Main Office
23456 Hawthorne Blvd.
Suite 300
Torrance, CA 90505
(310) 539-2055

Endoscopy Center
23560 Madison St.
Suite 109
Torrance, CA 90505
(310) 325-6331

Jerome Cohen, M.D.
Alexander Nguyen, M.D.
Oren Zaidel, M.D.
Daniel D. Cho, M.D.
Minh Q. Nguyen, M.D.
Wendy Ard, PA-C
Tonny Lee, M.D.
Gloria Sze, M.D.
Mary Ahmadian, N.P.
Melissa Munsell, M.D.
Tram Tran, M.D.
Jung Li, N.P.

Patient Information

Please complete this form in its entirety to allow us to serve your health care needs. The information is strictly confidential and will not be released unless you authorized us to do so or if required by law.

Name _____ Date of Birth _____

Social Security #* _____ Sex ☐ M ☐ F Marital Status ☐ S ☐ M ☐ D ☐ W

Address _____ Home Phone _____

City _____ State _____ Zip _____ Work Phone _____

Email Address _____ Cell Phone _____

Preferred method of contact: ☐ Email ☐ Cell ☐ Home ☐ Text

Referring Physician _____ Phone _____

Primary Care Physician _____ Phone _____

Reason for Referral _____

Emergency Contact _____ Relation _____ Phone _____

Name of Primary Insurance _____

Insurance Address (from card) _____

Subscriber Name _____ Subscriber Date of Birth _____

Subscriber Social Security #* _____ Relationship to You _____

ID# (from card) _____ Group # (from card) _____

Employer (of insured if it is not you) _____

Name of Secondary Insurance _____

Insurance Address (from card) _____

Subscriber Name _____ Subscriber Date of Birth _____

Subscriber Social Security #* _____ Relationship to You _____

ID# (from card) _____ Group # (from card) _____

RACE: ☐ WHITE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ OTHER

ETHNICITY: ☐ HISPANIC OR LATINO ☐ NON-HISPANIC OR LATINO

Preferred Language: ☐ ENGLISH ☐ OTHER _____

Signature of Patient _____ Date _____

As a Centers for Medicare/Medicaid Services and Electronic Health Records certified user, South Bay Gastroenterology is required to collect federal data on race and ethnicity, Statistical Policy Directive No. 15, as revised October 30, 1997 (see "Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity" available at http://www.whitehouse.gov/omb/fedreg_1997standards).

*The collection of Social Security number information is to assist with positive identification of patients and to assist with billing and billing to insurance.

PATIENT HISTORY FORM

Patient Name: _____ **Phone #:** _____

Date of Birth: _____ Age: _____

Occupation: _____

Marital Status: _____

Weight: _____ lbs Height: _____ ft _____ in

Reason for visit today: _____

Family History of cancer and hereditary disorders:

Father _____ age diagnosed or if deceased _____

Mother _____ age diagnosed or if deceased _____

Brother/Sister _____ age diagnosed or if deceased _____

Son/Daughter _____ age diagnosed or if deceased _____

Tobacco ☐ Never used tobacco

Current use: _____ packs per day

Prior use: Quit _____ months / years ago?

Alcohol ☐ Never used alcohol

Current use: _____ drinks per day _____ drinks per week

Prior use: Quit _____ months / years ago? ____ drinks per week

Recreational/Illegal Drugs ☐ Never used recreational/illegal drugs

Currently using: _____ How often? _____ Last used: _____

Previously used: _____ When? _____

Past Medical History: Illness / Surgeries

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Past colonoscopy ☐ Yes ☐ No Results: _____, last colonoscopy date: _____

Past endoscopy ☐ Yes ☐ No Results: _____, last endoscopy date: _____

Current Medications including Drug Name, dosage and how often taken

Medication Name	Dose	Frequency	Reason	Last Taken	Instructions
1.					
2.					
3.					
4.					
5.					
6.					

Pharmacy Name: Address: Phone #:

Allergic reaction to medication and other substances such as food and latex, include name and reaction:

1. _____
2. _____
3. _____

HEALTH QUESTIONNAIRE

Please complete both sides of this form and return it to our office. We appreciate your timeliness in this matter, as it will help ensure an efficient visit with our physician.

Patient Name: _____ Date of Birth: _____

Primary Physician: _____ Phone #: _____ Last Physical: _____

Do you see a specialist? ☐ Cardiologist ☐ Pulmonologist ☐ Nephrologist ☐ Oncologist ☐ Hematologist ☐ Other: _____

Name: _____ Phone #: _____ Last Visit: _____

HR Cardiac:

☐ Yes ☐ No Heart attack. Date _____
☐ Yes ☐ No Bypass surgery. Date _____
☐ Yes ☐ No Heart Stents. Date _____
☐ Yes ☐ No Cardiac arrhythmia
(If yes see questions on page 3)
Type _____
☐ Yes ☐ No Heart valve disease/surgery. Date _____
☐ Yes ☐ No Aortic Aneurysm ☐ Monitoring
☐ Surgery Date _____
☐ Yes ☐ No Chest pain/Angina
(If yes see questions on page 3)
☐ Yes ☐ No Blood thinners
☐ Yes ☐ No Congestive heart failure
☐ Yes ☐ No Congenital heart problems
☐ Yes ☐ No Cardiomyopathy
☐ Yes ☐ No Heart valve disease
☐ Yes ☐ No Pacemaker
☐ Yes ☐ No Defibrillator/AICD
☐ Yes ☐ No Become significantly short of breath when I walk a block.
Why? _____

HR Pulmonary:

☐ Yes ☐ No Shortness of breath
(If yes see questions on page 3)
☐ Yes ☐ No COPD
☐ Yes ☐ No Bronchitis/respiratory infection (pneumonia/flu)
☐ Yes ☐ No Emphysema
☐ Yes ☐ No Chronic lung disorder _____
☐ Yes ☐ No Oxygen home use
☐ Yes ☐ No Pulmonary hypertension (lungs)

HR Neurology:

☐ Yes ☐ No Stroke. Date _____
☐ Yes ☐ No Paralysis/residual deficits
☐ Yes ☐ No TIA. Date _____
☐ Yes ☐ No Brain surgery. Date _____
☐ Yes ☐ No Cerebral aneurysms
☐ Yes ☐ No Seizure
☐ Yes ☐ No Dementia/Alzheimer's
☐ Yes ☐ No Power of attorney
☐ Yes ☐ No Conservatorship

HR Hematology/Oncology:

☐ Yes ☐ No DVT/Pulmonary embolism
☐ Yes ☐ No Chronic low/high platelets
☐ Yes ☐ No Current chemotherapy/radiation
☐ Yes ☐ No Hemophilia or other bleeding disorder
Type _____
☐ Yes ☐ No Blood clotting disorder
Type _____
☐ Yes ☐ No History of cancer. Date _____
Type _____
☐ Yes ☐ No Chronic anemia
☐ Yes ☐ No Previous blood transfusion

HR Renal:

☐ Yes ☐ No Chronic kidney disease
Type _____
☐ Yes ☐ No Dialysis. Type _____ Frequency _____
☐ Yes ☐ No Kidney transplant

Cardiac:

☐ Yes ☐ No Coronary artery disease
☐ Yes ☐ No High Cholesterol
☐ Yes ☐ No Hypertension
☐ Yes ☐ No Peripheral vascular disease

Pulmonary:

☐ Yes ☐ No Asthma
☐ Yes ☐ No Obstructive sleep apnea
☐ Yes ☐ No CPAP machine
☐ Yes ☐ No Wheezing
☐ Yes ☐ No Chronic cough

Neurology:

Other neurologic diagnosis:
☐ Yes ☐ No Neuropathy
☐ Yes ☐ No Vertigo
☐ Yes ☐ No Migraines
☐ Yes ☐ No Parkinson's
☐ Yes ☐ No Multiple sclerosis
☐ Yes ☐ No Confusion
☐ Yes ☐ No Neuromuscular disease
☐ Yes ☐ No Memory loss

Constitutional:

☐ Yes ☐ No Fever
☐ Yes ☐ No Fatigue
☐ Yes ☐ No Chronic rash or itching
☐ Yes ☐ No Recent weight change

Renal:

☐ Yes ☐ No Kidney stones
☐ Yes ☐ No Kidney surgery
☐ Yes ☐ No Prostate problems

Endocrine:

☐ Yes ☐ No Diabetes
☐ Yes ☐ No Insulin pump
☐ Yes ☐ No Gout
☐ Yes ☐ No Lupus/SLE
☐ Yes ☐ No Hypothyroidism
☐ Yes ☐ No Hyperthyroidism
☐ Yes ☐ No Recent steroid use

Gastrointestinal:

☐ Yes ☐ No Cirrhosis
☐ Yes ☐ No Previous gastric bypass
☐ Yes ☐ No Any abdominal surgery
☐ Yes ☐ No Liver transplant
☐ Yes ☐ No Constipation
☐ Yes ☐ No Diarrhea
☐ Yes ☐ No Diverticular disease
☐ Yes ☐ No Change in bowel habits
☐ Yes ☐ No GI bleeding
☐ Yes ☐ No Melena
☐ Yes ☐ No Rectal bleeding
☐ Yes ☐ No Occult blood in stool
☐ Yes ☐ No Crohn's disease
☐ Yes ☐ No Ulcerative colitis
☐ Yes ☐ No Hemorrhoid surgery
☐ Yes ☐ No Personal history of colon cancer
☐ Yes ☐ No Personal history of polyps
☐ Yes ☐ No Family history of polyps
☐ Yes ☐ No Gallbladder disease
☐ Yes ☐ No Jaundice
☐ Yes ☐ No Difficulty swallowing
☐ Yes ☐ No Heartburn and indigestion
☐ Yes ☐ No Hiatal Hernia
☐ Yes ☐ No Nausea and vomiting
☐ Yes ☐ No Bloating and belching
☐ Yes ☐ No Change in appetite
☐ Yes ☐ No Abdominal pain
☐ Yes ☐ No Unexplained weight loss
☐ Yes ☐ No Abnormal CT scan
☐ Yes ☐ No Epigastric pain
☐ Yes ☐ No Barretts
☐ Yes ☐ No Gastric reflux/GERD
☐ Yes ☐ No Family history of esophageal cancer/ stomach cancer

Eyes, Ears, Nose, Throat:

☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Blindness
☐ Yes ☐ No Macular degeneration
☐ Yes ☐ No Retinal detachment
☐ Yes ☐ No Hearing loss
☐ Yes ☐ No Tinnitus
☐ Yes ☐ No Meniere's disease
☐ Yes ☐ No Sinus problems
☐ Yes ☐ No Hoarseness
☐ Yes ☐ No Recurrent mouth sores
☐ Yes ☐ No Recurrent nose bleeds

Infectious Disease:

☐ Yes ☐ No HIV/AIDs
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Herpes Simplex Virus
☐ Yes ☐ No Frequent urine infections
☐ Yes ☐ No C difficile
☐ Yes ☐ No Current communicable disease
☐ Yes ☐ No Other _____
☐ Yes ☐ No Hepatitis ☐ A ☐ B ☐ C
Date diagnosed _____

Psychiatric:

☐ Yes ☐ No Schizophrenia
☐ Yes ☐ No Bipolar
☐ Yes ☐ No Anxiety disorder
☐ Yes ☐ No Panic attacks
☐ Yes ☐ No Depression

Musculoskeletal:

☐ Yes ☐ No Rheumatoid arthritis
☐ Yes ☐ No Other arthritis
☐ Yes ☐ No Joint pain or swelling
☐ Yes ☐ No Chronic Neck/Back pain
☐ Yes ☐ No Fibromyalgia
☐ Yes ☐ No TMJ
☐ Yes ☐ No Carpal Tunnel
☐ Yes ☐ No Amputation/prosthesis
☐ Yes ☐ No Limited range of motion of your neck up and down or limited mouth opening

☐ Yes ☐ No Do you currently have any Cardiac, Respiratory, Neurologic conditions that are going to be evaluated? i.e.: ☐ Treadmill Stress Test ☐ Echocardiogram ☐ Holter Monitor ☐ Carotid U/S ☐ Pulmonary Function Test ☐ MRI ☐ CT of Brain ☐ Other _____

☐ Yes ☐ No Do you have any special medical or physical need we should know before we schedule your appointment? _____

Patient Signature: _____ Date: _____

FOLLOW UP QUESTIONS

Shortness of Breath If you answered yes to Shortness of Breath (Please Complete)

When you walk a block or climb a flight of stairs, do you have to stop and rest to catch your breath? ☐ Yes ☐ No

Please explain: _____

_____

Chest Pain If you answered yes to Chest Pain (Please Complete)

When was the last episode of chest pain? _____

Which best describes your chest pain. ☐ Pressure/Compression. ☐ Burning. ☐ Sharp Pain.

☐ Other: _____

_____

Do you have a family history of heart disease? _____

How often does your chest pain occur? _____

When did your chest pain first occur? _____ Last occur _____

Where is the pain? ☐ Midline in chest. ☐ Radiating down either arm. ☐ Radiating to neck or jaw.

☐ Left chest. ☐ Right chest. ☐ Other _____

When does the chest pain occur? ☐ During exercise. ☐ After eating. ☐ Randomly.

☐ Other _____

How long does the chest pain last? ☐ Less than one minute. ☐ 1 to 20 minutes. ☐ More than 20 minutes.

☐ Other _____

Associated factors with the chest pain. ☐ Shortness of breath. ☐ Nausea/vomiting. ☐ Weakness. ☐ Fatigue.

☐ Dizziness/syncope. ☐ Cold and clammy. ☐ Sweating. ☐ Other _____

Relieving factors. ☐ Rest. ☐ Antacids. ☐ Position change/sitting forward. ☐ Nitroglycerin.

☐ Other _____

Severity of the pain 1 to 10. (1 no pain - 10 worst pain imaginable) _____

Is your primary care provider aware of your chest pain? _____

Have you had your chest pain evaluated by a cardiologist? _____

Are you planning to have your chest pain evaluated by a cardiologist? _____

Have you had cardiac tests done (☐ Stress test, ☐ Echocardiogram, ☐ Holter monitor)? Date: _____

Do you have any upcoming cardiac tests scheduled? When _____

When was your last visit to your cardiologist? _____

What exercise are you able to do? _____

_____

Any other description of your chest pain? _____

_____

_____

Arrhythmia If you answered yes to Arrhythmia (Please Complete)

What arrhythmia do you have?

☐ Atrial fibrillation. ☐ PVC's. ☐ PAC's. ☐ SVT. ☐ V-Tach. ☐ Other _____

If A-fib, is it ☐ constant or ☐ occasional? Have you had an ablation? ☐ Yes ☐ No

Additional Notes (Anything else you want to explain) _____

_____

_____

_____

_____

SOUTH BAY GASTROENTEROLOGY
MEDICAL GROUP
AND
The Endoscopy Center of the South Bay

OFFICE POLICY FOR
INSURANCE BILLING

South Bay Gastroenterology Medical Group & Endoscopy Center of the South Bay have enrolled in numerous managed care insurance programs to accommodate the needs of our patients.

With each insurance program, there are many individual requirements of the plans having different stipulations regarding what services are covered and how often they may be performed. These plans differ depending on what type of contract your employer has negotiated.

Because we do not have access to each employers guidelines and stipulations; we must rely on you, the patient, to inform us EACH time of services exactly what those guidelines and stipulations are.

Unfortunately, if you do not inform us of special requirements in your insurance contract such as **lab work, screening / preventative care, hospitalization, and/or out-patient procedures** that are non-covered or must go to a specific location, or the need for a referral from your primary care physician, we have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

Please check with your insurance if you have any questions relating to the services we provide. We want you to receive all of the benefits offered to you.

. . . . . .

I have read and understand the office policy stated above and agree to accept responsibility as described.

_____ _____

Signature Date

The Endoscopy Center of the South Bay
And
South Bay Gastroenterology Medical Group

Authorization to Leave Message:

I hereby authorize **SBGMG/ECSB** to leave a message regarding pending appointments or tests at the following:

Home : ☐ Yes ☐ No Phone Number: _____

Cell Phone : ☐ Yes ☐ No Phone Number: _____

Work : ☐ Yes ☐ No Phone Number: _____

You may contact me via my Email : ☐ **Yes** ☐ **No** **Email Address:** _____

You may leave a message with any of the individuals listed below:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Print Patient Name: _____

Patient, Parent or Guardian _____ **Date:** _____

(Signature)

H2.6c NOTICE OF PRIVACY PRACTICES

Endoscopy Center of the South Bay - South Bay Gastroenterology Medical Group- 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. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your care and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health related benefits and services that may be of interest to you.
Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:
Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree on such restrictions, but if we do agree, we must abide by those restrictions. Also, if you have paid for your health care treatment out-of-pocket and in full, and if you request that we limit disclosure of your information to a health plan for purposes of payment or health care operations, we will abide by your request.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact: Center Director and /or Office Manager.

Effective Date: (date form implemented)

I, _____,
(print name)
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____

Date: _____

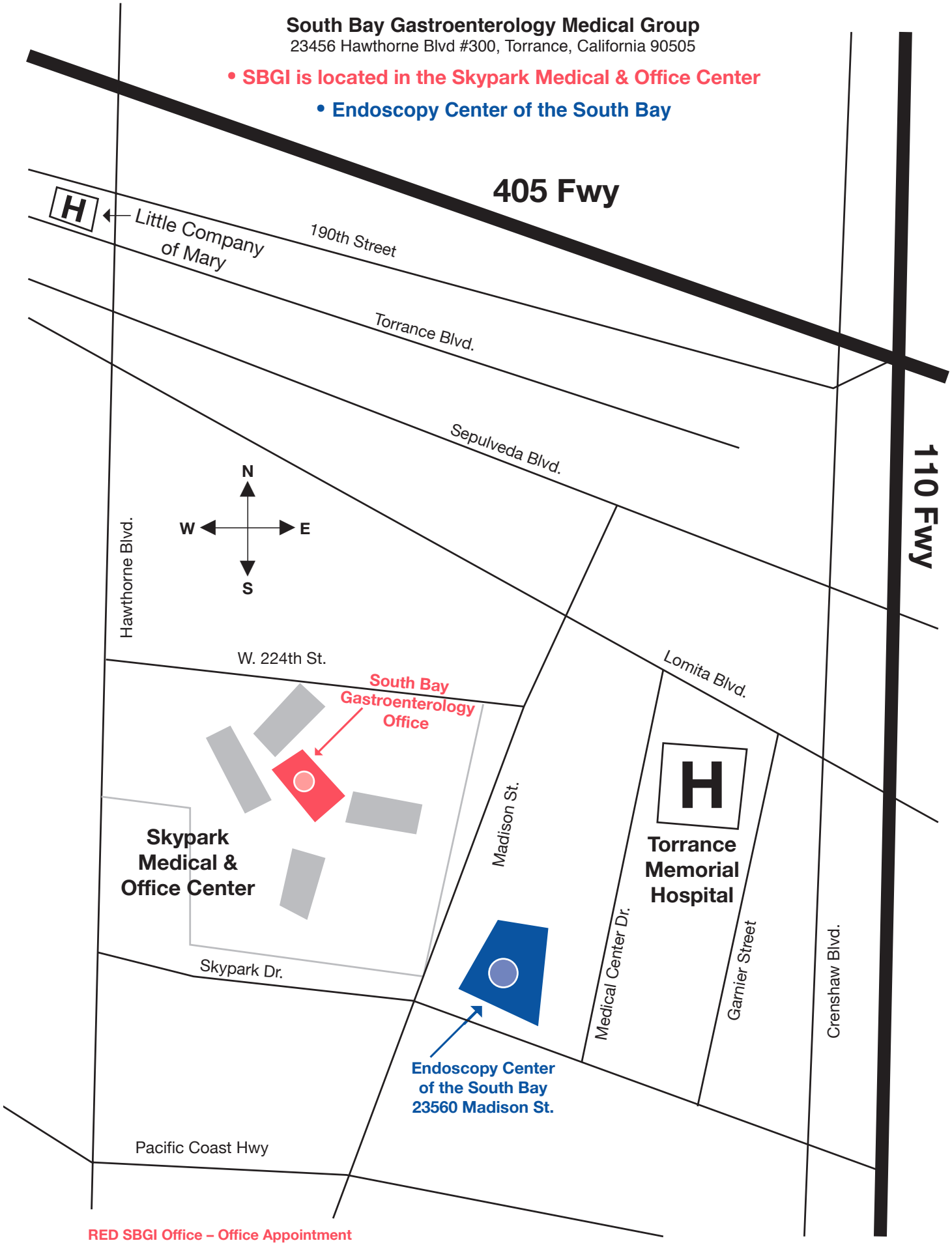
If not signed, reason why acknowledgement was not obtained:_____

Staff Witness seeking acknowledgement

_____ **Date:** _____

South Bay Gastroenterology Medical Group
23456 Hawthorne Blvd #300, Torrance, California 90505

- **SBGI is located in the Skypark Medical & Office Center**
- **Endoscopy Center of the South Bay**



RED SBGI Office – Office Appointment
BLUE Endoscopy Center SB – Procedure Appointment

South Bay Gastroenterology Medical Group
And
The Endoscopy Center of the South Bay

Patient Consent Form (Must Be Completed and Returned by Patient Prior To Treatment)

To the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____ , (Account Number: _____) understand that as part of my health care, South Bay Gastroenterology Medical Group and Endoscopy Center of the South Bay originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a **Notice of Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

Health Information Exchange (HIE):

I understand that South Bay Gastroenterology Medical Group and the Endoscopy Center of the South Bay may make my Individual health information available to a sponsored Health Information Exchange (HIE) and to a regional and or National Health Information Exchange and or state immunization registry.

I understand that the South Bay Gastroenterology Medical Group and the Endoscopy Center of the South Bay is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.520 of the Code of Federal Regulations. Should the south Bay Gastroenterology Medical Group and the Endoscopy Center of the South Bay change their notice, they will send a copy of any revised notice to the address I've provided (whether US mail or, if I agree, email).

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Can confidential messages be left on your answering machine or voicemail? ☐ YES ☐ NO

Please list, if any, person(s) whom we may inform about your medical condition, diagnosis, and/or financial account:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

I wish to have the following restrictions to the use or disclosure of my health Information: _____

_____

_____

I fully understand and ☐ accept ☐ decline the terms of this consent.

Patients Signature: _____ Date: _____

FOR OFFICE USE ONLY

☐ Consent received by _____ Date: _____

☐ Consent refused by patient, and treatment refused as permitted.

☐ Consent added to the patient's medical record on (Date) _____

AMSURG SOUTH BAY ANESTHESIA
IMPORTANT BILLING INFORMATION

Patient Information

OVERVIEW

AmSurg South Bay Anesthesia will provide anesthesia services for your procedure. Anesthesia is billed separately from the physician and the facility. Anesthesia is billed based on time the anesthesia provider monitors your care. The average anesthesia charge ranges from $1428-$1785. This is not the amount you would pay. Your procedure will be filed with your insurance. Your patient responsibility is determined after insurance processes your claim. Your insurance will process the claim according to your plan benefits. Insurance will send you an explanation of how the claim was processed. This is not a bill. If there is deductible, co-insurance or co-pay you will receive a bill from the billing office. If you have any questions regarding processing of the claim, about the amount you may owe or about making payment arrangements please call 855-717-2680.

- If at any time you feel the claim or determination were not correct please call our office and we will be happy to assist you.

High Deductible Health Plan

If you have a high deductible health plan and have not met your deductible please discuss your options with the billing office.

- Option 1-We will bill your insurance company. Once they process the claim and let us know what they allow, we will apply the discount and send you a bill for the allowed amount minus any payment received. Please note if you have not met your deductible this bill may be for the full allowed amount.
- Option 2-You can choose to be considered self-pay and pay a flat amount for anesthesia services. This means you pay the self-pay amount on the date of service and no claim will be sent to insurance. Please note this also means you will not get credit toward satisfying your deductible.

Out of Network or Not Medically Necessary

If your anesthesia provider is out of network or if your insurance determines that your anesthesia services were not medically necessary: we will bill your insurance company and wait for the claim to process. Once the claim is processed you will receive an explanation of benefits from the payor. Please understand this explanation of benefits is not a bill. Once we receive the explanation from the insurance company we will work with them to:

Out of Network:

- Have the payor reprocess the claim as in network allowing your full benefits. If this is not possible then;
- We will determine the in network responsibility (the amount you would have owed if you were in network) and you will receive a bill for that amount only.

Not Medically Necessary:

- Appeal the decision that the services were not medically necessary.
- If the decision is upheld, we will bill you the current self pay rate.

- If at any time you feel the claim or determination were not correct please call our office and we will be happy to assist you.