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

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

Date

Time

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
Steven Grant, MD
Jeffrey Islas, MD
Claire Chavez Sakae, MD

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STEVEN W. GRANT, MD JEFFREY T. ISLAS, MD CLAIRE J. CHAVEZ SAKAE, MD

REGISTRATION FORM (Please Print)

Today's date:	Primary Care Physician:

PATIENT INFORMATION

Patient's last name: First: Middle:		❑ Mr. ❑ Mrs.	❑ Dr. ❑ Ms.	Marital status ❑ Single ❑ Married ❑ 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*

	05/10/2011
Dates Revised:	10/07/2018

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

Name *(Last, First, M.I.):* ☐ M ☐ F			**DOB:**
Occupation			
Previous or referring doctor:		**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

Reason for visit ☐ Abdominal Pain ☐ Gallstones ☐ Hernia: Type: ☐ Rectal Problem

Mass	☐ Breast	☐ Melanoma	Site:
	☐ Colon	☐ Liver Biopsy	☐ Skin Lesion Location:
	☐ Thyroid	☐ Other	

Do you Smoke? ☐ NO ☐ YES: IF YES, #YEARS? # PACKS PER DAY?

Do you drink alcohol? ☐ NO ☐ YES: IF YES, PLEASE EXPLAIN

ALLERGIES TO MEDICATIONS: ☐ SULFA ☐ PENCILLIN ☐IODINE ☐CODEINE ☐VICODIN ☐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?	☐ Yes	☐ No
Please state any problems	☐ None	

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 reach 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.

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:

Yamile Godinez, 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

Revised 09/20/2018

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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:

Revised 09/20/2018

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**

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Revised 09/20/2018

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PATIENT CONSENT FORM

AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

I authorize Kent H. Azaren, MD Inc., doing business as **Associates in General Surgery** to use and disclose a copy of the specific health and medical information described below regarding:

Patient Name:_____

Description of the specific information to be used or disclosed:

_____
_____
_____

Person or entity requesting the information

_____

This information is being requested for the following purpose(s):

_____
_____
_____

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By:_____ Date_____
(Patient)
Or By:_____ Date_____
(Agent for Patient) Title

This authorization expires:_____
(date)

If we are requesting this Authorization from you for our own use and disclosure or to allow another health provider or health plan to disclose health plan to disclose information to us:

- We will provide services or treatment to you even if we have not received a signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this authorization; and
- We must provide you with a copy of the signed authorization

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated , this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.