PATIENT QUESTIONNARE

Newport Coast Surgery Center

Patient's Information

Patient's Name: _____
Last First Middle Initial

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Email Address: _____ Primary Contact Number: ☐ Cell ☐ Home Work

Home: _____ Cell: _____ Work: _____

Is this your first visit to our surgery center? YES NO Referring Physician: _____

Contact Preferences

I wish to be contacted in the following manner: (Check all that apply)	OK to leave a message with detailed information:	Leave a message with only a call back number:	OK to leave a message with a friend or family member regarding medication, surgery, appts., and health care?
☐ NONE ☐ Cell ☐ Home ☐ Work ☐ Email	☐ NONE ☐ Cell ☐ Home ☐ Work ☐ Email	☐ NONE ☐ Cell ☐ Home ☐ Work ☐ Email	☐ **YES** ☐ **NO** Patient Initials: _____

Name of Adult Person driving you home after your procedure: _____
Contact Number: _____ **Relationship:** _____

Patient Health History ☐ **Denies any Past Medical History**

Neurologic
☐ Stroke/TIA *Date:*_____
☐ Seizures / Tremors
☐ Multiple Sclerosis
☐ Muscle Weakness
☐ Parkinson's Disease
☐ Sensory Loss
☐ Numbness *Areas:*_____
☐ Migraines / Chronic Headache
☐ Hearing Loss
☐ Blindness *Full / Partial*
☐ Memory Difficulties
☐ Mental Illness _____
☐ Hallucinations
☐ Bipolar Disorder
☐ Schizophrenia
☐ OTHER : _____
_____
_____

Respiratory
☐ Asthma
☐ Emphysema
☐ Sleep Apnea
☐ CPAP Use
☐ Shortness of Breath
☐ Tuberculosis
☐ Pneumonia
☐ Oxygen Dependent
☐ Chronic Long Disease
☐ COPD
☐ OTHER: _____

Renal / Endocrine
☐ Hepatitis
☐ Kidney Failure / Infusion
☐ Thyroid Disease
☐ Diabetes *Type I / Type II*
☐ Take Insulin ☐ Take GLP1

Cardiovascular
☐ Hypertension
☐ Arrhythmia
☐ Pacemaker
☐ AICD
☐ Chest Pain
☐ Valvular Disease
☐ Heart Attack
☐ Rheumatic Fever
☐ Palpitations

Misc. Conditions
☐ Cancer *Type:*_____
☐ Chemotherapy
☐ Pregnancy
☐ Bleeding Tendencies
☐ Blood Transfusion
☐ Musculoskeletal Disease
☐ OTHER:_____

Gastrointestinal
☐ Reflux
☐ Ulcers
☐ Hernia
☐ Jaundice
☐ Bowel Obstruction
☐ Diverticulitis
☐ OTHER:_____

☐ **There are no changes in my health history since my last visit to Newport Coast Surgery Center.**
Date of Last Procedure:
_____
Physician: _____
Patient Initials: _____

Social History Please indicate your approximate use or intake of the following:

☐ Coffee: _____ cups/day ☐ Do Not Drink Coffee ☐ Alcohol: _____ glasses/ per day ☐ Do Not Drink Alcohol

☐ Tobacco Use: ☐ Marijuana Use: ☐ **NEVER**

☐ Cigarettes/Cigar/Pipe ☐ E-Cig/Vape ☐ Smokeless Tobacco ☐ Gummies or Other Form

☐ Current Smoker/Tobacco user _____ packs per day ☐ Former Smoker *Date Quit:* _____

Recreational Drugs:

☐ Never ☐ Former ☐ Current Substances Used: _____

Patient Surgical History ☐ **Denies any Past Surgical History**

List any operations and indicate the approximate date or your age at the time of the procedure:

_____
_____

☐ **There are no changes in my social or surgical history since my last visit to Newport Coast Surgery Center.**
Date of Last Procedure: _____ Physician: _____ Patient Initials: _____

Newport Coast Surgery Center

PATIENT QUESTIONNARE

Allergies ☐ **No Known *Drug* Allergies**

Please list any medication allergies and the allergic response/effect:

_____

_____

_____

Sensitivities ☐ **No Known *Drug* Sensitivities**

Please list any medication sensitivities and the response/effect:

_____

_____

_____

Medication Reconciliation ***THIS FORM NEEDS TO BE COMPLETED PRIOR TO EVERY PROCEDURE***

Please check if you are taking any of the blood thinning medications below? ☐ **Denies taking any blood thinners**

☐ Coumadin (Warfarin)	☐ Heparin	☐ Aggrenox (Dipyridamole/ASA)	☐ Aspirin
☐ Plavix (Clopidogrel)	☐ Brilinta (Ticagrelor)	☐ Agrylin (Anagreline)	☐ Other:
☐ Xarelto (Rivaroxaban)	☐ Arixtra (Fondiparinux)	☐ Elmiron (Pentosan)	_____
☐ Eliquis (Apixaban)	☐ Pletal (Cilostazol)	☐ Reopro (Abciximab)	_____
☐ Lovenox (Enoxaparin)	☐ Effient (Prasugrel)	☐ Trental (Pentoxifyline)	**Date Last Taken:**
☐ Pradaxa (Dabigatran)	☐ Fragmin (Dalteparin)	☐ Ticlid (Ticlopidine)	_____

List all Medications taken, dosage, frequency and last date/time taken:

Medication / Drug	*Amount or Dose*	*Frequency*	*Last Taken*

Pre-OP Nurse to verify medication list.	**Verified By:** **Date / Time:**
Bottom Section to be completed by PACU RN	
Resume all medications listed above Except:	☐ **YES** ☐ **NO** _____ _____
Medication Reconciliation Completed by PACU RN	**Completed By:** **Date / Time:** ☐ **Copy Given to Patient**

Newport Coast Surgery Center

CONDITIONS OF ADMISSION CONSENT

1. CONSENT TO MEDICAL AND SURGICAL PROCEDURES: The undersigned consents to the procedures which may be performed on an outpatient basis, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, anesthesia, or outpatient services rendered to the patient under the general and special instructions of the patient's physician or surgeon. The undersigned also consents to admission to a hospital post-operatively should the treating health care provider deem this necessary.

2. NURSING CARE: The surgery center provides only general duty nursing care unless, upon orders of the patient's attending physician or surgeon, the patient is provided with more intensive nursing care. If the patient's condition is such as to need the services of a special duty nurse, it is agreed that such must be arranged by the patient or his/her representative. The surgery center shall in no way be responsible for failure to provide the same and is hereby released from all liability arising from the fact that said patient is not provided with such additional care.

3. LEGAL RELATIONSHIP BETWEEN SURGERY CENTER AND PHYSICIAN/SURGEON: The patient is under the care and supervision of his/her attending physician or surgeon, and it is the responsibility of the surgery center and its nursing staff to carry out the instructions of such physician or surgeon. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures or outpatient services rendered to the patient under the general and special instructions of the physician or surgeon. Any questions concerning the nature or results of any examination or treatment should be directed at the patient's attending physician or surgeon and not to the surgery center employees.

4. RELEASE OF INFORMATION: Newport Coast Surgery Center may disclose all or part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV to any person or corporation (1) which is or may be liable under contract to Newport Coast Surgery Center for reimbursement for services rendered and (2) any health care provider for continued patient care. Newport Coast Surgery Center may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, and medical research, for the collection of statistical data or pursuant to State or Federal Law, statute, or regulation.

If the patient or the patient's representative does not want such information to be released, he/she must make a written request for said information to be withheld. The patient or his/her representative may obtain a separate form from the surgery center for this purpose, upon request.

The surgery center shall not release information, other than basic information, concerning the patient without the patient's consent and his/her written authorization to release such information, except in those circumstances where the surgery center is permitted or required by law to release information without the patient's consent or authorization.

The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, the surgery center may disclose portions of the patient's record, including his/her medical record, to any person or entity which is or may be liable for all or any portion of the surgery center's charges, including but not limited to government agencies (e.g. Medicare), insurance companies, health care services plans, or workers' compensation carriers. California state laws require us to report certain cases of infectious diseases and cancer to governmental health agencies.

5. PERSONAL VALUABLES: It is agreed and understood that the surgery center shall not be responsible for any personal property, including but not limited to money, jewelry, documents, or other articles of unusual value. It is agreed and understood that if the patient elects to leave personal valuables in the patient lockers during surgery, the surgery center is not liable for loss or damage to said property.

6. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Newport Coast Surgery Center, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Newport Coast Surgery Center for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, liable to the patient, are hereby assigned to Newport Coast Surgery Center. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Newport Coast Surgery Center. However, it is understood that the undersigned and/or patient are primarily responsible for the payment of the patient's bill. The undersigned assumes all financial responsibility for any post-operative hospitalization.

Newport Coast Surgery Center

CONDITIONS OF ADMISSION CONSENT

7. ASSIGNMENT OF INSURANCE BENEFITS: The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the surgery center of any insurance or other applicable (e.g. Medicare) benefits otherwise payable to or on behalf of the undersigned or patient for these outpatient services, including emergency services if rendered, at a rate not to exceed the surgery center's regular charges. It is agreed that payment to the surgery center, pursuant to this authorization, by an insurance company shall discharge said insurance company for any and all obligations under a policy to the extent of such payment. It is further understood by the undersigned that he/she is financially responsible for charges not collected by this assignment unless otherwise stated by applicable written contract or law.

8. HEALTH CARE SERVICE PLAN OBLIGATION: The surgery center maintains a list of the health care service plans with which it has contracted. A list of such plans is available upon request from the financial office. The surgery center has no contract, express or implied, with any plan that does not appear on the list. The undersigned agrees whether he/she signs as agent or patient, that he/she is individually obligated to pay the full charge for all services rendered to the patient by the surgery center, if he/she or the patient belongs to a plan which does not appear on the above-mentioned list.

9. NON-COVERED SERVICES: I understand that Newport Coast Surgery Center's contracts with health care service plans (ie: Medicare, Most PPO Payors, etc.) relate only to items and services which are "covered" by the health care services plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with health care service plan or in the benefit summary the health care service plan furnishes to the patient: and treatment or test not authorized by the health care service plan. The undersigned agrees to cooperate with Newport Coast Surgery Center to obtain necessary health care service plan authorizations.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute this document and accept and agree to its terms.

_____ _____

Patient Signature (If patient is unable to sign, please indicate authorized signer relationship) Date

_____ _____

Witness Signature Date

Newport Coast Surgery Center

FINANCIAL POLICY

Please note: This financial policy does not apply to Worker's Compensation patients.

- According to your insurance plan, you are responsible for any and **all co-payments, co-insurance and deductible.** These amounts are **not** negotiable.
- It is **your** responsibility to understand your benefit plan. It is your responsibility to know if a prior authorization is needed for a procedure and what services will be covered. We will assist with this process, but **we are not responsible for the ultimate payment determination by your insurance carrier.**
- If you are a cash patient, payment is required at the time of service (no exceptions).
- **Any balance over 60 days that is unpaid or not part of an agreed payment plan will be forwarded to a collection agency. You agree to pay all costs of collection including reasonable attorney fees and court costs should you fail to pay the amount owed when due.**
- We will require you to provide a credit card for us to keep on file. This card will be charged for any amounts applied to your responsibility.

NON-INSURANCE FEES (due prior to next visit being scheduled)

Appointments cancelled with less than 24 hours' notice	$35
Office visit no-show	$50
Surgery center appointment cancelled with less than 24 hours' (business day) notice	$175
Surgery center visit no-show	$250
NSF check	$40
Disability/EDD Forms	$25/per page
Medical records	$15/per page minimum $60
Report requiring physician dictation	$200/per page
Medication authorization	$30

I have read and understand this office's financial policy and agree to comply and accept responsibility for any payment that becomes due as outlined above.

Patient Name _____ Signature _____ Date _____

Newport Coast
Surgery Center

CREDIT CARD AUTHORIZATION FORM

Our facility requires that a credit card be kept on file for payment of any co-payment, coinsurance, deductible, or charge that may not be covered by your health insurance. This form will be kept confidential and only authorized staff has access to the information.

PATIENT'S NAME: _____

NAME, AS IT APPEARS ON CREDIT CARD: _____

BILLING ADDRESS: _____

_____

EMAIL ADDRESS: _____

AMEX/DISC/MC/VISA CARD # _____

EXPIRATION DATE: _____/_____ **VERIFICATION CODE (3 or 4 DIGITS)** _____

PLEASE PROVIDE THE CARDHOLDER'S DRIVER'S LICENSE

I acknowledge and authorize Newport Coast Surgery Center to charge the above credit card account for any co-payment, co-insurance, deductible and/or charges not covered by my health insurance provider.

I acknowledge that my card will be run in the event of a no show to a scheduled appointment or procedure, if I provide less than 24 hours (Business day) notice for a cancelled appointment or if payment is not received within thirty days after I receive a statement. I agree to receive billing statements, invoices and receipts via the email I have provided to this office. If I am an uninsured patient I authorize payment at time of service. I agree to update any information regarding this credit card account.

_____ _____

Cardholder Signature Date

Newport Coast Surgery Center

Patient Notification and Acknowledgement

Notice of Rights

Newport Coast Surgery Center has established a Patient's Bill of Rights, which is provided verbally and in writing in a language and manner the patient or patient's representative understands prior to the date of the procedure. The Newport Coast Surgery Center expects that observance of these rights will contribute to more effective patient care and greater satisfaction for patients, physicians, and the facility.

Financial Disclosure

Newport Coast Surgery Center is privately owned and has informed the patient prior to the date of the procedure that their physician may have a proprietary interest in this facility. The patient has the right to choose the facility of his/her choice for health-related services. The following are names of the Physician owners: Richard Paicius, MD., Sten Kramer, MD., Andrew Merritt, MD., Mark Wardenburg, MD, Clifford Bernstein, MD., Michael Weinstein, MD., Jon White, MD., Scott Small, DO.

Advance Directives

Because the scope of Newport Coast Surgery Center is limited to elective outpatient surgical procedures, it is the policy of this facility that any life-threatening situation that arises will be immediately treated with life-sustaining measures. Concurrently, the emergency medical system (EMS) will be activated for emergency patient transport to a hospital facility. The patient's right and need to be an active participant in the decision-making process regarding their care is recognized and respected. Acknowledgement of this policy does not revoke or invalidate any current health care directive or health care power of attorney.

Please check the appropriate box. Have you executed an advance health care directive, a living will and/or a power of attorney that authorizes someone to make health care decisions for you?

- ☐ **Yes**, I have an advance health care directive, living will and/or a power of attorney.
- ☐ I have provided a copy of my advance health care directive, living will and/or a power of attorney.
- ☐ **No**, I do not have an advance health care directive, living will and/or a power of attorney.
- ☐ I would like additional information on advanced health care directives.

By signing this document, I acknowledge that the above information was given to me prior to my day of surgery, and that I have read and understand the information on notice of privacy practices, patient rights, financial disclosure, and advance directives. I agree with the policies of Newport Coast Surgery Center. If I have indicated I would like additional information, I acknowledge receipt of that information.

_____ _____

Patient Signature (If patient is unable to sign, please indicate relationship) Date

_____ _____

Witness Signature Date

Patient Sticker

Newport Coast Surgery Center

Privacy Practices Acknowledgement

By signing this form, you acknowledge that you have been informed that Newport Coast Surgery Center provides information about how we may use and disclose your Protected Health Information (PHI). We encourage you to read the "Notice of Privacy Practices" posted in our lobby. If you would like a paper copy, please ask the receptionist.

Newport Coast Surgery Center may use the following methods of communication regarding information related to my personal health, treatment, or payment for treatment. I acknowledge I am responsible for updating this information as necessary. This request supersedes any prior request for methods of communication I may have made.

☐ Contact me by phone at home _____

☐ Work _____ ☐ Cell _____

☐ Newport Coast Surgery Center may leave a message on my voice mail/answering machine

☐ Newport Coast Surgery Center may speak to anyone who answers the phone

☐ Newport Coast Surgery Center may only speak to _____

☐ Newport Coast Surgery Center may leave a message for me at my work phone number

Questions or concerns about our Privacy Notice or Practices should be directed to the Privacy Officer at (949) 718-3600.

Signature_____ Date_____
(Patient/Parent/Conservator/Guardian)

Inability to obtain acknowledgement: *To be completed only if no signature is obtained:*

☐ Patient lacks the ability to understand the Notice of Privacy Practices

☐ Other_____

Signature_____ Date_____
(Provider Representative)

Patient Label/Printed Name_____

Newport Coast Surgery Center

PATIENT-PHYSICIAN 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 contractual agreement 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 of arbitration proceedings. Both parties to this contractual agreement, by entering into it, are giving up their constitutional right to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2: I understand and agree that this Arbitration Agreement binds me and anyone else who may have a claim arising out of or related to all treatment or services provided by the physician, including any spouse or heirs of the patient and any children, whether born or unborn at the time of the occurrence giving rise to any claim. This includes, but is not limited to, all claims for monetary damages exceeding the jurisdictional limit of the small claims court, including, without limitation, suits for loss of consortium, wrongful death, emotional distress or punitive damages. I further understand and agree that if I sign this Agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person(s) will also be bound by this Agreement, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this Agreement relates to claims against the physician and any consenting substitute physician, as well as the physician's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete resolution of any dispute arbitrated under this Agreement, as set forth in the Medical Arbitration Rules of the California Medical Association and the California Hospital Association.

ARTICLE 3: I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

ARTICLE 4: I UNDERSTAND THAT I DO NOT HAVE TO SIGN THIS AGREEMENT TO RECEIVE THE PHYSICIAN'S SERVICES, AND THAT IF I DO SIGN THIS AGREEMENT AND CHANGE MY MIND WITHIN 30 DAYS OF TODAY, THEN I MAY CANCEL THIS AGREEMENT BY GIVING WRITTEN NOTICE TO THE UNDERSIGNED PHYSICIAN WITHIN 30 DAYS OF THE DATE OF MY SIGNATURE BELOW STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT.

ARTICLE 5: On behalf of myself and all others bound by this Agreement as set forth in Article 2, agreement is hereby given to be bound by the Medical Arbitration Rules of the California Medical Association and the California Hospital Association, as they may be amended from time to time, which Rules are hereby incorporated into this Agreement. A copy of these Rules is included in the pamphlet in which this Agreement is found. Additional copies of the Rules are available from the California Medical Association, 1201 J Street, Suite #200 Attention: Publication Department, Sacramento, CA 95814 or at www.cmanet.org.I understand that disputes covered by this Agreement will be covered by California law applicable to actions against health care providers, including the Medical Injury Compensation Reform Act of 1975 (including any amendments thereto).

ARTICLE 6: OPTIONAL: RETROACTIVE EFFECT If I intend this Agreement to cover services rendered before the date this Agreement is signed (for example, emergency treatment), I have indicated the earlier date I intend this Agreement to be effective from as confirmed by my initials immediately below.

Earlier effective date: _____ **Patient's Initials:** _____

ARTICLE 7: I have read and understand all of the information in this pamphlet, including the Introduction to the Patient-Physician Arbitration Agreement, this Agreement, and the Rules. I understand that in the case of any pregnant woman, the term "patient" as used herein means both the mother and the mother's expected child or children.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY SIGNING THIS CONTRACTUAL AGREEMENT 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 AGREEMENT.

_____ _____

Patient, Parent/Guardian or Legally Authorized Representative Signature **Date**

If signed by other than patient, indicate relationship: _____

PHYSICIAN'S AGREEMENT TO ARBITRATE

I agree to be bound by the terms set forth in this Agreement and in the Rules specified in Article 5 above.

_____ _____ _____

Physician Signature **Physician Name, Medical Group or Association** **Date**