BASS MEDICAL GROUP

A division of BASS Medical Group

Audrey Arzamendi M.D.

Provider: _____ **Acct:** _____ **Date:** _____

Name: _____
First Middle Last

Date of Birth:_____ ❑Male ❑Female ❑X **SSN (last 4 digits)**_____
mm/dd/yyyy

Address:_____
City State Zip

Home Phone: (____)_____**Cell phone:** (___)_____**Email:**_____

Employer/Occupation: _____ **Disabled** **Retired** **Student**

Race:_____ **Ethnicity: Hispanic/Latino** YES NO

Marital status: ❑SINGLE ❑MARRIED ❑DIVORCED ❑ WIDOWED ❑COHABITATING

Emergency contact (name, phone, relation): _____

Primary Insurance Information	**Secondary Insurance Information**
Insurance name:	**Insurance name:**
Insurance ID :	**Insurance ID :**
Group or Policy Number:	**Group or Policy Number:**
Policy Holders Name:	**Policy Holders Name:**
Policy Holders Relationship to Patient:	**Policy Holders Relationship to Patient:**
Policy Holder's Date of Birth:	**Policy Holder's Date of Birth:**

Primary Care Physician (Family Doctor) _____
Address/Phone

Referring Physician_____
Address/Phone

Medicare/ Medi-Cal Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on the patient's behalf to Bay Area Surgical Specialists (dba: California Sinus Centers) for any services furnished the patient by the physician. I authorize any holder of medical information about the patient to release to the Centers for Medicare/Medi-Cal and its agents any information to determine these benefits payable for related services.

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned, authorize payment of medical benefits to Bay Area Surgical Specialists (dba: California Sinus Centers) for any services furnished the patient by the physician. I understand that my agreement with my insurance company is a separate agreement between myself and my insurance company and that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company, or their agent, information concerning health care, advice, treatment or supplies provided to the patient. This information will be used for the purpose of evaluating and administering claims of benefits. I understand that in the event I have no insurance coverage, I am responsible for all billed charges.

_____Patient/Legal Guardian Signature _____Date

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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.

_____ _____

Date Patient/Legal Guardian Signature

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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.

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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 each person by first and last name):**

_____

_____

❑**OK to other:**_____

❑**OK to leave health information on answering machine or voicemail**

❑**DO NOT RELEASE ANY INFORMATION TO ANYONE OTHER THAN MYSELF (the patient)**

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 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: _____

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Billing & Financial Policy

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 me 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 $100.00 may be billed directly to me 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.
- 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 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.

_____ _____

Patient/Legal Guardian Signature Date

_____

Patient/Legal Guardian Name

_____

Relationship to patient