GENERAL SURGERY MEDICAL GROUP OF VENTURA COUNTY (GSMGVC)

Account #: _____

PLEASE PRINT

Date _____ Referred by _____

Patient Name _____ E-mail _____

Home Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Preferred Method of Notification: ☐ Patient Portal ☐ Cell Phone ☐ Home Phone ☐ Mail ☐ Other _____

Date of Birth _____ Age _____ Sex: ☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ D ☐ W

Social Security # _____ Drivers License # _____ Exp. Date _____

Patient's Employer _____ Occupation _____

Is Today's Visit Work Related? ☐ Yes ☐ No If Yes, Date of Injury _____

Emergency Contact _____ Relationship _____ Phone _____

IF PATIENT IS A MINOR

Father's Name _____ Employer _____

Work Phone _____ Cell Phone _____ Social Security # _____

Mother's Name _____ Employer _____

Work Phone _____ Cell Phone _____ Social Security # _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Company _____

☐ HMO ☐ PPO Co-Pay _____ Deductible _____

Name of IPA: ☐ Seaview ☐ Kaiser Other _____

Primary Care Physician _____

Subscriber's Name _____

ID # _____ Group # _____

Birthdate _____ Social Sec. # _____

Subscriber's Relationship to Patient _____

Subscriber's Employer _____

SECONDARY INSURANCE

Insurance Company _____

☐ HMO ☐ PPO Co-Pay _____ Deductible _____

Name of IPA: ☐ Seaview ☐ Kaiser Other _____

Primary Care Physician _____

Subscriber's Name _____

ID # _____ Group # _____

Birthdate _____ Social Sec. # _____

Subscriber's Relationship to Patient _____

Subscriber's Employer _____

AUTHORIZATION FOR TREATMENT/ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I HEREBY AUTHORIZE EXAMINATION AND TREATMENT OF THE PATIENT NAMED ABOVE.

I HEREBY AUTHORIZE THE DIRECT PAYMENT TO GSMGVC OF ANY INSURANCE BENEFITS OTHERWISE PAYABLE TO, OR ON BEHALF OF, THE PATIENT FOR ANY MEDICAL REASON AND/OR SURGICAL EXPENSES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THESE CHARGES.

I HEREBY AUTHORIZE GSMGVC TO RELEASE TO MY INSURANCE COMPANY ANY INFORMATION ACQUIRED IN THE COURSE OF MY CARE TO ALLOW THEM TO PROCESS ANY CLAIMS FOR MEDICAL AND/OR SURGICAL SERVICES.

_____ _____ _____

Responsible Party Signature | Date | Responsible Party Name (Please Print)

Acknowledgement of Receipt of Notice of Privacy Practices

General Surgery Medical Group of VENTURA COUNTY

1700 N. Rose Avenue
Suite 430
Oxnard, CA 93030
phone: 805.485.8722
fax: 805.485.9311

168 N. Brent Street
Suite 506
Ventura, CA 93003
phone: 805.653.6580
fax: 805.653.6687

117 Pirie Road
Suite E
Ojai, CA 93023
phone: 805.485.8722
fax: 805.485.9311

2460 N. Ponderosa Drive
Suite #A 117
Camarillo, CA 93010
phone: 805.485.8722
fax: 805.485.9311

415 Rollin Oaks Drive
Suite #220
Thousand Oaks, CA 91361
phone: 805.485.8722
fax: 805.485.9311

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the office, and that I will be offered a copy of any amended Notice of Privacy Practices.

_____ _____
Signature Date

_____ _____
Print Name Telephone Number

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____

GENERAL SURGERY MEDICAL GROUP OF VENTURA COUNTY

OFFICE AND FINANCIAL POLICY

Please be assured that the physicians and staff of this practice are dedicated to providing medical care of the highest quality possible to all of our patients, in an atmosphere of caring, trust and mutual respect.

Your complete understanding of your financial responsibilities is essential; it takes a team that includes patient participation, to succeed with insurance processing and reimbursement. Failure by the insurance company to pay, results in the balance being transferred to the patient for payment. We thank you in advance for taking the time to review these policies. Please feel free to discuss any concerns or questions you may have with anyone of our billing staff or our practice manager. Although it is ultimately the patient's responsibility to understand the benefits of their own health plan, we would welcome the opportunity to assist you in your understanding the complexities of health insurance today.

Things to bring with you to your initial visit:

- Current Health Insurance Card(s) -If we do not have a copy of your current insurance card(s), you may be asked to pay up front for the visit, or reschedule to such a time that we have proof of your eligibility and coverage.
- Photo ID -This assists us in verifying identity and protecting patients against medical identity theft/fraud.
- Method of payment – Co-pays, deductibles, and other applicable out of pocket expenses are due at the time of service. If you do not have a method of payment, your appointment will be rescheduled. For your convenience, we accept checks, credit cards, debit cards and cash.

Cash Pay/Fee for Service:

- We offer a reasonable discount for our cash pay/fee for service patients who have no health insurance coverage in any form. Prior to your visit, you will be provided an estimate of the visit cost and will be required to pay in full at time of check in on the day of your appointment. In the event the physician carries out additional procedures/tests, you will be required to pay for these at the time of check out.

Co-pays, Deductibles, and Co-Insurance:

- We are obligated to collect the co-pay at the time of your visit, even if you are sick. We are required to do so by your insurance plan. The co-payment amount is determined by your individual insurance policy.
- Some insurance plans require that patients pay a predetermined dollar amount prior to services being covered. If verification of your deductible is unable to be made, payment of the full deductible is due at time of service.

Patient Responsibility:

- It is the patient's responsibility to know and understand their insurance plan benefits, and what services their plan will and will not cover, as well as verify provider network participation.
- It is the patient's responsibility to provide current and correct insurance information. Failure to do so may result in inability to collect from the insurance company, and the balance will be the patient's financial responsibility.

Insurance:

- We are contracted with multiple insurers to accept assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the authorized co-payment, co-insurance and deductible at the time of service.

Out of Network:

- If you have insurance coverage under a plan with which we do not have a contract, this is be considered OUT OF NETWORK and claims will be processed accordingly. We try our best to determine ahead of time if we are out of network with your plan, but it is ultimately the patient's responsibility to verify network participation and out of network benefits ahead of time. We will bill the insurance company as a courtesy to you, however payment in full will be required at the time of service.

HMO Insurance:

- If you are enrolled in an **HMO Plan** (including Medi-Cal HMO Plans such as *Gold Coast Health Care Plan*, or *Clinicas Del Camino Real)* a referral from your Primary Care physician is required. It is the patient's responsibility to verify that a referral is in place before the visit.

Medicare:

- Please make sure you have a full understanding of your Medicare benefits and what might be your responsibility if not covered by Medicare. We ask patients to sign an ABN whenever Medicare appears likely to deny payment for a specific service. Medicare requires that we provide patients with a written notification whenever it is likely that you will be responsible for the bill.

Medi-Cal:

- Eligibility is verified on a month-to-month basis. Please ensure that you bring your Medi-Cal card to every visit. In the event you do not bring your card, your visit may need to be re-scheduled until such a time that we have proof of your Medicaid eligibility and coverage.

Outstanding balances/ Collections:

- Prior to providing additional services to patients, payment in full of total outstanding balances will be required.
- We will make every effort to work with patients regarding outstanding balances and arranging payment plans when appropriate. It is the patient's responsibility to request assistance if they are unable to pay promptly. Unpaid balances that are greater than 90 days old will be referred to an outside collection agency.

Miscellaneous Fees:

- We may use an outside service to copy your records that you request. You may be charged for copies of medical records as per State and Federal guidelines. These charges cover the administrative costs of copying and mailing such records.
- There is a charge of $10 for most Disability forms (with the exclusion of State Disability Insurance Forms), payable prior to these forms being completed. Please allow the office 10 business days in which to review your medical record for the information requested, to be completed, copied and mailed or faxed.
- There is a $25.00 fee for all returned checks.

Refunds:

- Refunds are issued to the appropriate party. Patient refunds will not be processed until all active or past due charges are paid in full.

Cancellation Policy:

- As a courtesy to our surgeons and other patients, we require at least 72-hour notice to cancel surgeries and procedures. This allows us time to work with the hospital/surgery center and schedule other patient(s) in that time slot. We appreciate your consideration.

General Conduct:

- We treat our patients and their families with respect and concern at all times. Our physicians and staff expect to be treated with respect at all times. Threats of any kind, whether they be physical, verbal or written, will represent cause for immediate discharge of the patient involved. Foul language, intimidating behavior or aggressive body language will not be tolerated by anyone at any time in this office. Patients are held responsible for the behavior of any family member or friend who accompanies them to this office.

You may address any questions or concerns regarding our office and financial policy to our office manager during regular business hours. By signing below, you signify that you have read, understand, and agree to the Office and Financial Policies of General Surgery Medical Group.

Patient Name	Signature	Date

General Surgery Medical Group
VENTURA COUNTY

Surgery Scheduling and Cancellation Policy

Thank you for choosing General Surgery Medical Group as your health care provider. We are committed to providing you with the highest standard of care, and we will make every effort to ensure that your experience exceeds your expectations. You may be scheduled to undergo a surgical procedure. Please read the following information carefully, as your clear understanding of this process and our policies are important.

Surgery Scheduling: You will be contacted by our office to discuss and schedule this procedure within one week from your consultation. Our office will contact your insurance carrier prior to scheduling the procedure and will obtain any necessary prior authorizations or referrals on your behalf, as well as verify your benefits and coverage. It is our policy to collect any anticipated out of pocket expenses (for surgical services only- does not include hospital or other charges), including deductibles and co-insurance, at least 3 days prior to surgery.

Preparing for Surgery: Once you have been scheduled for surgery, you will be mailed a packet with the details of your surgery, as well as any pre-operative work up you may need. If you are required to undergo any pre-operative testing prior to your surgery, including bloodwork, EKG, x-rays and/or surgical clearances, it is your responsibility to schedule all appointments for required pre-operative testing or appointments. All testing and/or clearances must be received by our office at least 24 hours prior to the scheduled surgical date. If you are unable to have any of the recommended testing performed within this timeframe, you are asked to contact our office immediately. Failure to comply with this policy may result in a cancellation of your surgical procedure.

Cancellations: Our office will require at least 3 business days of notice for cancellation of any surgical procedure. We realize that certain circumstances may prevent you from keeping your surgical appointment, and you are asked to give our office as much notice as possible to cancel or reschedule a surgical appointment. If you fail to provide our office with at least 3 business days of notice to cancel or reschedule your surgery, you may be charged a $100.00 cancellation fee. This fee will be charged to you in the event of a last-minute cancellation and is due within 30 days of the cancellation.

Insurance Billing: Following your procedure, we will bill your insurance company for any surgical services rendered. Please be advised that you are responsible for any balance due as part of your contract with your insurance company. If you should have questions or concerns regarding your out-of-pocket expenses, please contact the customer service department of your insurance company. The telephone number should be listed on the back of your insurance card.

We thank you for your understanding and cooperation with our office policies and appreciate the opportunity to participate in your medical treatment.

I have read and understand the above surgical scheduling and cancellation policy.

Patient Name *(please print)* Date Patient's Signature

General Surgery Medical Group of Ventura County

Patient Name _____ Date of Birth _____ Age _____

Today's Date_____ Primary Doctor_____

Instructions: **Please complete the following information about your past and present health. You may give your best guess for dates. Please fill out *both sides* of the sheet.**

Preferred Method of Notification:

☐ **Patient Portal** ☐ **Cell Phone** ☐ **Home Phone** ☐ **Mail** ☐ **Other** _____

Medical Problems: Examples include diabetes, hypertension, heart disease, lung disease, cancer.

_____

_____

_____

_____

Previous Surgeries: Examples include appendectomy, hysterectomy, gallbladder, breast biopsy, etc.

	Date (Approximately)
_____	_____
_____	_____
_____	_____
_____	_____

Medications: Note those taken on a regular basis including aspirin, ibuprofen, etc. Please record name, dosage, and how often taken.

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy Name_____ Address _____

Allergies to Medication: Examples include penicillin, codeine, sulfa, morphine, demerol, aspirin. Note the type of reaction: rash, vomiting, swelling, or "life threatening" for each allergy.

_____

_____

Race: ☐ White ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American
☐ American Indian/Alaska Native ☐ More than 1 race ☐ Refuse to Report

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Refuse to Report

Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ Japanese ☐ Other

Please continue on the back side....

Family History (note any serious health problems such as cancers, heart attacks, strokes, diabetes, etc.)

Mother:

_____

_____

Father:

_____

_____

Siblings:

_____

_____

Social History

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation _____

Do you smoke? ☐ Yes ☐ No Previous smoker? ☐ Yes ☐ No

How many packs per day? ☐ < 1 ☐ 1 - 2 ☐ 3+

How many years have you smoked? _____

Did you smoke in the past? _____

Do you drink alcohol? ☐ Yes ☐ No

Drinks per day: ☐ 0 ☐ < 2 ☐ 2 - 3 ☐ >4

Systems Review

(questions about your health in recent months)

General

Are you feeling more tired or exhausted?	☐ Yes ☐ No
Have you lost weight lately without dieting?	☐ Yes ☐ No
Any problems with drug or alcohol abuse?	☐ Yes ☐ No
Are you HIV+ or think it is a possibility?	☐ Yes ☐ No

Cardiovascular

Do you have episodes of pain, tightness, or pressure in your chest?	☐ Yes ☐ No
Do you have frequent sensations of your heart skipping beats or racing?	☐ Yes ☐ No
Do you get short of breath easily?	☐ Yes ☐ No
Are your ankles often swollen?	☐ Yes ☐ No

Urinary

Do you have painful, urgent or frequent urination? (circle all that apply)	☐ Yes ☐ No
Have you had blood in the urine?	☐ Yes ☐ No

Respiratory

Do you have asthma or other chronic lung disease?	☐ Yes ☐ No
Do you have a frequent or persistent cough?	☐ Yes ☐ No
Have you coughed up blood?	☐ Yes ☐ No

Gastrointestinal

Do you have frequent episodes of upper abdominal pains or upset stomach?	☐ Yes ☐ No
Have you noticed black or bloody stools?	☐ Yes ☐ No

Musculoskeletal

Do you often have pain in your shoulders, hips or knees?	☐ Yes ☐ No
Do you suffer from chronic back or neck pain?	☐ Yes ☐ No

Neurologic

Are you having fainting or blackout spells?	☐ Yes ☐ No
Have you suffered a stroke or transient ischemic attack (TIA)?	☐ Yes ☐ No

Psychiatric

Do you have any mental problems?	☐ Yes ☐ No

Circle all that apply: severe depression, extreme anxiety, or panic attacks.

Hematologic

Do you take blood thinning medication including aspirin?	☐ Yes ☐ No
Have you been told you have a bleeding disorder?	☐ Yes ☐ No
Have you ever been treated for venous blood clots?	☐ Yes ☐ No

Vision

Have you had a loss of eyesight in one or both eyes?	☐ Yes ☐ No
Have you been treated for glaucoma or cataracts?	☐ Yes ☐ No