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)

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

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

555 Marin Street, Suite 270
Thousand Oaks, CA 91360
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
VENTURA COUNTY

To Our Patients:

We are pleased to announce that **General Surgery Medical Group's** new **Follow My Health Portal** is now available. This online tool gives you the flexibility to access your health information and other resources on your time and between visits to the office. The **Follow My Health Portal** is available over the Internet, which means that you can use it from virtually anywhere. You can log on through your existing account with Yahoo, Google, Facebook or Microsoft.

As a patient of **General Surgery Medical Group**, enrolling in the **Follow My Health Portal** will allow you to:

- Download pre-surgery instructions
- Download post-op instructions
- Securely Message with our Office
- Request Appointments
- Submit Payments (coming soon)
- Review Your Lab Results
- Update Personal Information
- Request Prescription Renewals
- See Visit History and Discharge Information

The **Follow My Health Portal** is completely secure, so you can be confident that your private information is protected. Only you – or an authorized family member – can access your **Follow My Health Portal**.

We hope this new tool will help you take an active role in your healthcare. For more information, including enrollment details, please visit our website at **www.mygeneralsurgeon.com**(under Patient Login) or respond to the invitation to register that will be emailed to you shortly. Please be sure to check your SPAM folder if you do not receive the invitation in your in-box.

Sincerely,

The Physicians and Staff of
General Surgery Medical Group

NOTICE OF PRIVACY PRACTICES

1700 N. Rose Avenue, Suite 430, Oxnard, CA 93030

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer.

A. How This Medical Practice May Use or Disclose Your Health Information

The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or following your death.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires for payment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign-in Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in., We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life-threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

11. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to dis-

close your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

18. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

19. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the bottom of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website: www.mygeneralsurgeon.com

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed below:

Privacy and Security Officer:
Nancy Kennedy • 1700 N. Rose Avenue, Suite 430, Oxnard, CA 93030 • (805) 485-8722

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office of Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Phone: (415) 437-8310 • TDD: (415) 437-8311 • Fax: (415) 437-8329 • e-mail: OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

Revised 09-23-2013