THE STERNBERG CLINIC

Patient Name:____ Today's Date: _____________

Birthdate: __________ Age:___ What name would you prefer to be called? __________ Gender (Circle one): Male Female

Parent's Name (if patient is a minor):___________________________________ Parent's DOB: ___/___/___

Address:________________________City:______________________State:_____Zip:_______

Home Phone: ( )__________ Work Phone: ( )____________ Cell Phone: ( )_____________

Email:____ SSN#_______-_____-_________

Employed by:___________________________ Occupation:___________________________

Spouse's Name:____________________ Spouse's DOB: ___/___/___ Occupation:_______________

Please provide the front desk with your ID & health insurance card so they may make a copy

Health Insurance ID#_______________________________ Customer Service Phone # ___________

Preferred Pharmacy: __________________________ Pharmacy Phone: ( )_______________

In case of emergency call:______________ Relationship: _________ Phone Number: ( )________

What is the reason for your visit today? ____

MEDICAL HISTORY

Primary Care Physician (include address if not local) ___________________________ Phone number: ( )__________

Who referred you to our practice? __________________ ☐ Same as above

Please list other physicians you wish reports sent to ________________________________

(Mark all that apply)

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding/Blood Disorder
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Glaucoma
- ☐ Heart Problems ________
- ☐ Heart Attack
- ☐ Hepatitis, type ________
- ☐ High Blood Pressure
- ☐ High Cholesterol or lipids
- ☐ HIV/AIDS
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Immune Disorder
- ☐ Kidney Disease
- ☐ Liver Disease (type __________)
- ☐ Pneumonia/Bronchitis
- ☐ Stomach Ulcer/Acid Reflux
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcerative Colitis
- ☐ Other ______________

Please list all of your previous operations and the approximate date (use back side of paper if needed):

1. ____ Date: _______________
2. ____ Date: _______________
3. ____ Date: _______________

Have you ever had problems with anesthesia? ☐ No ☐ Yes Explain: ______________________

Do you have a **pacemaker, defibrillator, or port?** ☐ No ☐ Yes

If yes, what is the Manufacturer's Name: ____________________, Model Number: ______________

Name: ______________________ Birthdate: ______________ Today's Date: ______________

MEDICATIONS

If you don't take any medications, check this box: ☐

Please list the medications (including over the counter) you take regularly and why you're taking it:

1. ____________ Reason ________ 2. ____________ Reason ________

3 ____________ Reason ________ 4. ____________ Reason ________

5. ____________ Reason ________ 6. ____________ Reason ________

7. ____________ Reason ________ 8. ____________ Reason ________

9. ____________ Reason ________ 10. ____________ Reason ________

11. ____________ Reason ________ 12. ____________ Reason ________

If you take a blood thinning medication, which one do you take?
Aspirin, Coumadin, Warfarin, Plavix, Pradaxa, Xarelto, Aggrenox, or other ______________________

ALLERGIES

If you don't have any known drug allergies, check this box: ☐

Please list the medications that you are allergic to:

1. ______________________ Reaction ______________________

2. ______________________ Reaction ______________________

3. ______________________ Reaction ______________________

4. ______________________ Reaction ______________________

Do you have a latex allergy? ☐ No ☐ Yes If yes, what's your reaction ______________
Do you have an allergic reaction to adhesives/tapes? ☐ No ☐ Yes
Are you allergic to iodine or shellfish? ☐ No ☐ Yes

SOCIAL HISTORY

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partner ☐ Decline to answer

Sexual Orientation ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Decline to answer

Use of Alcohol ☐ Never ☐ Rarely ☐ Moderate ☐ Daily, _____ drinks per day

Use of Tobacco ☐ Never ☐ Previously, but quit: __________ ☐ Current, packs/day: __________

Use of Illicit Drugs ☐ Never ☐ Type/Frequency: __________ ☐ Decline to answer

Do you engage in anal-receptive intercourse? ☐ No ☐ Yes ☐ Decline to answer

Name: ______________________ Birthdate: ______________ Today's Date: ______________

FAMILY MEDICAL HISTORY

Has anyone in your family had cancer ☐ No ☐ Yes

Type of cancer ______________ Relationship to you ______________ Age diagnosed ________

Type of cancer ______________ Relationship to you ______________ Age diagnosed ________

Type of cancer ______________ Relationship to you ______________ Age diagnosed ________

Check (✓) if your blood relatives have ☐ Colon polyps ☐ Crohn's or ulcerative colitis ☐ Thyroid/Endocrine Problems

REVIEWS OF SYSTEMS (ROS)

Please only check the boxes only if they are bothering you TODAY

CONSTITUTIONAL SYMPTOMS
- ☐ Good General Health
- ☐ Recent Weight Change
- ☐ Fever/Sweats
- ☐ Fatigue
- ☐ Headache

SKIN
- ☐ Rashes
- ☐ Psoriasis
- ☐ Bruise Easily
- ☐ Abnormal Lumps
- ☐ *No symptoms*

NOSE
- ☐ Sinus Problems
- ☐ Breathing Problems
- ☐ *No symptoms*

CARDIOVASCULAR
- ☐ Palpitations
- ☐ Heart Murmur
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ *No symptoms*

EARS
- ☐ Decreased Hearing
- ☐ Ringing in Ears
- ☐ *No symptoms*

GENITOURINARY
- ☐ Blood in Urine
- ☐ Frequency of Urination
- ☐ Painful Urination
- ☐ Loss of Bladder Control
- ☐ Enlarged Prostate
- ☐ *No symptoms*

GASTROINTESTINAL
- ☐ Nausea/Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Loss of Bowel Control
- ☐ *No symptoms*

ENDOCRINE
- ☐ Excessive Thirst/Appetite
- ☐ *No symptoms*

NEUROLOGIC
- ☐ Headache/Migraine
- ☐ Dizziness
- ☐ *No symptoms*

EYES
- ☐ Visual Loss
- ☐ Double Vision
- ☐ Painful Eyes
- ☐ *No symptoms*

THROAT
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Snoring
- ☐ *No symptoms*

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Cough
- ☐ *No symptoms*

MUSCULOSKELETAL
- ☐ Fractures/Sprains
- ☐ Osteoporosis
- ☐ Joint Swelling
- ☐ *No symptoms*

OTHER
- ☐ Pregnant: ______ weeks

____

____

____

____

____

Reviewed by: ______________________________ Date: ______________

MEDICAL ASSISTANTS USE ONLY

Ht: __________ Wt: __________ BP: __________ P: __________ T: __________

THE STERNBERG CLINIC

Office Policies & Procedures

By signing below you affirm that you have read and understood the policies as outlined below. You are accepting financial responsibility for all services received.

Printed Name: ______________________ Signature: ________________________ Date: ____________

Legal Representative Printed Name (if applicable): ______________________________

Legal Representative Signature (if applicable): _________________________________

Notice of Privacy Practices

All of our employees, managers, and physicians are trained to understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act of 1996 (HIPPA). We strive to achieve the highest standard of ethics and integrity in performing services for our patients. It is our policy to determine uses of Personal Health Information in accordance with government rules, laws and regulations.

We are required by law to provide individuals with this notice of our legal responsibilities and privacy practices with respect to Protected Health Information. We are also required to maintain the privacy of, and abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at the number listed below.

Tori Hastings	415-379-9015	tori@pacificplasticsurgerygroup.com
HIPAA COMPLIANCE OFFICER	*PHONE*	*EMAIL*

Office Policy

All patients must have proof of insurance.
You are responsible to know the requirements of your policy. Your insurance card will have an 800 number listed. Please call them directly. If you have no proof of insurance, you will pay in full at the time service is provided.

All Payments is expected at the time of visit
Payment is required at the time services are rendered. This includes applicable co-insurance, co-payments, and deductibles for participating insurance companies. If our office must bill you for a co-payment, you will be charged a $15.00 administrative fee. This fee cannot be charged to your insurance carrier. We accept cash, personal checks, Visa and MasterCard. A $35.00 fee will apply on any returned check.

Outstanding Balance
Patients with an outstanding balance must make arrangements for payment prior to scheduling appointments.

Copies of Records
For copies of medical records, an advance payment of $25.00 is required. The fee cannot be charged to your insurance carrier.

Disability Forms
For completion of all insurance disability forms other than California State Disability forms, an advance payment of $20.00 is required. This fee cannot be charged to your insurance carrier.

Billing Questions/Refunds
If you need any assistance, please call our billing department between 9:00am and 4:30pm, Monday through Friday at (415) 379-9015. Overpayments will be refunded upon written request within 30 days of our office confirmation. Invoices over 30 days will incur a late fee of $10.00

Insurance
We will bill participating insurance companies as a courtesy; however you are responsible for all charges not covered by your medical insurance, including but not limited to: copayments, deductibles, co-insurances and non-covered services.

Cancellation Policy
All patients who fail to arrive for their scheduled appointment or who cancel with less than 24 hour notice may be charged a non-refundable administrative fee of $50. Failure to cancel any surgeries or procedures within 48 hours of your scheduled appointment will result in a $100 fee. Any patient who cancels and reschedules a procedure two or more times may be charged an administrative fee for each occurrence. These fees cannot be charged to your insurance carrier.

Assignment of Benefits & Treatment Authorization
You are financially responsible for any changes not covered by your insurance carrier. It is your responsibility to notify us of any changes in your health care coverage. You are responsible for payment if the submitted claims or any part of them are denied for payment.

Notice of Financial Interest

While under our care, you may be advised to undergo certain endoscopic procedures or surgery for screening, diagnosis, management and possible treatment of your symptom or condition. We are in partnership with California Pacific Medical Center at the San Francisco Endoscopy Center and the Presidio Surgery Center, where these procedures can be safely and effectively performed.

California Business and Professions Code Section 654.2 require that The Sternberg Clinic disclose that we have a financial interest in the named centers. You may choose to have your procedures or surgery at a site in which we do not have a financial interest. If you wish, we can recommend an alternative site.

Presidio Surgery Center
A California Pacific Medical Center Affiliate

San Francisco Endoscopy Center
An Affiliate of
California Pacific Medical Center

Financial and Insurance/Health Maintenance Organization Assignment Policy

Thank you for selecting our office for your medical/surgical care. It is our mission to provide you with the best quality care, and we are happy to discuss or answer any questions you may have regarding your treatments. However, before we begin, we ask that you read and understand your insurance/health maintenance organization contract and agree to our office policies. Important points you need to know regarding your medical insurance and/or medical benefits:

1. Your insurance policy and/or health maintenance organization policy is a contract between you, the insurance company and possibly your employer or other parties. We as medical care providers are not party to this contract. Our relationship is with you, not with your insurance company or your health maintenance organization. As a courtesy to you we may file your insurance claims. However, all charges for services rendered are your responsibility, whether or not it is covered by your insurance policy or health maintenance organization.

2. Although your insurance policy or health maintenance organization may offer a list of benefits and their level of coverage, the insurance company or health maintenance organization does not guarantee payment. We can obtain an estimate of your coverage prior to beginning your treatment, but we will not know your exact benefit or the covered amount until the insurance company or health maintenance organization makes the payment on the claim submitted by you or submitted by us on your behalf. I hereby authorize payments of medical benefits from my insurance company or health maintenance organization to be directly assigned to The Sternberg Clinic ("the Corporation") for services rendered. I understand and agree that I am financially responsible to the Corporation for all charges whether or not paid by my insurance company or health maintenance organization. I further agree that I am responsible for any costs incurred by the Corporation in attempts to collect debts owed by me to the Corporation including but not limited to reasonable attorneys' fees. I understand and agree that payments are due at the time of service, and late charges up to 1.5% per month may be assessed to delinquent accounts. I authorize The Sternberg Clinic and its agents and business associates to release all information necessary to secure the payment of benefits.

I understand and agree to all of the above.

Print Patient Name ____ Date ___________

Patient Signature (or Parent/Guardian if patient is a minor) ______________________________

Office Representative's Signature: ______________________________________ Date ___________

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception are, and that I will be offered a copy of any amended Notice of Privacy Practices in each appointment.

____ I would like to receive a copy of any amended Notice of Privacy Practices by email at:

____

Signature: ______________________________________ Date: ____________

Print Name: ________________________________ Telephone: ______________

Acknowledgement of Notice of Association

The Physicians in this office are not partners or otherwise affiliated in the same medical practice with 77 Plastic Surgery or Dr. Fan. They are all independent practitioners and simply share office space, equipment, and staff in their separate practices. They are not responsible for each other practices or patients.

Signed:____ Date:______________

Notice to Consumers

Medical doctors are licensed and regulated by the Medical Board of California.

(800) 633-2322 www.mbc.ca.gov

and,

Physician Assistants are licensed and regulated by the Physician Assistant Board.

(916) 561.8780 www.pac.ca.gov

Signed:____ Date:____________

If not signed by the patient, please indicate:

Relationship:_____ Parent or guardian of minor patient

_____ Guardian or conservator of an incompetent patient

Name of Patient: ____

For Appeal to My Insurance/Health Plan to Pay for My Medical Claims
Designation of Authorized Representative

RE: Patient Name: Plan No.:

Insured Name: Insured ID:

Employer for Insured:

In the event that my claim(s) in a significant amount for medically appropriate health care is/are improperly denied by my insurance/health plan, which may result in financial hardship, disturbance or medical indigence in paying for such significant amount of medical expenses at this time, **I hereby designate my healthcare provider listed above to take all necessary steps, as my authorized representative on my behalf, to pursue administrative or judicial appeals, in order to seek reimbursement payments for my medical expenses that I am otherwise legally entitled to under the terms of my insurance/health plan as well as pursuit of any fiduciary breach in administration of the plan.** I would like to make this designation and authorization absolutely clear and to the fullest extent permissible under applicable federal and state laws, for my authorized representative to pursue and appeal a benefit determination under my insurance/health plan, to act and to **directly receive reimbursement payment checks**, notices and any applicable judicial remedies, on my behalf with respect to my significant balance for this medical claim. In the absence of a contrary direction from myself, my insurance/health plan must comply with applicable federal and state laws by directing all information and notifications, to which I am otherwise legally entitled to under the terms of my insurance/health plan and applicable federal and state laws, to my authorized representative, as listed above, authorized to act on my behalf with respect to that aspect of the claim (e.g., initial determination, request for documents, appeal, SPD and remedies, reimbursement checks, etc.).

Both federal and state laws protect my rights to appeal for improper denials for my medically appropriate health care, especially in this case with such a significant balance in my account. The applicable federal laws specifically prohibit anyone from precluding or interfering with my rights to designate, to assign my healthcare provider as my authorized representative to exercise such protected right in helping me in this regard of medical and financial security because my healthcare provider has better knowledge and skills in medical science, clinical experience, billing and coding terminology in healthcare delivery industry.

Time is of the essence, and the applicable federal laws require prompt verification procedure completed and response to my appeal in 30 days and no more than 45 days if you need additional information. If you have any questions regarding this authorization, please act so within timeline as mandate by federal laws. Failure to adjudicate my claims and my appeals as required by federal law may impose more financial hardship on me and negatively affect my credit profile, more dangerously; refusal to pay my account properly will discourage me or prevent me from seeking prompt medically necessary care for my current and future medical conditions.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

______________________________ ____________________

Signature of Patient / Guardian Date

Arbitration Agreement

ARTICLE 1

It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2

a. Parties To The Agreement. The term "Patient" as used in this Agreement includes the undersigned individual, his or her spouse, children (whether born or unborn), and heirs, assigns, or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons, and intends to bind each of them to arbitration to the full extent permitted by law.

The term "Provider" as used in this Agreement includes the undersigned doctor, nurse practitioner, nurse midwife, or other health care provider and his or her professional corporation or partnership, and any employees, agents, successors-in-interest, heirs, and assigns of the foregoing individuals or entities. The provider signing this Agreement signs it on behalf of all the foregoing individuals and entities, and intends to bind each of them to arbitration to the full extent permitted by law.

b. Treatment Covered. Patient understands and agrees that any dispute of the sort described in Article 1 between Provider and Patient will be subject to compulsory, binding arbitration.

c. Other Providers (If Applicable). Patient understands that he or she may at times receive treatment from one or more health care providers who take call for, render medical services by arrangement with, or otherwise substitute for the undersigned Provider. It is understood and agreed that any dispute of the sort described in Article 1 between Patient and such health care providers will also be subject to compulsory, binding arbitration.

d. Coverage of Prenatal Claims (If Applicable). Patient understands and agrees that, if Provider treats her during pregnancy, any dispute of the sort described in Article 1 as to medical treatment rendered to or affecting the unborn child will be subject to compulsory, binding arbitration.

ARTICLE 3

a. Informal Resolution of Disputes. In the event Patient feels that an issue has arisen in connection with the medical care rendered by Provider, Patient will promptly notify Provider so that the parties may have an opportunity to resolve the matter informally.

b. Method of Initiating Arbitration. If the issue cannot be resolved informally, Patient may initiate arbitration by sending a written demand to the Provider briefly describing the nature of his or her claim. Patient and Provider shall each designate an arbitrator to act as their respective party arbitrators. If more than two parties participate in the arbitration, parties aligned with Patient shall select one party arbitrator, and parties aligned with Provider shall select the other party arbitrator. The two party arbitrators shall select a third person to serve as a neutral arbitrator, and the decision of the three arbitrators shall be final and binding upon the parties.

c. Applicable Law. The arbitration shall be conducted pursuant to the California Arbitration Act (C.C.P. 1280-1296). The arbitrators shall, in addition, have authority to order such other discovery as they deem appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California which shall apply to the same extent as if the dispute were pending before a superior court of this State.

d. Interpretation of Agreement. If any part of this Agreement is held unenforceable, it shall be severed and shall not affect the enforceability of the remainder. This Agreement supersedes and replaces any previous arbitration agreement between Provider and Patient and applies to all care previously rendered by Provider to Patient.

ARTICLE 4

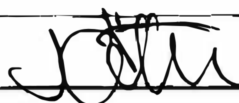
a. Rescission. Once signed, this Agreement governs all subsequent medical services rendered by Provider to Patient until or unless rescinded by written notice within 30 days of signature. Written notice may be given by a guardian or conservator of Patient if Patient is incapacitated or a minor.

NOTICE; BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient's Name *(Please Print)*: ______________________________

Dated: ____________________ Signed: ______________________________

Provider's Name *(Please Print)*: ______________________________

Dated: ____________________ Signed:  ______________________________