Thousand Oaks Surgery Center
1120 Newbury Rd, Suite 100
Thousand Oaks, Ca. 91320

Date_____

PATIENT INFORMATION

Name_____ Social Security No._____

Home Address _____ City_____ State/Zip_____

Home Phone_____ Cell_____ D/L # _____

Employer _____ Occupation_____

Work Address_____ City_____State/Zip _____

Work Phone_____ Email _____

Gender ☐ M ☐ F Age_____ DOB_____ ☐Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact _____ Relationship_____

Phone # Home _____ ☐ Cell _____ ☐ Work _____

Do you have an Advance Directive for Healthcare? ☐ Yes ☐ No

Do you have a copy with you? ☐ Yes ☐ No

Referred to this Office by _____

Please Circle (*optional Survey Data*)

Race: American Indian Asian Black or African American Caucasian Other

Ethnicity: White Hispanic/Latino Other

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PRIMARY INSURANCE

Insurance Company Name _____ Subscriber #_____ Group #_____

Address _____City_____State/Zip _____

Name of Subscriber (*if other than Patient*) _____ Relationship_____

Subscribers Date of Birth_____

PLEASE SUBMIT YOUR INSURANCE CARD AND PICTURE ID WITH THIS FORM, SO WE MAY MAKE A COPY.

SECONDARY INSURANCE

Insurance Company Name _____ Subscriber #_____ Group #_____

Address _____City_____State/Zip _____

ASSIGNMENT OF INSURANCE BENEFITS

I CERTIFY THAT I HAVE INSURANCE COVERAGE WITH THE ABOVE INSURANCE CARRIER(S) AND HEREBY AUTHORIZE THOUSAND OAKS SURGERY CENTER TO RELEASE TO THE CARRIER(S) ANY INFORMATION THAT IS NECESSARY TO OBTAIN INSURANCE BENEFITS. I ASSIGN TO THOUSAND OAKS SURGERY CENTER ALL MY RIGHT, TITLE, AND INTEREST IN AND TO ANY AND ALL HEALTHCARE AND/OR SURGICAL BENEFITS OTHERWISE PAYABLE TO ME FOR ANY MEDICAL TREATMENT, RENDERED BY THOUSAND OAKS SURGERY CENTER AS DESCRIBED IN THE ATTACHED MEDICAL CLAIM FORM. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE** FOR ALL CHARGES INCURRED, WHETHER OR NOT PAID BY INSURANCE AND AGREE TO PAY ANY APPLICABLE DEDUCTIBLE AND CO-PAYMENT AMOUNT NOT COVERED BY MY INSURER, PLAN OR PAYER.

I UNDERSTAND THAT MY INSURANCE COMPANY MAY ISSUE A CHECK FOR SERVICES PROVIDED BY THOUSAND OAKS SURGERY CENTER TO MY SELF OR POLICY HOLDER. AS PART OF THIS ASSIGNMENT I AUTHORIZE THE PROVIDER TO ENDORSE ANY CHECK MADE PAYABLE TO THE PROVIDER AND TO MYSELF FOR SERVICES RENDERED. IN ADDITION, I AGREE TO ENDORSE ANY INSURANCE CHECK SENT TO ME BY MY INSURANCE CARRIER FOR SERVICES RECEIVED AND FORWARD TO THOUSAND OAKS SURGERY CENTER (***WITHIN 10 DAYS UPON RECEIPT OF SUCH CHECK***).

IF I DEPOSIT SUCH A CHECK INTO MY PERSONAL ACCOUNT, I AGREE TO SEND THOUSAND OAKS SURGERY CENTER A PERSONAL CHECK FOR THE EQUIVALENT AMOUNT. FAILURE TO REMIT PAYMENT WITHIN THE GIVEN TIME FRAME CAN RESULT IN COLLECTIONS EFFORTS BY THE PROVIDER, OUTSIDE COLLECTIONAGENCY, AND/OR LEGAL ACTION.

Signed_____ Date_____

Print Name_____

If not signed by Patient please circle: Parent (for a minor) Guardian Minor/Other Spouse Beneficiary/ Personal Representative

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Patient Name_____ DOB_____Date_____

AGE_____ Approximate HEIGHT _____ Approximate WEIGHT _____ □ Male □ Female

SYMPTOMS: Check (√) symptoms you currently have or have had in the past:

General
□ Chills
□ Dizziness
□ Fainting
□ Fever
□ Headache

Skin
□ Bruise easily
□ Itching
□ Rash
□ Scars
□ Sores that don't heal

Urinary
□ Blood in Urine
□ Frequent Urination
□ Lack of Bladder Control
□ Painful Urination

Cardiovascular
□ Chest Pain
□ High Blood Pressure
□ Irregular Heart beat
□ Swelling of ankles
□ Varicose Veins
□ Low Blood Pressure

Eye, Ear, Nose, Throat
□ Bleeding Gums
□ Difficulty Swallowing
□ Earache
□ Hoarseness
□ Persistent Cough
□ Sinus Problems

Gastrointestinal
□ Bowel Changes
□ Nausea
□ Rectal Bleeding
□ Stomach Pain

Women Only
□ Inter-Period Bleeding
□ Breast Lump
□ Extreme Menstrual pain
□ Other
□ Abnormal Pap Smear

Date of last Menstrual Period

_____

No of Children _____

CONDITIONS: Check (√) conditions you currently have or have had in the past year

□ Alcoholism
□ Anemia
□ Arthritis
□ Asthma
□ Bleeding Disorders
□ Bronchitis
□ Cancer
□ Chemical Dependency
□ Diabetes
□ Emphysema
□ Epilepsy
□ Glaucoma
□ Goiter
□ Gout
□ Heart Disease
□ Hepatitis
□ High Cholesterol
□ HIV Positive
□ Kidney Disease
□ Liver Disease
□ Migraine Headaches
□ Mononucleosis
□ Pacemaker
□ Pneumonia
□ Prostate Problem
□ Rheumatic Fever
□ Stroke
□ Thyroid Problem
□ Tuberculosis
□ Ulcers
□ Vaginal Infections
□ Other

PAIN □ NO □ YES **Scale** (0-10) _____

Medications & Over the Counter Medications including Herbs (*Must include dosage and frequency*)	**Allergies**

□ **Blood Transfusion** □ **Tobacco**

Major Hospitalizations (Hospital & Outcomes)	**Surgery/Serious Illness/Injuries (Date and Outcome)**

I certify the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____**DATE** _____

Signature □ Patient □ Parent/Guardian □ Representative

Reviewed by Physician _____ DATE _____

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DISCLOSURE NOTICES

Patients Rights:

In recognition of the responsibility of this Center in the rendering of patient care and our commitment to high standards of quality professional care, these rights and responsibilities are affirmed as the policies and practices of Thousand Oaks Surgery Center.

1. Patients may exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation, marital status, or the source of payment for care. These rights also apply to adolescent patient and their parent/guardian.
2. Patients have the right to considerate and respectful care, with consideration given to the psychosocial, spiritual and cultural variables that influence the perception of illness.
3. Patients have the right to receive as much information about any proposed treatment or procedure as the patient may need in order to make an informed consent or to refuse treatment. This information shall include a description of the procedure or treatment and the medically significant risks involved in the treatment, expected benefits, alternate courses of treatment or non treatment, and the risk involved in each and to know the name of the person who will carry out the procedure or treatment.
4. Patients or his/her representative have the right to actively participate in the development and implementation of his/her plan of treatment allowing his/her to make informed decisions as to the treatment. To the extent permitted by law, this includes the right to refuse treatment and to be informed of medical consequences of such refusal. This right must not be construed as a mechanism to demand the provision of treatment or services to be deemed medically unnecessary or inappropriate.
5. Patients have the right to choose their own physicians.
6. Patients have the right to privacy concerning the medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discretely. The patient has the right to be advised as to the reason for the presence of any individual.
7. Patients have the right to confidential treatment of all communications and records pertaining to the care and stay at *Thousand Oaks Surgery Center.* Written permission shall be obtained before the medical records can be made available to anyone not directly concerned with the care.
8. Patients have the right to a response to any reasonable request made for service within *Thousand Oaks Surgery Center's* capacity and mission.
9. Patients have the right to refuse treatment to the extent permitted by law and are informed of the medical consequences of such refusal. The patient accepts responsibility for his/her actions should he/she refuses treatment or not follows the instructions of the physician or facility.
10. Patients have the right to reasonable continuity of care and to know, in advance, the time and location of their procedure as well as the identity of persons providing the care.
11. Patients have the right to be informed of continuing healthcare requirements following discharge.
12. Patients have the right to examine and receive an explanation of bill, regardless of source of payments.
13. All patients' rights apply to the person who may have legal responsibility to make decision regarding medical care on behalf of the patient.
14. Patients have the right to designate visitors of his/her choosing in accordance with our Centers policy.
15. Patients, or designated representative, have the right to participate in the consideration of the ethical issues that a rise in the care of the patient.
16. Patients have the right to be informed of the mechanism for the review and resolution of concerns regarding the quality of care.
17. Patients and/or their legal representative have access to the information contained in the medical record. Written permission will be obtained before medical records can be made available to anyone not directly concerned with their care. Picture ID will be required upon arrival.
18. Patients have the right to reasonable access to care.
19. Patients have the right to access protective services.

20. Each Patient or, when appropriate, the patients representative will be given a written copy of the patients rights in advance of furnishing or discontinuing patient care whenever possible.
21. Patients have the right to participate in the development and implementation of his plan of care.
22. Patients have the right to appropriate assessment and management of pain.
23. Patient has his/her right to personal privacy.
24. Patient or his/her representative has the right to make informed decisions regarding his /her care. The patients rights include being informed of his her health status, being involved in care planning and treatment, and being able to request or refuse treatment
25. The patient will be free from any act of discrimination or reprisal.
26. If a patient is adjudged incompetent under applicable state laws by a court of a proper jurisdiction, the rights of the patient are exercised by the person appointed under state law to act on the patients behalf.
27. If a state court has not adjudged a patient incompetent, any legal representative or surrogate designated by the patient in accordance with state law may exercise the patient's rights to the extent allowed by state law.
28. The patient will be free from all forms of abuse or harassment.
29. Patients have the right to the confidentiality of his/her clinical record(s).
30. Patients have the right to access information contained in his/her clinical records within a reasonable time frame.

PATIENT RESPONSIBILITIES:

1. To work with your healthcare team and to follow all safety rules.
2. To show respect and consideration to our staff, and to other patients and visitors.
3. To respect the privacy of other patients.
4. To give your healthcare team complete and correct information to the best of his/her ability about health, any medications, including over the counter products and dietary supplements, and any allergies or sensitivities.
5. To tell your Doctor about any changes in your health after you leave our facility.
6. To keep, or cancel your appointments for your healthcare.
7. To tell your healthcare team if you wish to change any of your decisions.
8. To ask for clarification if information or instructions are not understood.
9. Inform his/her provider about any Advance Directive and provide a copy at admission.
10. To accept personal financial responsibility for any charges not covered by his/her insurance.
11. Provide transportation by a responsible adult to take him/her home from the facility and remain with him/her for 24 hours, if required by his/her Physician.
12. Follow treatment plan prescribed by his /her provider and participate in his/her care.

COMMENTS ABOUT THE CARE YOU RECEIVED:

If you have a comment, complaint or grievance about the quality of care or services received, we would like to hear from you. Please contact our patient advocate, Kelly Kapp at 1120 Newbury Rd, Thousand Oaks Ca. 91320 (805-230-3100)

Complaints and grievances can be filed with any of the following:

Medical Board of California Central Complaint Unit 2005 Evergreen Street, Suite 1200 Sacramento, CA 95815 http://www.mbc.ca.gov 800-633-2322 916-263-2424	Accreditation Association for Ambulatory Healthcare 5250 Old Orchard Rd, ste 200, Skokie, Ill 60077; 847-853-6060 www.AAAHC.org	Office of the Medicare Beneficiary Ombudsman www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html 877-486-2048

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NOTICE OF PRIVACY PRACTICES:

The Health Insurance Portability & Accountability Act of 1966 (HIPPA) requires all health records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally to be kept confidential. This Federal Law gives you, the patient, significant new rights to understand and control how your health information is used. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information, and how we may use and disclose your health information. You have the right to file a formal written complaint with us or with the Department of Health and Human Services, Office of Civil Rights, 200, Independence Ave., South Washington, DC. 20201 Phone: 877-696-6775, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

ADVANCE DIRECTIVES:

An Advance Directive refers to your written instructions about your future medical care, in the event you become unable to speak for yourself. There are two (2) types of Advance Directives: A living will and a medical power of attorney. If you would like a copy of the official state Advanced Directive forms you may download them from wwwcalhealth.org. or a copy is available to you upon request.

Please be advised, based on reasons of organization conscience, Thousand Oaks Surgery Center, will initiate all reasonable efforts to revive a patient should a medical emergency occur, including resuscitative or other stabilizing measures, regardless of the contents of any advance directive/living will/health care proxy or instructions from a healthcare agent. The center will ensure that patients are fully informed of this policy prior to receiving any care. We will provide patients with information on applicable State health and safety laws relative to advance directives/living wills.

OWNERSHIP/ FINANCIAL INTEREST:

Please be advised that these Physician's have a financial interest in Thousand Oaks Surgery Center LLC.
Alexander P. Hersel MD
Bradley Spiegel MD
Anthony Virella MD
Brooke Gifford DPM
Michael Vercillo MD
Gary Pattee MD
Jeffrey Feinfield MD

_____ DATE_____ TIME_____
Print Name (Patient)

_____ _____
Signature Patient Staff Signature

Patient Name: _____ Date of Surgery: _____

Advance Directive

_____I have an Advance Directive. YES___ NO ____ I would like information on Advance Directive. YES_____ NO ____

_____I brought a copy of my Advance Directive and gave a copy to Thousand Oaks Surgery Center. YES _____ NO _____

PATIENT FINANCIAL AGREEMENT

PROPOSED PROCEDURE(S):

We would like to share the following policies with you so that you understand your responsibilities regarding charges for the service rendered to you by this facility.

Patients who cancel less than 48 hours prior to their procedure (or are a NO show) will be charge **$100.**

A Tuesday surgery must be cancelled before 5pm on the Friday prior to the procedure.

There will be no exceptions for the late cancellation, i.e. illness, work- related, etc. Your Surgery costs include physician and anesthesiologist's time, nursing staff, supplies ordered for your visit, and the time reserved for you, during which no other patients can be booked for appointment and/or surgical procedures.

You the Patient are also responsible for other associated fees that may include anesthesia, professional, lab and prescriptions. Surgery fees are payable to the surgery center and billed separately through a billing agency.

Thousand Oaks Surgery Center, LLC will bill your Insurance for the facility fees. Patient is responsible for his/her deductible, if not met prior to billing for facility fees. If your Insurance carrier fails to pay for services within 90 days, you will be notified about the unpaid charges and asked to contact your Insurance carrier to help collect payment for your procedure. *In the event any charges are uncollectible from your Insurance carrier we will balance bill you for the remaining balance (after we have received a denial from your Insurance carrier)*. Thousand Oaks Surgery Center, LLC will work with you on amounts that are owed in the event this should happen.

There will be two (2) or three (3) separate charges for your procedure. If you are having anesthesia there will be a charge from the anesthesiologist. There will be a charge for the facility. There will also be a professional charge from the doctor and possible pathology fees.

We would be glad to try and help answer any questions you may have regarding co-insurance; however, since there are multiple insurance plans it is advisable that you contact your Member Services Department with you Insurance carrier to obtain this information.

I, _____, understand that the fees are for performance of the procedure(s) outlined, and are being done in OUT OF NETWORK FACILITY with all insurance companies (except Medicare and Some HMO's). I am choosing to use my out of network benefits and NOT for a guaranteed result. If additional procedures are added on the day of the surgery, or if re-operation is necessary, there may be additional charges.
I have read, understand and agree to the terms of this agreement.

_____ Date: _____
Signature □ *Patient* □ *Parent/Guardian* □ *Representative*

_____ _____ _____
Staff Witness Signature Print Name Date

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Member Authorization Form for a Designated Representative to Appeal a Determination

To: **Insurance Carrier**

Date: _____

Member Name: _____

Member Insurance ID Number: _____

I hereby authorize: _____ to appeal Insurance Carriers determination concerning_____

_____

on my behalf, as my Designated Representative, and as a part of the appeal. I hereby authorize Insurance Carrier in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative in all aspects of the appeal. I understand that these communications may contain the following:

> All medical and financial information contained in my insurance file, including but not limited to treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder and HIV status relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed.

I understand this information is privileged and confidential and will only be released as specified in this Authorization, or as required or permitted by law. This authorization is valid for a period of one year.

_____
Signature of Member or Legal Guardian/Representative

_____
Signature of Witness_____ **OR** Designated Representative_____

_____
Print Name of Witness/Designated Representative

_____
Title (if on Providers staff) **OR** Relationship to Member

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The undersigned certifies:

_____I have received a copy of the Patients Rights.
My Responsibilities as a Patient.
Grievance procedures: In addition, I have been informed that any grievance will be appropriately investigated and I will receive a written response within 30 days.

_____I have received notice on The Policy of Thousand Oaks Surgery Center regarding Advance Directives.

_____I have an Advance Directive. YES___ NO ____ I would like information on Advance Directive. YES_____ NO ____

_____I brought a copy of my Advance Directive and gave a copy to Thousand Oaks Surgery Center.

YES _____ NO _____ Comment _____

_____I received notification of Ownership and Financial Interest.

_____I have received Notification that Thousand Oaks Surgery Center is an Out of Network provider and that my Insurance may send the reimbursement check to me the patient. I understand that this payment is to be endorsed and the attached EOB (explanation of Benefits) will be mailed or brought to Thousand Oaks Surgery Center upon receipt.
I understand that My Insurance Company notifies Thousand Oaks Surgery Center when the check has been mailed to me.

_____ I also understand that if I receive the payment from my Insurance Company and I deposit these check(s) I will be Fully Responsible for the check(s) and amount as well as any associated legal fees incurred to collect this money.

_____I understand that my Insurance contract is between my insurance company and myself.

_____I understand I am responsible for all Payments due to Thousand Oaks Surgery Center for my procedure that my Insurance does Not cover.

_____ **DATE** _____

Print: Patient/Representative Name

_____ **Relationship**_____

Signature: □ Patient, □ *Parent/ Guardian* □ *Representative*

INSURANCE INFORMATION FOR OUT-OF-NETWORK PATIENTS

Thousand Oaks Surgery Center is a Non-Contracted Facility with your Insurance Carrier.

All patients seen at the Thousand Oaks Surgery Center will be receiving an EOB (Explanation of Benefits) from your Insurance Carrier.
This EOB clearly states

THIS IS NOT A BILL!

Thousand Oaks Surgery Center will not penalize you for using us, a Non-Contracted Facility.

If you have further questions after receiving your EOB, please feel free to contact the center's Business Office ' Virtuoso Medical Management' at 805-367-7522.

This will reassure you of your financial responsibility with Thousand Oaks Surgery Center

Thank you for choosing Thousand Oaks Surgery Center.
Management & Staff