www.bassmedicalgroup.com

IMPORTANT!!

It is critical that we know all medications that you are taking.

Please bring a complete list of your current medications (including strength and how many you take a day) to your appointment.

If you are unable to bring a list, then bring all of your medications in a bag and our staff will make a list for the doctor.

DO WE HAVE YOUR CURRENT BILLING INFORMATION?

Please make sure you have your current insurance cards with you at the time of check in.

BASS Medical Group

NEW PATIENT REGISTRATION

Date: ____________________ Social Security Number __________ - ________ - __________

Email Address ____________________________________ Pharmacy ________________________________

Patient's Name: ____
Last Name First MI

Date of Birth: ________________ ☐ Male ☐ Female Marital Status: S M W D Age ________

Race: ____________________ Are you Hispanic? __Yes __No

Language: __________________________ Religion: ________________________ /or ☐ Declines to specify

Street Address: ____ City: ________________________________

State/zip code: ____________________________________ Home Phone #: (______) __________ -- __________

Cell Phone #: (______) __________ -- ____________ Driver's License#: ______________________________

Patient's Employer: ________________________________ Work Phone #: (______) __________ -- __________

Is this work-related? ☐ Yes ☐ No If yes, date of injury: ____________________ Claim #: ______________

Spouse's Name: ____________________________________ SS# ____________________________________

PATIENT'S INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: ______________________________________

Insurance is through: ☐ Patient ☐ Spouse ☐ Parent ☐ Other DOB of Insured: ________________

SECONDARY INSURANCE CARRIER: ____

Insurance is through: ☐ Patient ☐ Spouse ☐ Parent ☐ Other DOB of Insured: ________________

If patient is a Minor, are parents ☐ Married, ☐ Divorced? Custodial Parent ________________________________

Custodial Parent's Home Phone: (______) ________ -- ________ Work Phone: (______) ________ -- ________

Custodial Parent's SS #: ____________________________ Date of Birth: __________________________________

PHYSICIAN INFORMATION

Referring Physician's Name: ____________________________________ City: ______________________________

Primary Care Physician: ______________________________________ City: ______________________________

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact: ____

Phone #: (______) __________ -- ___________ Relationship to Patient: ____________________________________

PATIENT/RESPONSIBLE PARTY FINANCIAL AGREEMENT

I, the responsible party, certify that the above information is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges regardless of delays in insurance payment or denial of insurance coverage.

It is my responsibility to understand and have personally verified if my insurance is contracted with this practice and/or the doctor I am seeing.

I hereby authorize Bay Area Surgical Specialists, Inc. to apply for benefits and receive payments directly on my behalf for covered services rendered. They may also disclose any or all parts of my clinical record to any insurance company covering services for the purpose of satisfying charges billed.

I further agree to pay all collection costs, attorney fees and any other collection costs that may be incurred in the attempt to collect outstanding patient responsibility amounts.

I also understand, that if any insurance payments are sent directly to me, it is my responsibility to send these monies directly to Bay Area Surgical Specialists, Inc. immediately upon receipt.

I, the patient or the patient's representative, understand that all medical doctors at Bay Area Surgical Specialists, Inc. are licensed and regulated by the Medical Board of California. I can verify this by contacting the Medical Board at (800) 633-2322 or via the internet at their website: www.mbc.ca.gov.

______________________________	____________________	__________
Signature of Patient, Parent or Legal Guardian	**Relationship to Patient**	**Date**

HIPAA / NOTICE OF PRIVACY PRACTICES – Page 1

In accordance with HIPAA laws, this notice describes how your health information may be used or disclosed and how you, the patient, can access this information. Please review the following carefully.

The law permits us to use or disclose your health information to the following:

- Another specialist or physician who is involved in your care.
- Your insurance company, for the purpose of obtaining payment for our services.
- Our staff, for the purpose of entering your information into our computerized system
- Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent via fax which is a permitted use allowed by law. We have on file with these sources verification for the confidentiality of the fax used and its limited access by authorized personnel.
- If this practice is sold, your health information will become the property of the new owner.
- We may release some or all of your health information when required by law. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

Federal and State law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations.

We also use a shared Electronic Medical Record that allows both our physicians and staff and certain of the participating physicians of the Muir Medical Group IPA and their staffs' access to our patients' health information. The purpose for this access is to expedite the referral of patients within the Muir Medical Group IPA systems and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the Muir Medical Group IPA system only with the patient's express authorization or as otherwise specifically permitted or required by law.

The law also establishes patient rights and our responsibility to inform you of those rights. These include:

- You have the right to request in writing any uses or disclosures we make with your health information beyond the normal uses referenced above.
- You have the right to limit the use or restrict the use disclosure of your health information. Our office will follow any restrictions notated by you on the reverse side of this form.
- You have the right to request in writing to inspect and/or receive a copy of your health information.* Our office may charge a reasonable fee to cover copying and mailing of these records to you.
- You have the right to request an alternate means or location to receive communications regarding your health information.*
- You have the right to request in writing an amendment or change to your health information. Our office may agree or disagree with your written request, but we will be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the reason for it and add it to your records.

* Conditions and limitations may apply; obtain additional information from our Privacy Officer.

HIPAA / NOTICE OF PRIVACY PRACTICES – Page 2

- We may use your information to contact you. For example, we may mail you an appointment reminder card or call you with information regarding your care. If you are not at home, this information may be left on your answering machine or with the person who answered the phone. In an emergency, we may disclose your health information to a family member or another person designated responsible for your care. **Please designate who our offices CAN disclose your health information to by checking the boxes below:**

☐ **OK to Spouse: ____**
☐ **OK to ALL family members: Please list names of family members:**

____

☐ **OK to Other: ____**
☐ **OK to leave health information on answering machine or voice mail**

☐ **DO NOT RELEASE ANY INFORMATION to anyone other than myself (the patient).**
☐ **DO NOT RELEASE TO__________________________**

We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and our office will notify you of the changes in writing. You have the right to file a complaint with the Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, Washington, DC 20201. Our office will not retaliate against you for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Jenny Aivazian, at **(925) 932-6330.**

This notice goes into effect as of July 28, 2011.

ACKNOWLEDGEMENT

This acknowledges that you have received and read a copy of our Privacy Practices Notice. This document is not a contract, authorization, release, or consent form. This document will remain as part of your records.

Signed:____ Date:__________________

Patient's Name:____________________________________ Date of Birth:___________

If person signing is not patient please provide:
Name:____

Relationship to patient: ____

BILLING AND FINANCIAL POLICY – pg 1

The following sets forth the policies of Bay Area Surgical Specialists, Inc. Please review this information and sign where indicated below.

- I understand that it is my responsibility to furnish Bay Area Surgical Specialists, Inc. with current, accurate insurance information at the time services are rendered and/or notify us in a timely manner of any changes in coverage, which may affect the payment of services already rendered.

- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $25.00 NSF Fee. These amounts must be cleared with our financial office prior to your next appointment.

- I understand that a cancellation fee of $25.00 may be billed directly to myself if a 48 hour cancellation notice is not provided to our office. All cancellation fees must be cleared with our financial office prior to your next appointment. Specialty Ultrasound Appointments will have a $50.00 cancellation fee per test scheduled.

- I understand that a surgery cancellation fee of $250.00 may be billed directly to myself if a surgery is cancelled. Our office will allow one cancellation with no fee charged but if a surgery is cancelled by the patient or patient's family again, this fee will be assessed. This fee must be cleared with our financial office before surgery can be rescheduled.

- I understand that Bay Area Surgical Specialists, Inc. are not providers for any **HMO** insurances unless it is through John Muir Health or Sutter Delta Medical Group, Alta Bates, Hill Physicians, &Affinity.

- We are not **Medi-Cal** providers. You will be responsible for all charges if you elect to see one of our physicians.

- It is the responsibility of each patient to verify with their insurance if this practice and the physician you are seeing is a contracted provider. BASS and/or its representatives will make every effort to assist you but BASS will not be held accountable for understanding every insurance plan.

- I understand that there is a $15.00 fee (per form) to complete disability paperwork associated with my care.

BILLING AND FINANCIAL POLICY – pg 2

- I understand that the clinic will verify my insurance eligibility for surgery, but until claims are processed deductible amounts and co-insurance amounts prior to surgery cannot be determined. I further understand that a surgery co-pay may be collected upfront and applied to those fees. I further understand that ANY FEES I AM QUOTED ARE ESTIMATED based on 1) anticipated surgery to be performed and 2) current information provided to clinic by my insurance carrier.

- I understand that I will be billed for any amounts due by me (co-payments/co-insurance amounts/deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with three (3) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the third statement being mailed, the third statement will be marked as "Final Notice" and may result in my account being sent to an outside collection service if I still do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with those collection efforts.

- I understand that the clinic will obtain the necessary authorizations prior to surgery. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for all charges not paid by my insurance carrier. This also applies if your insurance company delays payment over 90 days after billing or denial of insurance coverage. If your insurance company demands a refund of any monies paid to us, you become financially responsible for those charges.

- I understand that the clinic may also take a verbal request by me over the phone to make a credit card payment on my account. I give authorization for the clinic to bill my card for the amount specified and acknowledge that verbal requests can only be made by the responsible party since no credit card information is kept on file.

My signature below confirms that I have read these billing policies and my financial obligations as pertains to the physicians of Bay Area Surgical Specialists, Inc..

____________________________________ ________________

Legal Signature Date

____

Print Patient's Name

____

Relationship to Patient

BAY AREA SURGICAL SPECIALISTS

General, Vascular, Thoracic, Bariatric and Trauma Surgery

PATIENT HISTORY FORM

DATE ____/____/____ REFERRING DOCTOR______________________

NAME ______________________________ PRIMARY CARE DOCTOR ______________________

DOB ______________________ REASON FOR VISIT ______________________

MEDICATIONS

Please list all current medications, including vitamins:

Name of medication	Dose	Frequency

ALLERGIES

Please list all drug allergies:

Drug	Reaction

PAST MEDICAL HISTORY

Please check whether you have or have had any of the following conditions:

Diabetes ☐ Yes ☐ No
High blood pressure/Hypertension ☐ Yes ☐ No
Coronary artery disease ☐ Yes ☐ No
Congestive heart failure ☐ Yes ☐ No
Chronic renal failure ☐ Yes ☐ No
Atrial fibrillation ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Type

____

Type

____

High cholesterol ☐ Yes ☐ No
COPD/emphysema ☐ Yes ☐ No
Asthma ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Dementia (e.g., Alzheimer's) ☐ Yes ☐ No
Parkinson's Disease ☐ Yes ☐ No
Hepatitis B ☐ Yes ☐ No
Hepatitis C ☐ Yes ☐ No
HIV ☐ Yes ☐ No

Others:

PAST SURGICAL HISTORY

Please list all prior surgeries:

Surgery	Year	Surgery	Year

NAME ______________________________ DOB ______________

FAMILY HISTORY Please answer the following questions about your family members.			
Father	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Medical problems:		
Mother	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Please list any significant medical problems:		
Sister	Please list any significant medical problems (if any):		
Brother	Please list any significant medical problems (if any):		
Family h/o	Please list any significant medical problems of other relatives (e.g., grandparents, uncles, aunts, etc.)		
Additional Space for Family History:			

SOCIAL HISTORY		
Drinks Alcohol	Do you drink alcohol? ☐ Yes ☐ No If yes how often? Daily - Weekly – Monthly – Socially - Rarely	
	☐ Beer ☐ Wine ☐ Liquor Amount? When was your last drink?	
Tobacco Use	Do you smoke? ☐ Yes ☐ No If yes, how many packs per day?	
	How many years did you smoke?	What year did you quit?
Drug Use	Do you currently use recreational drugs? ☐ Yes ☐ No Have you in the past? ☐ Yes ☐ No	
	Have you ever used intravenous drugs? ☐ Yes ☐ No	
Caffeine Use	If yes, what kind? Please circle: Coffee – Soda – Chocolate – Tea – Other? How many cups? How many sodas?	
Employment	Occupation (past or present):	
Social History	Marital Status, please circle one: Single , Married , Widowed , Divorced Who Lives in your home with you? ______________________ Do you have children? _______ If so how many ______________________	
Miscellaneous	Have you ever received a blood transfusion? ☐ Yes ☐ No	

NAME ______________________________ DOB ____________________

REVIEW OF SYSTEMS

Please check whether you have any of the following problems, either CURRENTLY OR REPEATEDLY:

Constitutional

	Yes	No
Fever	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Unexplained weight loss	☐ Yes	☐ No

Other: ____________________

HEENT

	Yes	No
Runny nose	☐ Yes	☐ No
Difficulty hearing	☐ Yes	☐ No

Other: ____________________

Neurologic/Psychiatric

	Yes	No
Numbness	☐ Yes	☐ No
Tingling	☐ Yes	☐ No
Weakness	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Memory loss	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Spinal cord injury	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Difficulty Sleeping	☐ Yes	☐ No

Other: ____________________

Metabolic/Endocrine

	Yes	No
Excessive thirst	☐ Yes	☐ No
Too hot	☐ Yes	☐ No
Too cold	☐ Yes	☐ No

Other: ____________________

Immunologic

	Yes	No
Hay fever	☐ Yes	☐ No
Food allergies	☐ Yes	☐ No

Other: ____________________

Respiratory

	Yes	No
Shortness of breath	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Cough	☐ Yes	☐ No

Other: ____________________

Musculoskeletal

	Yes	No
Joint pain	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Artificial joints	☐ Yes	☐ No

Other: ____________________

Hematologic

	Yes	No
Easy bruising or bleeding	☐ Yes	☐ No
Blood clots in arms or legs	☐ Yes	☐ No
Anemia	☐ Yes	☐ No

Other: ____________________

Cardiovascular

	Yes	No
Chest pain	☐ Yes	☐ No
Irregular pulse	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No
Heart valve problem	☐ Yes	☐ No

Other: ____________________

Genitourinary

	Yes	No
Back Pain	☐ Yes	☐ No
Cloudy Urine	☐ Yes	☐ No
Nausea		

Other: ____________________

Gastrointestinal

	Yes	No
Abdominal pain	☐ Yes	☐ No
Nausea/vomiting	☐ Yes	☐ No
Indigestion/heartburn	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No

Other: ____________________

Dermatologic

	Yes	No
Rash	☐ Yes	☐ No
Boils/infections	☐ Yes	☐ No

Other: ____________________

Vascular

	Yes	No
Cool Extremity	☐ Yes	☐ No
Pain in limb	☐ Yes	☐ No
Varicose Veins	☐ Yes	☐ No

Other: ____________________

Elizabeth A. Cunningham, M.D., F.A.C.S.
Board Certified General Surgery
Fellowship Trained Surgical Oncologist
Breast Surgery
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Napa, CA 94558 F: (707) 266-7052
www.bayareasurgical.com

BREAST PATIENT HISTORY

Name: ______________________________ **Date:** __________

Referring M. D.: ______________________________

Reason for visit: ______________________________

Date of last mammogram: __________

Age at onset of menses: _________

History of birth control use: How many years? ____

Current form of birth control: ____________ **None:**____

History of hormone replacement therapy: How many years? ____

Currently: Yes___ No ___

Age at menopause: ______

Number of pregnancies: ____ **Number of children:** ____
Number of miscarriages: ____

Age at first pregnancy: ____

Did you breastfeed?: Yes ____ No____

Personal history of breast cancer: ______________________________

Family History: (To the best of your knowledge please fill in information below including if cancer is from mother/ father side of the family.)

Family History of breast cancer: Yes___ No ___

If yes, whom and at what age: ______________________________

Family history of ovarian cancer: Yes ____ No ____

If yes, whom and at what age: ______________________________

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Napa, CA 94558

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Family History of Prostate Cancer: Yes____ No ____
If yes, whom and at what age: ____

History of previous breast biopsy: ____________________________________
Right____ Left____ Both____

History of nipple discharge/ blood: Yes ____ No ____
If yes, which breast: Right ____ Left ____ Both____

History of breast lump: Yes ____ No ____
If yes, which side: Right____ Left ____ Both ____

Pain in breasts: Yes ____ No ____
Mass or Lump in Breast: Yes ____ No ____
If yes, how severe: Mild____ Moderate ____ Severe____
If yes, how frequent: Constant____ Daily____ Weekly____ Random____
When was it first discovered? ______________________________

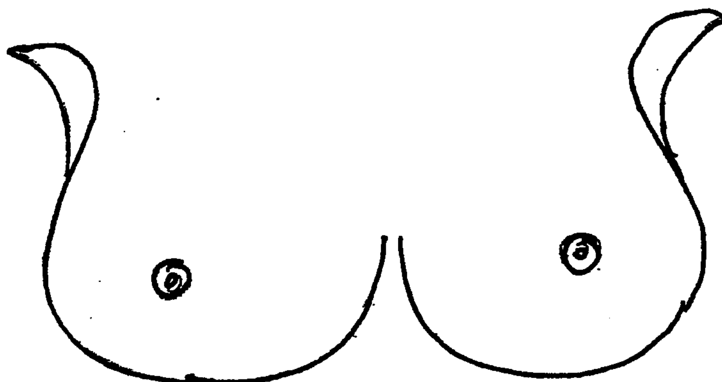
Aggravated by ____

Relieved by ____

Do you perform self-breast exams? Yes____ No ____

Are you pre-menopausal? ____
Are you peri-menopausal? ____
Are you post-menopausal? ____

APPROXIMATE LOCATION OF BREAST MASS/ LUMP



HEREDITARY CANCER QUESTIONNAIRE

Personal Information

Patient Name: ______________________ **Date of Birth:** ______________ **Age:** __________

Gender (M/F): ________ **Today's Date(MM/DD/YY):** ____________ **Healthcare Provider:** ________________

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☑Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	----	--	*Aunt* *Cousin*	*45* *61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER *(Female or Male)*							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	UTERINE (ENDOMETRIAL) CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME GASTROINTESTINAL POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid*						

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Personal and/or family history of any one of the following:

☐	**Multiple** A combination of cancers on the same side of the family:	○ **2 or more**: breast / ovarian / prostate / pancreatic cancer ○ **2 or more**: colorectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas) ○ **2 or more**: melanoma / pancreatic
☐	**Young** Any 1 of the following at age **50 or younger**:	○ Breast cancer ○ Colorectal cancer ○ Endometrial cancer
☐	**Rare** Any 1 of these rare presentations at **any age**:	○ Ovarian cancer ○ Breast: Male breast cancer or Triple negative breast cancer ○ Colorectal cancer with abnormal MSI/IHC, or MSI associated histology†† ○ Endometrial cancer with abnormal MSI/IHC ○ 10 or more gastrointestinal polyps*

††Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern *Adenomatous type

Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com

Hereditary Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature:______________________________ Date: ______________

Healthcare Provider's Signature: ______________________ Date: ______________

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment:__________

RESOURCE SUPPLIED BY MYRIAD GENETIC LABORATORIES, INC. MYRIAD myRisk™ Hereditary Cancer