



PATIENT INFORMATION

Name (Last, First Middle Name): SS#
Address: City:
State: Zip: Driver License #: State: Gender: M F
Date of Birth: Age: Marital Status: Home Phone: ( )
Ethnicity: Caucasian African American Hispanic Asian Other Decline to State
Email:
Employer: Business Phone: ( )
Occupation: Cell Phone ( )
Business Address City: State: Zip:
Name of Spouse/Parent: SS#
Spouse/Parent Address: City: State: Zip:
Spouse/Parent Home Phone: ( ) (if patient is minor) Parent Driver License# State:
Spouse/Parent Employer: Business Phone: ( )

EMERGENCY CONTACT

Contact Telephone #: ( ) Name Relationship:
INSURANCE/PAYMENT INFORMATION:
Type of Payment: Insurance (attach photocopy of information) Cash Lien (attach Lien document)
Primary Insurance Policy #: Policy Holder:
Secondary Insurance Policy #: Policy Holder:

Patient/ Responsible Adult Signature: Date:
Patient/Responsible Adult Print Name: \*Relationship to Patient
\*If signed by person other than patient
Interpreter (If required) Signature: Print Name
Interpreter relationship to patient (if applicable)

Fill out this section ONLY if you accept financial responsibility for the patient for whom you have NO legal responsibility.

I, the undersigned person, hereby certify that I have accepted total financial responsibility for the above patient, for the care/treatments rendered to the patient by the Center and all their providers including but not limited to: Physicians, anesthesiologists, radiology, laboratories, and clinical care workers. I understand that I do not currently have any legal responsibility to provide financial support for this patient. I also understand that, by signing below, I agree to personally accept full responsibility for all financial costs associated with the care/treatments/services provided to the patient by Center. Furthermore, I certify that I have had the opportunity to ask all questions related to this matter and was given adequate answers. Please fill in all sections below and sign where indicated.

Last Name: First M.I. SS#:
Relationship to Patient: Home phone: Date of Birth:
Address: City State Zip
Driver License OR photo ID # Type of ID: State issued:
Occupation: Employer: Bus Phone:
Signature of Responsible Party Print Name:



# Patient's Communication Preferences Regarding their PHI

## 1. Telephone Communication Preferences

Home # \_\_\_\_\_

Work # \_\_\_\_\_

Mobile # \_\_\_\_\_

Other \_\_\_\_\_

## 2. E-Mail Communication Preferences

Email Address \_\_\_\_\_

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that Pacific Endoscopy and Surgery Center or one of its legal agents, or affiliates may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device.

If an email address has been provided, Pacific Endoscopy and Surgery Center or one of its legal agents, or affiliates may contact me with an email notification regarding my care, our services, or my financial obligation.

I recognize that text messaging is not a completely secure means of communication because these messages can be accessed improperly while in storage or intercepted during transmission. The text messages you receive may contain your personal information. If you would like us to contact you by text message please sign this consent below. If you consent to receiving text messages you also agree to promptly update Pacific Endoscopy and Surgery Center when your mobile phone number changes. You are not required to authorize the use of text messaging and a decision not to sign this portion of the authorization will not affect your health care in any way.

Patient's Signature for consent to text message.

## 3. Mail Communication Preferences

May we send mail to your home address? (If no, please provide an alternate mailing address below.)

## 4. Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply)

	<u>Name:</u>	<u>Telephone</u>
<input type="checkbox"/> Spouse	_____	_____
<input type="checkbox"/> Caretaker	_____	_____
<input type="checkbox"/> Child	_____	_____
<input type="checkbox"/> Parent	_____	_____
<input type="checkbox"/> Other	_____	_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

Patient or Personal Representative Signature

Date

Printed Name

Relationship to Patient



**ASSIGNMENT OF BENEFITS**

I hereby authorize my Insurance Company to pay by check made payable and mailed directly to:  
**Pacific Endoscopy & Surgery Center  
P.O. Box 8539  
Fountain Valley, CA 92728**

for the medical and surgical benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for the services rendered. I understand that as a courtesy to me, Pacific Endoscopy & Surgery Center will file a claim with my insurance company on my behalf. However, I am financially responsible for, and hereby do agree to pay, in a current manner, any charges not covered by the insurance payment. If it is necessary to file a formal collection action, I agree to pay all costs incurred by the outpatient center in the collection of the outstanding fees. Actual Plan Benefits cannot be determined until the claim is received by your insurance company and is based on their determination of medical necessity. The information received from the above stated is not a guarantee of payment.

**I hereby authorize my Insurance Company to pay by check made payable to Pacific Endoscopy & Surgery Center.**

Patient Name (Please Print)

Patient's Signature

Date/Time

Authorized Representative (Please print if applicable)

Relationship to Patient

Authorized Representative's Signature

**NOTICE TO PATIENT:**

**All** the physicians who provide you with **any** care during your admission to Pacific Endoscopy and Surgery Center are **not** employed by the surgery center. These physicians have private practices and will bill you separately for the professional services they decide, in the exercise of their professional judgment, to provide to you during your admission

**I understand that my treating Doctors are not Pacific Endoscopy and Surgery Center, LLC employees.**

Patient Name (Please Print)

Patient's Signature

Date/Time

**Are you participating in a clinical research study?**    No    Yes    Unknown



## ASSIGNMENT OF BENEFITS

For ANESTHESIA SERVICES rendered, I hereby authorize my Insurance Company to pay by check made payable and mailed directly to:

Dr. P. Nguyen  
18760 E. Amar Rd PMB 187  
Walnut, CA 91789

for the anesthesia benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for the services rendered. I understand that as a courtesy to me, my anesthesia provider will file a claim with my insurance company on my behalf. However, I am financially responsible for, and hereby do agree to pay, in a current manner, any charges not covered by the insurance payment. If it is necessary to file a formal collection action, I agree to pay all costs, including reasonable attorney's fees incurred by the outpatient medical center in the collection of the outstanding fees.

Actual Plan Benefits cannot be determined until the claim is received by your insurance company and is based upon their determination of medical necessity. The information received from the above stated is not a guarantee of payment.

X

\_\_\_\_\_  
Patient Signature or Responsible Person

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Relationship to patient if not patient



**NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT**

A **Notice of Privacy Practices (NPP)** is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Name Patient's Personal Representative

\_\_\_\_\_  
Signature of Patient's Personal Representative

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Signed

**FOR INTERNAL USE ONLY**

\_\_\_\_\_  
Name of Employee

\_\_\_\_\_  
Signature of Employee

If applicable, reason patient's written acknowledgement could not be obtained:

- Patient was unable to sign.
- Patient refused to sign.
- Other \_\_\_\_\_

\_\_\_\_ - \_\_\_\_ (Version: As noted on NPP)

\_\_\_\_/\_\_\_\_/\_\_\_\_ (Date: As noted on NPP)



## PACIFIC ENDOSCOPY AND SURGERY CENTER FINANCIAL AGREEMENT

We see patients with many different insurance plans and it is impossible for us to know all the covered benefits, co-pays and deductibles for each plan. However, we will do our best to get the most accurate information and any pre-authorizations/pre-certification for your procedure from the information you provide at the time of scheduling. Therefore, it is imperative that you provide the most current and accurate insurance information at the time of scheduling and at the time of service. If there is a change you must notify your doctor's office prior to your procedure. Failure to provide the most current insurance information may result in a denial of payment from your insurance company and the entire balance will be your responsibility. Ultimately, it is the patient's responsibility to know and understand their own benefits and policy responsibilities.

You may receive up to 4 individual bills for your procedure: a facility claim, performing doctor's office, laboratory if you have biopsies and anesthesia, if anesthesiologist is present. Our office is only responsible for the facility portion of your claims; you will need to contact the other offices if you have questions on their bills.

A "covered" benefit does not imply that your procedure will be paid in full by your insurance company. It simply means that the insurance company covers this type of procedure/facility under your plan and they will process the claim under your individual plan coverage guidelines. Additional procedures may be required during your procedure as part of your treatment and this may increase the out of pocket responsibility for my procedure.

The guarantor is responsible for paying facility co-pays, deductibles, estimated facility co-insurance amounts, and any balance not covered by insurance.

The facility will file primary and secondary insurance claims for patients who are not scheduled as "self-pay".

### **Medicare patients:**

- You must have Medicare Part B coverage to have your procedure done at our facility
- We are a Medicare provider; please check your secondary plan benefit to determine what your responsibility for deductible and co-insurance will be
- If you are having a screening colonoscopy you may be required to sign an Advanced Beneficiary notice if our office feels that you may not be covered.

### **Contracted insurances:**

- We are currently contracted with Aetna, Blue Cross, Blue Shield, Cigna/Greatwest, Coventry, First Health, Healthnet, and United Healthcare.
- Contracts may change at any moment, which could result in a change of out of pocket responsibility.
- Once a claim is filed to the insurance company, you cannot change your information and request to be considered self-pay.
- Any quote provided to you at the time of service is only an estimate.
- HMO-insurances-it is the patient's responsibility to ensure that there is a current authorization for their procedure. At the time of service if you did not provide the correct insurance and the new insurance required authorization, which was not obtained due to patient error, the balance will become patient responsibility. If you receive services for a denied procedure, the balance will become patient responsibility.

### **Out of network insurance:**

- You must have out of network benefits for your type of procedure in our facility
- You may receive an explanation of benefits from your insurance company for your procedure reflecting a large patient responsibility, this is NOT a bill. Your insurance company may process your claim as out of network, but we may make an additional adjustment in our office to reflect in network benefits. Please wait until you receive a statement from Pacific Endoscopy to question your balance.
- Any deductible that is inclusive for your plan will be your responsibility
- If you have a co-pay for in-network procedure you will be responsible for this amount
- If you have co-insurance responsibilities you will be responsible for the in-network rate, please understand that this portion may or may not be applied to your annual out of pocket maximum.



**No insurance-Self pay**

- Patients without insurance will be extended our discounted price that is due in full at the time of service.
- No claim will be filed to an insurance company once you request the self-pay status.
- You must designate yourself as self-pay on the date of your procedure prior to your procedure.

**Additional notices**

- The Affordable Care Act passed in March 2010 allowed for preventative colonoscopies to be covered at no cost to patients. However, there are many caveats that prevent patients from taking advantage of this provision. There are strict and changing guidelines on which colonoscopies are defined as a preventative service (screening). These guidelines may exclude many patients with gastrointestinal histories from taking advantage of the service at no cost.
- Diagnostic/therapeutic colonoscopies-patient has past and/or present gastrointestinal symptoms, polyps, or gastrointestinal disease
- Surveillance/high risk screening colonoscopy-patient is asymptomatic (no gastrointestinal symptoms either past or present), has a personal history of gastrointestinal disease, colon polyps, and/or cancer. Patients in this category are required to undergo colonoscopy surveillance at shortened intervals (e.g. every 2-5 years)
- Preventative Colonoscopy screening-Patient is asymptomatic (no gastrointestinal symptoms either past or present), over the age of 50, has no personal or family history of gastrointestinal disease, colon polyps, and/or cancer. The patient has not undergone a colonoscopy within the last 10 years.
- Depending on the type of colonoscopy you have, will determine how your insurance processes your procedure for payment and your responsibility
- If the doctor removes a polyp during the procedure, your insurance may no longer consider the procedure a screening and process it under different benefits, this may incur additional costs to you.
- It is your responsibility to understand your insurance coverage, screening benefits and age and/or occurrence limitations. It is also your responsibility to make sure the insurance information is current and if not, it will be your responsibility to resolve any billing issues with your insurance.
- If our facility billing was submitted correctly to your insurance based on your physician's procedure report and you feel it is incorrect, it will be your responsibility to contact the doctor's office and request a review.
- If our facility submitted a claim to your insurance as a preventative colonoscopy and your insurance did not cover it at 100%, it will be your responsibility to contact your insurance to have them reprocess it correctly.
- Many times the insurance representative informs you that "if the facility codes it as screening it would be covered at 100%". However, the "screening" diagnosis can only be amended if it applies to the patient. An insurance representative should never suggest a physician change their billing to produce better benefit coverage. It will be your responsibility to contact the provider and request review of your medical records for the procedure.
- Non-covered services-if a service has been denied by your payer or is considered a non-covered benefit under your health plan, you will be responsible for the entire amount of the billed charges for the service.
- Point of Service- patients electing to use out of network or point of service coverage for services acknowledges this choice will result in higher out-of-pocket expenses for services rendered.
- If you provide the wrong insurance information at the time of service your claim may be denied due to timely filing, no authorization, non-contracted or no pre-certification. The balance of full charges will become patient responsibility.

**I have read and understand the Financial Policy of Pacific Endoscopy and Surgery Center**

Patient Name (Please Print)

Patient's Signature

Date/Time



## Medicare Conditions for Coverage for Ambulatory Surgery Centers

I acknowledge that I have received verbal and written notice of the patient's rights in advance of the date of the procedure, in a language and manner that I, the patient (or patient's representative), understands. This notice also contains information on advance directives, resolution of patient grievances and a list of the physicians who are limited partners at Pacific Endoscopy & Surgery Center, and HIPPA Privacy Notice.

Printed Name \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_