

Signature: _____

Date: _____

COASTAL SURGEONS

Patient Registration Form

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

Race: _____ **Ethnicity:** _____ **Preferred Language:** _____

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email: _____ **SSN:** _____

Marital Status(Check One): ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Birth Gender (Check One): ☐ Male ☐ Female ☐ Other ☐ Decline To Answer

Current Gender(Check One): ☐ Male ☐ Female ☐ Non-Binary ☐ Other ☐ Decline to Answer

☐ Transgender Male (FTM) ☐ Transgender Female (MTF)

Gender Identity(Check One): ☐ Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Other ☐ Decline to Answer

Primary Physician (PCP): _____ **Referring Physician:** _____

Employer: _____ **Occupation:** _____

Drug/Food Allergies: _____ **Diabetic:** ☐ Yes ☐ No **Dialysis Days:** ☐ M/W/F ☐ T/Th

Emergency Contact Information

Name: _____ **Relationship:** _____

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Name: _____ **Relationship:** _____

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Employer Name: _____ **Employer #:** _____

Insurance Information

Primary Insurance: _____

Name of Insured: _____ **Date of Birth:** _____

Insurance ID# : _____ **Group #:** _____

Secondary Insurance: _____

Name of Insured: _____ **Date of Birth:** _____

Insurance ID# : _____ **Group #:** _____

CSMG Financial Policy

(Please read and sign below)

ALL CO-PAYS ARE DUE AT TIME OF SERVICE

As a courtesy to our patients, we will bill your insurance company for hospital and surgical fees provided you have presented us with all necessary billing information. It is the sole responsibility of the patient to ascertain their benefit information with the insurance company. After we receive the payment from your insurance company, we will then send you a statement of any remaining balance left on your account which is due within 30 days. We will be happy to discuss any fees or financial issues with you.

MEDICARE PATIENTS: I request payment of authorized Medicare benefits be made either to me or on my behalf to the provider indicated to the claim. I authorized any holder of medical information about me to be released to the Healthcare Financing Administration and its agents to determine these benefits, or the benefits payable for the related services.

I understand that I am financially responsible for all charges whether or not they are covered by my insurance. I hereby authorize the release of any medical information necessary to process this insurance claim. A copy of this signature is as valid as the original.

I have read and fully understand the abovementioned CSMG Financial Policy.

Signature: _____

Date: _____

Patient Financial Agreement Form

Date: _____

Physician: **K. TOOSIE**

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

The Physicians of Coastal Surgeons require this form to be signed by our Patients. We appreciate your cooperation. If you have any questions, please speak to our Billing Department. We are pleased to assist with your insurance.

FINANCIAL RESPONSIBILITY: I understand that I will be responsible for any charge incurred by **not providing the most current, and accurate insurance information** to Coastal Surgeons. Exceptions to this policy: those patients with current authorization with HMO, a state federally funded program, or a PPO in which Coastal Surgeons is currently contracted with.

I understand that with the exemptions explained above, I am personally responsible for any medical fees I will incur with Coastal Surgeons.

Print Name: _____ **Signature:** _____ **Today's Date:** _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: *I hereby authorize payment for medical services provided directly to Coastal Surgeons Physicians*.

Print Name: _____ **Signature:** _____ **Today's Date:** _____

Coastal Surgeons will be responsible for billing and collection on Professional charges. Coastal Surgeons is not responsible for any bills you may receive from the hospital, including Anesthesia, Pathology, or Laboratory services when surgery is performed. Please be aware that most surgery cases performed require an assistant to be present, not all assistants maybe contracted with your insurance policy. We will do our best to acquire a contacted assistant, but this is solely based on availability of the assistant.

I understand and agree with the terms and conditions listed above.

Print Name: _____ **Signature:** _____ **Today's Date:** _____

Notice of Privacy Practices

This notice describes how health information about our patients may be used and disclosed, and how you can get access to your health information. This, required by the Privacy Regulations, is created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our Commitment to Your Privacy

Our Practice is dedicated to maintaining the privacy of your health information. We are required by the law to maintain the confidentiality of your health information.

Use and Disclosure of Your Health Information in Certain Special Circumstance

The following circumstances may require us to use or disclose your health information:

1) To Public Health authorities/Health oversight agencies that are authorized by law to collect information.
2) Lawsuits and similar proceedings in response to a court or administrative order.
3) If required by Law Enforcement Official(s).
4) When necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5) If you are a member of U.S. Armed Forces or Foreign military (including veterans) and if required by the appropriate authorities.
6) To federal official(s) for intelligence and national security activities authorized by law.
7) To correctional institutions or law enforcement official(s) if you are an inmate, or under custody of a law enforcement official.
8) For Workers' Compensation and similar programs.
9) Data that is collected by Coastal Surgeons, which does not include the identity of the patient may be utilized for research purposes.

Your Rights regarding your Health Information:

1) You can request that out practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2) You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care: such as family members, or friends. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when required by law, in emergencies or when the information is necessary to treat you.
3) You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical and billing records, but not including psychotherapy notes. You must submit your request in writing to Coastal Surgeons who will have up to 30 days to comply.
4) You may ask us to amend health information if you believe it is incorrect or incomplete, if the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Coastal Surgeons who will have 60 days to respond. You must provide us with a legitimate reason that supports you request for amendment.
5) You are entitled to receive a copy of this Notice of Privacy Practices. At any time, you may obtain a copy of this notice by contacting our front desk receptionist.
6) If you believe that your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of Use, Department of Health and Human Services. To file a complaint, contact Coastal Surgeons at (760)724-5352. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7) Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice, or our health information privacy policies, please contact your physician.

General Authorization to Release Health Information

I hereby authorize the release of my personal health information to any healthcare provider approved by my treating physician. I understand that I may cancel this authorization at anytime by notifying my treating physician in writing.

Print Name:_____ **Signature:**_____ **Today's Date:**_____

Coastal Surgeons Notice of Privacy Practices

I hereby acknowledge that I have been presented with a copy of this office's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Print Name:_____ **Signature:**_____ **Today's Date:**_____

Breast Questionnaire

PLEASE FILL OUT THE TOP PORTION PRIOR TO YOUR FIRST VISIT:

Name: _____ **Referring Physician:** _____

Reason(s) for Visit: _____

_____

Age: _____ **Age at First Menstrual Period:** _____ **Age at First Pregnancy:** _____

Number of Live Pregnancies: _____ **Number of Live Births:** _____ **Number of Abortions/Miscarriages:** _____

Please check YES or NO for the following questions below:

Did you breastfeed?	Yes	No		Any previous problems?	Yes	No	
Previous Hysterectomy?	Yes	No		Ovaries removed?	Yes	No	
Any nipple discharge?	Yes	No		Do you do self breast exams?	Yes	No	
Any mass you feel?	Yes	No		Any nipple or breast skin problems?	Yes	No	
Do you have heart disease?	Yes	No		Any bone problems?	Yes	No	

Family history of breast cancer?	Yes	No	Who?		Age of Diagnosis?	
Family history of ovarian cancer?	Yes	No	Who?		Age of Diagnosis?	

Physician Evaluation

Gail model risk assessment score: _____ Tamoxifen discussion: _____ min

Exam:

Mammogram review:

Past Medical History:

Impression/Plan:

Medication List

Date of Visit: _____ **Date of Birth:** _____

Patient Name: _____

Please write in current **PRECRIBED** or **OVER-THE-COUNTER** medications. ☐ No medication(s) being taken.

Name of Medication	Dosage	Directions	Prescribed By

Do you take any of the following?

Aspirin ☐ No ☐ Yes *If **YES**, how much?* _____

Coumadin ☐ No ☐ Yes *If **YES**, how much?* _____

Drug Allergies: _____

☐ No Drug Allergies

_____

Pharmacy Name: _____ **Pharmacy Phone #:** _____

Pharmacy Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Health History Questionnaire

Date of Visit: _____ **Referring Physician:** _____

Patient Name: _____

Date of Birth: _____ **Age:** _____ **Birthplace:** _____

Marital Status(Check One): ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

WHY ARE YOU HERE?: _____

Operations / Surgeries / Procedures: ☐ No Operations/Surgeries/Procedures

Year	Surgical / Procedure Name:

Hospitalization(s): ☐ No Hospitalizations

Year	List reasons of Hospitalization(s) / Admission(s)

Major Medical Illness: _____

MEDICATIONS: Please write in **prescribed** or **over-the-counter** medications you take and check how many times a day you take it?

☐ No Medications

Name of Drug	Dosage	1 a Day	2 a Day	3 a Day	As Needed

Do you take any of the following?

Aspirin ☐ Yes ☐ No *If **YES**, how much?*

Coumadin ☐ Yes ☐ No *If **YES**, how much?*

Drug Allergies: _____

☐ No Drug Allergies

Other Allergies:

Iodine: ☐ Yes ☐ No

Novocaine: ☐ Yes ☐ No

Latex: ☐ Yes ☐ No

Have you had any problems with ANESTHESIA? ☐ Yes ☐ No

If YES, please explain: _____

_____

Do you have SLEEP APNEA? ☐ Yes ☐ No

SOCIAL HABITS:

Tobacco Use: ☐ Current ☐ Former ☐ Never

If **current** or **former smoker,** what type and how much tobacco product? _____

☐ Cigarettes or Cigars ☐ Pipe ☐ Chewing ☐ Smokeless ☐ E-Cigs/Vape

Alcohol Use: ☐ Yes *(If YES, what kind?* _____ *How Many?* _____ ☐ No ☐ Former

Have you felt or have been told that you were an alcoholic? ☐ Yes ☐ No

Drug Use: ☐ Yes *(If YES, what kind?* _____ *How Many?* _____ ☐ No ☐ Former

Family Medical History: Please write down any medical history that runs in the family such as cancer, major illnesses, or history of colon polyps and/or colon cancer. If deceased, please fill in age and cause of death. Please use the space below for additional information.

Family Member	Age	Medical History/Illness	Cause of Death
Mother			
Father			
Brother			
Brother			
Sister			
Sister			

Review of Systems (ROS): *Place **Checkmark** in the proper columns.*

CONSTITUTION: Do you or have ever had the following**?**

Loss of appetite?	☐ Yes	☐ No
Any weight loss over the past 6 months? _____ How much? _____	☐ Yes	☐ No
Fevers?	☐ Yes	☐ No
Night Sweats?	☐ Yes	☐ No

SKIN: Do you or have ever had the following**?**

Eczema?	☐ Yes	☐ No
Hives?	☐ Yes	☐ No
Rash needing treatment(s)?	☐ Yes	☐ No
Unexplained itching?	☐ Yes	☐ No
Skin Cancer? _____ Where? _____	☐ Yes	☐ No

HEAD – EYES – EARS – NOSE - MOUTH: Do you or have ever had the following**?**

Head Injury?	☐ Yes	☐ No
Difficulty seeing?	☐ Yes	☐ No
Glaucoma?	☐ Yes	☐ No
Cataracts?	☐ Yes	☐ No
Loss of hearing?	☐ Yes	☐ No
Loss of smell?	☐ Yes	☐ No
Mouth sores?	☐ Yes	☐ No

CARDIOVASCULAR: Do you or have ever had the following**?**

High Blood Pressure?	☐ Yes	☐ No
A thumping heart?	☐ Yes	☐ No
Chest pains, or tightness with exertion (walking, climbing stairs)?	☐ Yes	☐ No
Waking up at night short of breath?	☐ Yes	☐ No
Swollen feet or ankles?	☐ Yes	☐ No
Leg cramps or leg discomfort with walking?	☐ Yes	☐ No
Heart murmur?	☐ Yes	☐ No
Artificial heart valve or infected heart valve?	☐ Yes	☐ No
Heart attack?	☐ Yes	☐ No
Pacemaker?	☐ Yes	☐ No
Varicose veins?	☐ Yes	☐ No

RESPIRATORY: Do you or have ever had the following**?**

Wheezing?	☐ Yes	☐ No
Coughing up a lot of phlegm (sputum)?	☐ Yes	☐ No
Coughing up blood?	☐ Yes	☐ No
Asthma?	☐ Yes	☐ No
Chronic bronchitis?	☐ Yes	☐ No
Emphysema?	☐ Yes	☐ No
Tuberculosis?	☐ Yes	☐ No

GASTROINTESTINAL: Do you or have ever had the following**?**

Hepatitis (Liver infection) Type A, B, or C?	☐ Yes	☐ No
Yellow jaundice?	☐ Yes	☐ No
Stomach Ulcers?	☐ Yes	☐ No
Ever had a Colonoscopy? *If YES, date of last Colonoscopy?* _____	☐ Yes	☐ No
Liver disease? Cirrhosis or scarring of the liver?	☐ Yes	☐ No
Disease of the pancreas including Pancreatitis?	☐ Yes	☐ No
Problems swallowing food?	☐ Yes	☐ No
Blood in the stool?	☐ Yes	☐ No

GENITOURINARY: Do you or have ever had the following**?**

Kidney disease?	☐ Yes	☐ No
Kidney stones?	☐ Yes	☐ No
Painful urination?	☐ Yes	☐ No
Blood in your urine?	☐ Yes	☐ No
Difficulty with urination?	☐ Yes	☐ No

MUSCULOSKELETAL: Do you or have ever had the following**?**

Stiff, painful, swollen joints or muscles?	☐ Yes	☐ No
Arthritis?	☐ Yes	☐ No
Pain in the back?	☐ Yes	☐ No
Muscle weakness or disease?	☐ Yes	☐ No

NEUROLOGICAL: Do you or have ever had the following**?**

Epilepsy or seizures?	☐ Yes	☐ No
Stroke?	☐ Yes	☐ No
Frequent severe headaches?	☐ Yes	☐ No
Dizziness?	☐ Yes	☐ No

PSYCHIATRIC: Do you or have ever had the following**?**

Hospitalized for nervous breakdown?	☐ Yes	☐ No
Tension/Anxiety/Depressive Disorder?	☐ Yes	☐ No
Bipolar Disorder (Manic/Depressive)?	☐ Yes	☐ No
Schizophrenia?	☐ Yes	☐ No

ENDOCRINE: Do you or have ever had the following**?**

Thyroid disease?	☐ Yes	☐ No
Diabetes?	☐ Yes	☐ No
Diabetes requiring Insulin?	☐ Yes	☐ No
Diabetes requiring pills?	☐ Yes	☐ No

HEMATOPOIETICAL/LYMPHATIC: Do you or have ever had the following**?**

Anemia?	☐ Yes	☐ No
The need for blood transfusions?	☐ Yes	☐ No
Tendency to bleed easily when cut?	☐ Yes	☐ No
A blood clotting disorder?	☐ Yes	☐ No
Are you known to HIV (AIDS Antibody) positive?	☐ Yes	☐ No
Swelling of the lymph glands?	☐ Yes	☐ No

FOR MEN ONLY: Do you or have ever had the following**?**

Weak or very slow urine system?	☐ Yes	☐ No
Prostate trouble?	☐ Yes	☐ No
Discharge from your penis?	☐ Yes	☐ No
Swelling or lumps in your testicles?	☐ Yes	☐ No
Painful testicles?	☐ Yes	☐ No

FOR WOMEN ONLY: Do you or have ever had the following**?**

Excess bleeding with your periods recently?	☐ Yes	☐ No
Bleeding between your periods recently?	☐ Yes	☐ No
Lumps in your breast?	☐ Yes	☐ No
Cancer in the female organs?	☐ Yes	☐ No
Do you think you may be pregnant?	☐ Yes	☐ No