SOUTH ORANGE COUNTY | SURGICAL MEDICAL GROUP
Comprehensive, Compassionate Care

BLAKE ASHLEY, M.D., F.A.C.S.
D. DANIEL DEARING, M.D., F.A.C.S.
ROBERT DUENSING, M.D., F.A.C.S.
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DIPLOMATES, AMERICAN BOARD SURGERY
GENERAL, VASCULAR, ENDOVASCULAR, BREAST, COLORECTAL, LAPAROSCOPIC & ROBOTIC SURGERY

Patient Information

LAST_____ FIRST_____ MI _____

SEX ___F ___M BIRTHDATE _____/_____/_____ AGE _____ SS# _____
MO DAY YEAR

ADDRESS_____ CITY_____ ST_____ ZIP _____

CHECK PREFERRED CONTACT #: □ HOME PHONE_____ □ CELL PHONE _____

□ WORK PHONE _____ EMAIL _____

NAME OF EMPLOYER _____

EMPLOYER
ADDRESS _____ CITY_____ ST_____ ZIP_____

PLEASE LIST EMERGENCY CONTACT:

NAME _____ RELATIONSHIP _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

REFERRING PHYSICIAN _____ PRIMARY CARE PHYSICIAN _____

FINANCIAL POLICY

We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and agree to, prior to any treatment.
WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS.

Insurance Billing

We will bill your insurance company as a courtesy. Your insurance policy is a contract between you and your insurance company. It is your responsibility to know your benefits and how they will apply to your treatment by the doctor. We are not a party to that contract. If your insurance company has not paid your account in full within 60 days, the balance will be transferred to you and /or the guarantor listed on the Patient Information form. If unable to make the payment in full, contact the billing department immediately to make payment arrangements. In the event that the account is referred for collections, you will be responsible for the balance of your account plus a collection agency charge of 25% of the balance and reasonable attorney fees. If your account becomes delinquent or is referred for collections, your provider has authorization to obtain your credit report to assist them in the collection of your bill.

HMO Plans (with which we are contracted): All co-pays must be satisfied at every visit. Due to contractual and uniform compliance issues with your insurance company, there are no exceptions to the policy of collecting co-pays at every visit. You are responsible for obtaining authorization and approval for treatment with your Medical Group or PCP prior to treatment.

PPO Plans (with which we are contracted): We have negotiated rates with your insurance company. Your co-insurance and unmet deductible is your responsibility and payment is due at the time of your treatment or upon receiving notification from your insurance of the amount owed by you.

In the event that your insurance coverage changes to a plan where we are not a participating provider, you will be responsible for any out of network deductible or coinsurance amounts.

Medicare: We accept assignment with Medicare. Medicare pays 80% of the allowed amount after satisfaction of the annual deductible. We will bill your secondary insurance for the remaining 20% of the Medicare allowed payment as a courtesy; however, you are responsible for any remaining balance regardless of payment from a secondary insurance.

Usual and Customary Rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

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Cash Patients

Cash patients are accepted on an individual basis. All services must be paid in full at the time of your treatment. Our office can provide you with an estimate of the cost of treatment prior to your visit with the physician. We are willing to extend a discount of 25% off of our usual and customary fees for full payment at the time the services are rendered. The discounted price for your initial consultation (new patient visit) is **$285.00** and follow-up visits (established patient visit) are **$120.00**. Again these services must be paid at the time the services are rendered or the discount is not applicable. The fees without the discount are $380.00 and $160.00.

Other Services and Fees

Returned Checks: A $35.00 fee will be charged for any returned checks. We will be unable to accept your check for any services thereafter. If any discount was applied to the pricing of the service(s) the discount will be revoked and you will owe the full price of the service(s) rendered in addition to the aforementioned fee.

Medical Records: All Medical Record requests are subject to a clinical preparation fee of $25.00 for legal cases, personal injuries and other matters that involve your attorney requesting your records.

Paperwork Fees: We do charge for completing paperwork on your behalf. This fee covers our costs and time involved in accessing your medical records, reviewing the documents, completing and signing the forms. We require a $40.00 fee. These fees must be paid prior to the forms being completed.

I have read and understand the policies and fees, and I agree to these terms. I hereby give a lifetime authorization for payment of insurance benefits made directly to South Orange County Surgical Medical Group, Inc (SOCSMG, Inc.). I understand that I am financially responsible for all charges and fees whether or not they are covered by insurance. I hereby authorize SOCSMG, Inc. to release all information and medical records necessary to secure payment for my services. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient Signature: _____ Print Name: _____ Date: _____

Signature of responsible party if not signed by the patient:

Signature: _____ Print Name: _____ Date: _____

GUARANTOR INFORMATION (PERSON FINANCIALLY RESPONSIBLE FOR PATIENT)

LAST _____ FIRST _____ MI _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

GUARANTOR DOB_____ RELATIONSHIP _____

EMPLOYER _____ WORK PHONE _____

ADDRESS _____ CITY _____ ZIP _____

If no insurance card present at time of office visit, please provide:

Insurance carrier: _____ **ID #:** _____

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This agreement between the patient _____ (print Patient's name) and Prescribing Physician (Doctor) is for the purpose of establishing agreement between Doctor and Patient on clear conditions for the prescription and use of pain controlling medications prescribed by the Doctor for the Patient. Doctor and Patient agree this Agreement is an essential factor in maintaining the trust and confidence necessary in a doctor-patient relationship.

The Patient agrees to and accepts the following conditions for the management of pain medication prescribed by the Doctor to the Patient:

- I understand the reduction in the intensity of my pain and an improvement in my quality of life are the goals of this program.
- I realize that all of the medications have potential side effects, and I will have any recommended laboratory studies required to keep the regimen as safe as possible.
- I realize that it is my responsibility to keep myself and others from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have not used any medication for at least four days.
- I will not use any illegal controlled substances, including marijuana, cocaine, etc.
- I will not share, sell, or trade my medication for money, goods or services.
- **I will not fill a prescription for pain medication from any other health care provider without telling them that I am taking pain medication prescribed by the Doctor**. I understand is it against the law to do so. If another physician (including dentists) prescribes pain medication for me,
- **the Doctor must approve arrangements prior to filling the prescription for pain medication to verify no duplication.**
- I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is that I will be without my prescribed medication for a period of time.

For all my pain medication, I agree to use:

- _____ (Name of Pharmacy),
- located in _____ (City),
- on _____ (Street),
- telephone number _____.

If I change pharmacies for any reason, I agree to notify the Doctor at the time I receive a prescription, and advise my new pharmacy of any prior pharmacy's address and telephone number.

- I agree to waive any applicable privilege or right of privacy of confidentiality with respect to the prescribing of my pain medication. I authorize the Doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the California Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medication. I authorize the Doctor to provide a copy of this agreement to the pharmacy.
- I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medication for a period of time.
- I understand that this medication regiment will be continued for the period of time seen beneficial by my Doctor. My case will be reviewed at the end of that period. If there is no evidence that I am improving or that progress is being made to improve my function or my quality of life, the regiment will be tapered to my pre-trial medications and my care will be referred back to my primary care physician.
- Doctor and Patient agree this Agreement is essential to the Doctor's ability to treat the Patient's pain effectively, and failure of the patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed medication by the Doctor and the termination of the Doctor/Patient relationship.

This agreement is entered into on _____ day of _____, _____

_____ _____

Patient's signature **Doctor's Name**

_____

Witness signature

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Name _____ DOB _____ Birthplace_____ Marital Status □S □M □D □W

Occupation _____ Date of last physical exam: _____

Do you drink alcohol? □No □Yes How much?_____ **SMOKING History** □ Past / Former □ Current □ Never

Briefly describe present problem:_____

_____

_____

_____

Personal History: Have YOU ever had? (Check appropriate box for each)

Irregular heartbeat	□No	□Yes	Kidney disease or stones	□No	□Yes
Angina	□No	□Yes	Bladder or kidney infection	□No	□Yes
Heart attack	□No	□Yes	Prostate problem	□No	□Yes
Stroke / TIA	□No	□Yes	Seizures	□No	□Yes
Congestive heart failure	□No	□Yes	Arthritis	□No	□Yes
High Blood Pressure	□No	□Yes	Diabetes	□No	□Yes
Pneumonia or lung infection	□No	□Yes	Varicose veins	□No	□Yes
Emphysema	□No	□Yes	Anemia	□No	□Yes
Asthma	□No	□Yes	Cancer	□No	□Yes
Jaundice	□No	□Yes	Blood Transfusion	□No	□Yes
Have you ever had hepatitis	□No	□Yes	Bleeding Problems	□No	□Yes
Liver or gallbladder disease	□No	□Yes	Phlebitis or blood clots	□No	□Yes
Ulcers	□No	□Yes	Do you take any "blood thinners?"	□No	□Yes
Colitis	□No	□Yes	Do you take aspirin containing medications?	□No	□Yes
Diverticulitis	□No	□Yes	Do you have sleep apnea?	□No	□Yes
Hemorrhoids	□No	□Yes	If sleep apnea, do you use CPAP?	□No	□Yes
Other bowel Disease	□No	□Yes			

Medications, Allergies, Surgeries, Hospitalizations:

MEDICATIONS: Please list all medications you take including dosage. (If you need more space, please include additional pages).

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

ALLERGIES: Please **circle** if allergic to any of the following:

Shellfish Contrast Dye Iodine Latex Tape

Please list all MEDICATION ALLERGIES you have:

Medication name:	**Reaction:**

SURGERIES: List all previous operations and approximate dates.

1._____

2._____

3 _____

4. _____

List any other hospitalizations in last 5 years with reason and date:

1. _____

2. _____

3. _____

4. _____

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Name _____ Date of Birth _____

Family History	If Living		If Deceased			Family History	If Living		If Deceased		
	Age	Health	Age at Death	Cause			Age	Health	Age at Death	Cause	
Father						Son/Daughter 1.					
Mother						2.					
Brother/Sister 1.						3.					
2.						4.					
3.											

List any blood relative who has been diagnosed with cancer:

Relationship to Patient:	Type of Cancer:	Relationship to Patient:	Type of Cancer:

Do you recently note?

Weight Loss ☐No ☐Yes
Fevers ☐No ☐Yes
Appetite loss ☐No ☐Yes

Do you now have or have you ever had?

Ears, Nose, Throat:

Any eye disease, injury, impaired sight ☐No ☐Yes
Any ear disease, injury, impaired hearing ☐No ☐Yes
Trouble with nose, sinuses, mouth and/or throat ☐No ☐Yes

Neck:

Enlarged thyroid or goiter ☐No ☐Yes
Enlarged gland(s) ☐No ☐Yes

Cardio-Respiratory:

Chronic or frequent cough ☐No ☐Yes
Chest pain, pressure, or discomfort ☐No ☐Yes
Swelling of feet or ankles ☐No ☐Yes
Shortness of breath ☐No ☐Yes
Palpitation or irregular heartbeat ☐No ☐Yes

Gastrointestinal:

Abdominal pain or swelling ☐No ☐Yes
Trouble swallowing ☐No ☐Yes
Indigestion or heartburn ☐No ☐Yes
Nausea or vomiting ☐No ☐Yes
Black or bloody stools ☐No ☐Yes
Constipation or diarrhea ☐No ☐Yes
Rectal pain, swelling or bleeding ☐No ☐Yes

Changes in appetite or eating habits ☐No ☐Yes
Changes in your bowel habits or stools ☐No ☐Yes

Genito-Urinary:

Urinary frequency or burning ☐No ☐Yes
Do you get up at night to urinate ☐No ☐Yes
How many times _____
Any difficulty urinating ☐No ☐Yes

Extremities:

Pain in leg or calf when walking ☐No ☐Yes
Bone or joint pain ☐No ☐Yes

Neurological:

Dizziness or vertigo ☐No ☐Yes
Temporary loss of vision ☐No ☐Yes
Temporary numbness or weakness of face, arm, or leg ☐No ☐Yes
Trouble with speech ☐No ☐Yes
Fainting or loss of consciousness ☐No ☐Yes
Any recent development of headaches ☐No ☐Yes

EKG:

Electrocardiogram ☐No ☐Yes
When was your last EKG? _____

List all recent studies:

1. _____
2. _____
3. _____
4. _____

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Notice of Privacy Practices

We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law, professional accreditation standards and our internal policies and procedures.

The Notice of Privacy Practices explains your rights, our legal duties and our privacy practices. It also describes how medical information about you may be used and disclosed and how you can get access to this information. The policy in its entirety can be requested from the receptionist. For your convenience the following is a summary of the information discussed in the notice.

- Our Pledge
- Your Personal Information
- Our Privacy Practices
- How We May Use or Share Your Information for:
  - Treatment
  - Payment
  - Health Care Operations
  - Notifications and Special Circumstance and the Law
  - Research and Marketing
- Your Written Permission
- Other Restrictions
- Your Rights
- Changes
- Questions or Complaints

Your agreement only acknowledges that we have made available for your review a paper copy of our Notice of Privacy Practices and have retained a copy of this acknowledgement as required by law.

Prescription Refill Policy

The patient is responsible for knowing when medication(s) will need to be refilled. The specific protocol is outlined below. All patients are requested to execute acknowledgement that they have read the protocol and agree with its requirements.

It is the policy of South Orange County Surgical Medical Group that medications will only be refilled between 9:00am to 3:30pm, Monday – Friday. **No prescription refills will be given on Saturday, Sunday or holidays.**

- At least 24 business hours are needed to process a refill request.
- Early refills will not be authorized.
- Medications or prescriptions will not be replaced if lost or misplaced.
- If your physician is not in the office, or is unavailable, you may have to wait until he/she returns for medication refills to be authorized.
- Prescriptions may be picked up between 9:00am – 12:00pm and 1:30pm – 4:30pm. Our office is closed for lunch from 12pm – 1:30pm.
- When picking up a prescription for a controlled substance, you may be asked to provide a valid form of picture identification.

The physicians of South Orange County Surgical Medical Group, Inc. do not routinely prescribe narcotics on a long term basis. Individuals who are seeking “pain killers” for chronic pain use will be advised to make an appointment with a pain management or primary care physician.

Diagnostic Testing Results

While under the care of a Physician/Provider with South Orange County Surgical Medical Group, Inc. you may be sent to have diagnostic testing performed (MRI, CT-scan, bone scan, lab work or other diagnostic testing). It is the patient’s responsibility to make an appointment to return to the office to receive the results of any diagnostic testing. Most testing is completed at an outside facility. It is the patient’s responsibility to obtain the results of all tests in addition to ensuring all outside results are sent to the Physician’s office prior to the follow up appointment. Reports may be faxed to (949) 588-8719. We are able to directly access testing performed at Saddleback Vascular Lab located in suite 380 of our building.

By initialing below you are acknowledging that you have received, read, and agree to South Orange County Surgical Medical Group, Inc.’s:

Notice of Privacy Practices (enclosed)

_____ Initials — I hereby acknowledge the receipt of the Notice of Privacy Practices. A personal copy of the Privacy Practices will be available per my request

Prescription Refill Policy (enclosed)

_____ Initials — I have read the Prescription Refill Policy. I understand and agree to this Prescription Refill Policy

Acknowledgement of Diagnostic Testing Results (enclosed)

_____ Initials — I have read and understand the Diagnostic Testing Results.

_____ _____ _____
Signature of Patient or Responsible Party | Printed Name | Date

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Authorization for Medical Records Request

I, _____hereby give my permission

for Dr. _____

to obtain any and/or all test results, consults, and doctors notes that may be needed to aid in my medical treatment and care.

Signature_____Date_____

Print Name _____

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Authorization for Medical Records Release

Please list the family members, significant others, or other persons, if any, whom we may inform about your general medical condition and your diagnosis. This may also include information regarding treatment plan, prognosis, payment info and health care options.

Name **Relationship to Patient** **Phone #**

_____

_____

_____

_____

Patient Signature: _____

Please Print Patient Name: _____

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