

Associates in General Surgery
NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", 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.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include diagnostic services, i.e. X-ray.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be calling your insurance company to obtain authorization for a specific surgical procedure.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, internal auditing functions, cost-management analysis, and customer service. An example would be an audit of our billing and coding practices.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. An example would be Federal and State mandates regarding AIDS reporting.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to obtain a paper copy of this notice from us upon request.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.

Associates in General Surgery

Notice of Privacy Practices

Page II

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of March 1, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA
Or to file a complaint:

Rosa Warntjes, HIPAA Compliance Officer
Associates in General Surgery
3610 Long Beach Blvd. Suite 101
Long Beach, CA 90807
(562)424-0421

The U.S. Department of Health & Human
Services – Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Associates in General Surgery, A MEDICAL CORPORATION
KENT H. AZAREN, MD JEFFREY T. ISLAS, MD STEVEN W. GRANT, MD
REGISTRATION FORM (Please Print)

Today's date: _____ Primary Care Physician: _____

PATIENT INFORMATION

Patient's last name: _____ First: _____ Middle: _____
 Mr. Dr. Marital status Single Married
 Mrs. Ms. Div Sep Wid Partner

Is this your legal name? Yes No
 If not, what is your legal name? _____ (Former name): _____ Birth date: ____/____/____ Age: _____ Sex: M F

Street address: _____ Social Security no.: _____ 1)Home phone no. _____
 () _____

Work phone #: () _____ Cell phone #: () _____ Best # to call _____ Best time to call _____

P.O. Box: _____ City: _____ State: _____ ZIP Code: _____

Occupation: _____ Employer: _____ Employer phone no.: _____
 () _____

Referred by (please check one box): Dr. Insurance Plan Hospital
 Family Friend Close to home/work Yellow Pages Other

INSURANCE INFORMATION

(Please give your insurance card and photo ID to the receptionist.)

Person responsible for bill: _____ Birth date: ____/____/____ Address (if different): _____ Home phone no.: _____
 () _____

Is this person a patient here? Yes No

Occupation: _____ Employer: _____ Employer address: _____ Employer phone no.: _____
 () _____

Is this patient covered by insurance? Yes No

Please indicate primary insurance PPO: _____ Point of Service EPO _____ Medicare Medi-Cal
 Workers Comp CCS _____ HMO _____ Ins Name _____ Medical Group _____

Subscriber's name: _____ Subscriber's S.S. no.: _____ Birth date: ____/____/____ Group no.: _____ Policy no.: _____ Co-payment: _____
 \$ _____

Patient's relationship to subscriber: Self Spouse Child Other

Name of secondary insurance (if applicable): _____ Subscriber's name: _____ Group no.: _____ Policy no.: _____

Patient's relationship to subscriber: Self Spouse Child Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): _____ Relationship to patient: _____ Home phone no.: _____ Work or cell ph# _____
 () _____ () _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Associates in General Surgery or insurance company to release any information required to process my claims.

 Patient/Guardian signature Date

Original Date:	05/10/2011
Dates Revised:	05/17/2011

Associates in General Surgery, A MEDICAL CORPORATION

HEALTH HISTORY QUESTIONNAIRE (All questions contained in this questionnaire are strictly confidential)

Name (<i>Last, First, M.I.</i>):		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Occupation			
Previous or referring doctor:		Date of last physical exam:	

PERSONAL HEALTH HISTORY

Reason for visit	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Hernia: Type:	<input type="checkbox"/> Rectal Problem
Mass	<input type="checkbox"/> Breast	<input type="checkbox"/> Melanoma	Site:	
	<input type="checkbox"/> Colon	<input type="checkbox"/> Liver Biopsy	<input type="checkbox"/> Skin Lesion	Location:
	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Other		
Do you Smoke? <input type="checkbox"/> NO <input type="checkbox"/> YES: IF YES, #YEARS? # PACKS PER DAY?				
Do you drink alcohol? <input type="checkbox"/> NO <input type="checkbox"/> YES: IF YES, PLEASE EXPLAIN				
ALLERGIES TO MEDICATIONS: <input type="checkbox"/> SULFA <input type="checkbox"/> PENCILLIN <input type="checkbox"/> IODINE <input type="checkbox"/> CODEINE <input type="checkbox"/> VICODIN <input type="checkbox"/> LATEX				
OTHER ALLERGIES: Reactions that you had:				

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

PAST MEDICAL HISTORY: ANEMIA ASTHMA BLEEDING DISORDER CANCER CHRONIC RENAL FAILURE
 COPD CORONARY ARTERY DISEASE DIABETES DIZZINESS EPILEPSY HEART ATTACK HIV/AIDS HYPERTENSION
 LEUKEMIA MITRAL VALVE DISEASE SEIZURE DISORDER OTHER (STATE BELOW)

OTHER MEDICAL PROBLEMS:

PREVIOUS SURGERIES		
Year	Reason	Hospital

Have you ever had General Anesthesia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Please state any problems	<input type="checkbox"/> None	

Associates in General Surgery
3610 Long Beach Blvd., Suite 101 Long Beach, CA 90807
PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your "Notice of Privacy Practices" containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the "Notice of Privacy Practices."

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Patient Representative: _____ Relationship: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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Revised 04/27/2011

Associates in General Surgery, A MEDICAL CORPORATION

**STATEMENT OF FINANCIAL RESPONSIBILITY
ADVANCE BENEFICIARY NOTIFICATION**

Dearest Patient:

It is our honor and privilege to participate in your medical care. We will do our best to provide excellent care for you. We will provide coverage 24 hours per day, seven days a week. If you have any problems or questions we are here for you.

You may have insurance and we will be happy to bill your insurance for you. On occasion your insurance may not pay our charges. Some reasons may be pre-existing medical conditions, the service performed may be excluded from coverage, you may not be eligible for coverage when the service is actually performed or there may be a change in your insurance coverage. In the event your insurance does not cover our charges, you are still responsible for payment to your doctor and this office.

Associates in General Surgery and Affiliated Providers

_____ I understand that my insurance may not pay the charges for your services and that you may bill me, and I may have to pay the bill in advance, or while my insurance is making it's decision. If my insurance denies payment, I agree to be personally and fully responsible for payment. If my insurance does pay, you will refund to me any payments I made to you, less co-payments and deductibles.

_____ I have decided not to receive services from you. I understand that you will not submit a claim to my insurance for services not rendered.

Signature of patient or person acting on patient behalf

Date

Associates in General Surgery, A MEDICAL CORPORATION

Kent Azaren, MD
Jeffrey Islas, MD
Steven Grant MD

Revised 04/27/2011

Associates in General Surgery, A MEDICAL CORPORATION
KENT H. AZAREN, MD JEFFREY T. ISLAS, MD STEVEN W. GRANT, MD
3610 LONG BEACH BLVD., SUITE 101
LONG BEACH, CA 90807
(562) 424-0421

Dear New Patient:

Thank you for selecting our practice. I look forward to meeting you. Your appointment is scheduled:

Date: _____

Time: _____ AM/PM.

In order to expedite your appointment on a timely basis, I do ask you to arrive 15 minutes early. If for some reason you are running late on your appointment day, please notify the office immediately.

Enclosed is our ***Information Packet***, which we ask to be filled out completely, and bring this with you on the day of your appointment date. If you have any questions regarding this information, please do not hesitate to call our office. If you need additional copies for friends or family members, we will be pleased to provide them. Again, thank you for selecting our practice. We promise to do our best to provide you with the best of care.

Sincerely,

Associates in General Surgery

Kent Azaren, MD
Jeffrey Islas, MD
Steven Grant, MD

A MAP OF OUR NEW LOCATON IS PROVIDED FOR YOUR CONVENIENCE ON THE NEXT PAGE!



**Associates in
General Surgery**

E. 36th St.



Long Beach Blvd.

Atlantic Ave.

W. Wardlow Rd.

710 Fwy

W. Spring St.

405 Fwy