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

**Gender (Check One):** ☐ Male ☐ Decline To Answer ☐ Female ☐ Other (please specify): _____

**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:** _____

## Insurance Information

**Primary Insurance:** _____

**Name of Insured:** _____

**Insurance ID# :** _____

**Group # :** _____

**Secondary Insurance:** _____

**Name of Insured:** _____

**Insurance ID# :** _____

**Group # :** _____

# PATIENT RESPONSIBILITY AND BILLING POLICY

Date: _____

Physician: _____

**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.

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.

**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.

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

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.

**EDD (State Disability) and Medical Records** $25.00 Fee

*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.*

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

## ZERO-TOLERANCE POLICY

I acknowledge that COASTAL SURGEONS has a Zero-Tolerance policy when it comes to patient acts of aggression, obscene language, property destruction, verbal, mental or physical threatening or malicious behavior of any kind. If this should occur, we will call the authorities and press charges if we feel necessary. We reserve the right to immediately terminate patient/physician relationship if this kind of act occurs.

**Patient 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.*

**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.*

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

COASTAL SURGEONS

# Appointment No-Show / Surgery Cancellation Agreement

## Same Day Cancellations or No-Show for Office Visits

**$50.00 Fee**

*[Please contact our office 2 business days (48 hours) prior to avoid fees]*

## Surgery Cancellations less than 48 Hours

**$250.00 Fee**

*(If surgery is cancelled 2 business days (48 hours) prior to scheduled surgery date, NO FEE will be charged)*

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

**Patient Name:** _____

**Signature:** _____

**Date:** _____

# Health History Questionnaire

**Date of Visit:**_____ **Patient Name:**_____

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

**Reason(s) for Visit:**_____

**Allergies:** ☐ No Drug Allergies ☐ Yes *(If **YES**, please list below)*

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

| Year | Surgical / Procedure Name: |
|---|---|
| | |
| | |
| | |
| | |

**Hospitalization(s)/Medical Problem(s):** ☐ No Hospitalizations/Medical Problems

| Year | List reasons of Hospitalization(s) / Medical Problem(s) |
|---|---|
| | |
| | |
| | |
| | |

**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 | | | |
| Siblings | | | |
| Siblings | | | |

**Tobacco Use:** ☐ No ☐ Yes If **YES,** what type of tobacco product and how much?

**Alcohol Use**: ☐ No ☐ Yes If **YES**, how many drinks per week?

# Health History Questionnaire

Please write in current **PRESCRIBED** or **OVER-THE-COUNTER** medications.

☐ No medication(s) being taken.

| Name of Medication | Dosage | Directions | Prescribed By |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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

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

**Do you have any of the following? Please check box if YES.**

| | |
|---|---|
| | Chills |
| | Fatigue |
| | Fever |
| | Malaise |
| | Night Sweats |
| | Weight Gain |
| | Weight Loss |
| | Ear Drainage |
| | Ear Pain |
| | Eye Discharge |
| | Eye Pain |
| | Hearing Loss |
| | Nasal Drainage |
| | Sinus Pressure |
| | Sore Throat |
| | Visual Changes |
| | Chronic Cough |
| | Cough |
| | Known TB Exposure |
| | Shortness of Breath |
| | Wheezing |

| | |
|---|---|
| | Chest Pain |
| | Claudication |
| | Edema |
| | Palpitation |
| | Abdominal Pain |
| | Blood in Stools |
| | Change in Stools |
| | Constipation |
| | Diarrhea |
| | Heartburn |
| | Loss of Appetite |
| | Nausea |
| | Vomiting |
| | Difficulty Urinating |
| | Blood in Urine |
| | Excessive Urination |
| | Urinary Frequency |
| | Urinary Incontinence |
| | Urinary Retention |

| | |
|---|---|
| | Dizziness |
| | Extreme Numbness |
| | Extreme Weakness |
| | Gait Disturbance |
| | Headache |
| | Memory Impairment |
| | Seizures |
| | Tremors |
| | Diarrhea |
| | Anxiety |
| | Depression |
| | Insomnia |
| | Cold Intolerance |
| | Heat Intolerance |
| | Excessive Thirst |
| | Excessive Hunger |
| | Backpain |
| | Joint Pain |
| | Joint Swelling |
| | Muscle Weakness |
| | Neck Pain |

| | |
|---|---|
| | Brittle Hair |
| | Brittle Nails |
| | Hair Loss |
| | Hirsutism |
| | Hives |
| | Pruritus |
| | Mole Changes |
| | Rash |
| | Skin Lesion |
| | Back Pain |
| | Joint Pain |
| | Joint Swelling |
| | Muscle Weakness |
| | Neck Pain |
| | Easy Bleeding |
| | Easy Bruising |
| | Lymphadenopathy |
| | Contact Allergy |
| | Environmental Allergies |
| | Food Allergies |
| | Seasonal Allegies |

| FOR FEMALES ONLY: | |
|---|---|
| | Abnormal Pap |
| | Dysmenorrhea |
| | Dyspaurenia |
| | Hot Flashes |
| | Vaginal Discharge |
| | Memory Impairment |
| | Breast Discharge |
| | Breast Lump |
| FOR MALES ONLY | |
| | |
| | Erectile Dysfunction |
| | Penile Discharge |
| | Sexual Dysfunction |