PATIENT INFORMATION FORM

Patient's Last Name _____ First _____ M.I. _____
Address _____ City _____ State _____ Zip _____
Home Phone _____Work Phone _____Date of Birth_____
Gender: ☐ Male ☐ Female Ethnicity: ☐ Hispanic/Latino ☐ Non Hispanic/Non Latino
Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ White
☐ Native Hawaiian or Other Pacific Islander ☐ Other Race
Social Security Number _____ Driver's License Number _____
Patient's Employer: _____ Work Phone: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Spouse's Name: _____
Responsible Person/Guarantor: _____ Phone Number: _____
In case of an emergency, may we have the name of the nearest relative *not living with you?*
Name: _____ Phone Number: _____
Relationship:_____

PRIMARY INSURANCE

Name of Ins. _____
Member: _____

SECONDARY INSURANCE

Name of Ins. _____
Member _____

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to **San Joaquin Laser & Surgery Center**, for services furnished to me by **San Joaquin Laser & Surgery Center.** I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid services (formerly Health Care Financing Administration) and its agents Any information needed to determine these benefits payable for related services. I understand my Signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated on Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. **San Joaquin Laser & Surgery Center** accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

_____

2. MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorized release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to **San Joaquin Laser & Surgery Center.**

_____

3. Private/HMO/PPO: I request payment of benefits be made on my behalf to **San Joaquin Laser & Surgery Center** for services furnished to me by **San Joaquin Laser & Surgery Center**. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

_____ _____
Beneficiary Signature or Authorized Party Date

MEDICATION LIST

Patient Name:____Date:__________________

Please bring ALL of you medications with you for your pre-operative visit with the anesthesia provider.

☐ I do not take any medications

Please list all medication allergies:

Medication	**Reaction or Symptoms (check all that apply)**
	☐ Rash ☐ Nausea ☐ Stomach upset ☐ Anaphylaxis ☐Hives ☐ Other
	☐ Rash ☐ Nausea ☐ Stomach upset ☐ Anaphylaxis ☐Hives ☐ Other
	☐ Rash ☐ Nausea ☐ Stomach upset ☐ Anaphylaxis ☐Hives ☐ Other
	☐ Rash ☐ Nausea ☐ Stomach upset ☐ Anaphylaxis ☐Hives ☐ Other
	☐ Rash ☐ Nausea ☐ Stomach upset ☐ Anaphylaxis ☐Hives ☐ Other
	☐ Rash ☐ Nausea ☐ Stomach upset ☐ Anaphylaxis ☐Hives ☐ Other

Please list All the Medications you are currently taking below (include herbal and over the counter medications).

Medication	**Dose**	**Times Per Day**	**How Long?**	**Last Taken**

TO BE COMPLETED BY ANESTHESIA PROVIDER

Medication Information Source: ☐ Patient ☐ Family Member ☐ Other__________
Patient is compliant and taking medication as prescribed: ☐ Yes ☐ No
Patient brought medications with them for review: ☐ Yes ☐ No

Medication history obtained by:____Date:_______

Reviewed morning of surgery by surgeon / anesthesia:____________________________Date:_______

Reviewed morning of surgery by surgeon / anesthesia:____________________________Date:_______

Information for Anesthesia

Please Fill Out This Form and Bring it With You for Your Pre-Operative Visit.

Mr./Mrs./Miss_____Date of Birth_____HT_____WT_____Sex M/F
Address_____Phone_____

Are you allergic to **LATEX, Novacaine, Lidocaine**, or any other 'caines' for local anesthetics? _____ Are you allergic to **Iodine, Betadine** or Shellfish? _____List any other Allergies (medications, tape, eggs, or other foods). _____

Are you **pregnant** or is there a chance you could be pregnant? _____

Have you or anyone in your family ever had a problem with anesthesia?_____

Can you walk across a room unassisted?_____

Please **Bring ALL** of Your Current Medications With You or mark None_____.

Please List Below **All** the Medications You are Currently Taking**.**

Name of Medicine	**Dose**	**Times per Day**	**How Long?**

Please list any **Hospitalizations, Surgeries, and Illnesses** you have had in the past.

Year of Surgery/Illness	**Type of Surgery/Illness**

Please fill in any **Relevant Medical History** that may assist us for the following:

Heart History:

_____Open Heart Surgery or CABG
_____Pacemaker of Defibrillator
_____Heart Attack
_____Angina
_____Other Heart Trouble?
_____High Blood Pressure
_____Stroke
_____Stents or Angioplasties
Explain:_____

Lung History:

_____Asthma
_____Emphysema
_____Chronic Bronchitis
_____COPD
_____Other Lung Problems?
_____Can you lie flat or with one pillow?
_____Can you do housework or take a short walk without getting short of breath?
_____Do you use Oxygen at home?
Explain:_____
Do you smoke? Y/N _____packs per day for _____years

Kidney History:

_____Dialysis
_____Other Kidney Problems?
_____A/V Fistula or Shunt
Explain:_____

Liver History:

_____Hepatitis or Yellow Jaundice
_____Other Liver Problems?
Explain:_____
Do you drink alcohol? Y/N _____drinks per day for _____years

Other Relevant History:

_____Arthritis
_____Back or Neck Problems
_____Thyroid Problems
_____Bleeding Problems
_____History of Seizures
_____Diabetes
_____Claustrophobia
_____Do you have a History of any other Infectious Diseases?
Explain:_____

Patient Signature_____ Date Completed_____

SAN JOAQUIN LASER & SURGERY CENTER
1805 N. California Street, Suite 101A, Stockton, CA 95204
(209) 948-3241

PATIENT NOTIFICATION

DISCLOSURE OF OWNERSHIP

The following physicians who perform surgical services at this facility have ownership interest in San Joaquin Laser & Surgery Center.

- Andrew Chen, M.D.
- Philip Edington, M.D.
- Jeffrey Ing, M.D.
- Stevens Kim, M.D.
- Stephen Lin, M.D.

You have the right to choose the provider of your health services. Therefore, you have the option to use a surgical facility other than San Joaquin Laser & Surgery Center.

PATIENTS RIGHTS:

The basic rights of human beings are of great importance.

1. The right to impartial access to treatment or accommodations that is available or medically indicated.
2. The right to independent expression.
3. The right for independent decision and action.
4. The right for independent personal dignity.
5. The concern for personal relationships.
6. The right to be free from abuse and harassment at all times.

During sickness, no matter how minor it may seem to medical and nursing staff, the absence or presence of these factors are of vital importance and may become the deciding factor in the survival or recovery of the patient. It is this facility's primary responsibility to assure these factors are preserved for the patients.

The following basic rights and responsibilities of patients are considered reasonably applicable to all hospitals and surgery centers. The patient may exercise his/her rights without being subject to discrimination or reprisal.

Access to Care

Individuals shall be accorded impartial access to treatment accommodations that are available or medically indicated regardless of race, creed, sex, national origin, religion, or sources of payment of care.

Respect and Dignity

The patient has the right of considerate, respectful care at all times and under all circumstances, with recognition of his personal dignity. The patient has the right to be free from mental and physical abuse.

Privacy and Confidentiality

The patient has the right, within the law, to personal and informational privacy, as manifested by the right to:

- Refuse to talk with or see anyone not officially connected with the facility, including visitors, or person officially connected with the facility but who are not directly involved in their care.
- Wear appropriate personal clothing and religious or other symbolic items, as long as they do not interfere with diagnostic procedures or treatment.
- Be interviewed and examined in surroundings designed to assure reasonable audiovisual privacy. This includes the right to have a person of one's own sex present during certain parts of a physical examination, treatment, or procedure performed by a health professional to the opposite sex, and the right not to remain disrobed any longer than is required for accomplishing the medical purpose for which the patient was asked to disrobe.
- Expect that any discussion or consultation involving their case will be conducted discreetly, and that individuals not directly involved in their care will not be present without his/her permission.
- Have their record kept confidential and private. Written consent by the patient must be obtained prior to release of information except to persons authorized by law. If the patient lacks capacity, written consent is required from the patient's health care decision maker.
- Have their medical record read only by individuals directly involved in their treatment or the monitoring of its quality, and by other individuals only on their written authorization

PATIENT NOTIFICATION

or that of their legally authorized representative.
- Expect all communications and other records pertaining to their care, including the source of payment for treatment to be treated as confidential.
- Be placed in placed in protective privacy when considered necessary for personal safety.

Personal Safety
The patient has the right to expect reasonable safety insofar as the facility practices and environment are concerned.

Identity
The patient has the right to know the identity and professional status of individuals providing service to him/her, and to know which physicians or other practitioner is primarily responsible for their care. This include the patient right to know of the existence of any professional relationship among individuals who are treating him/her, as well as the relationship among individuals who are treating him/her, as well as the relationship to any other healthcare or educational institutions involved in their care. Participation by patients in clinical training programming or in the gather of date for research purposes should be voluntary.

Information
The patient has the right to obtain from the practitioner responsible for coordination of their care, complete and current information concerning their diagnosis (to the degree known), treatment, and any known prognosis. This information should be communicated in terms the patient can reasonably be expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to a legally authorized individual.

Communication
The patient has the right of access to people outside the facility by means of visitors, and by verbal and written communication.

When the patient does not speak or understand the predominant language of the community, he/she should have access to an interpreter.

Consent
The patient has the right to be involved in the decision making of all aspects of their care. The patient has the right to reasonably informed participation in the decisions involving their healthcare. To the degree possible, this should be based on a clear, concise explanation of his/her condition and all proposed technical procedures, including the possibilities of any risk or mortality or serious side effects, problems related to recuperation and probability of success. The patient should not be subjected to any procedure without his/her voluntary, competent, and understanding consent, or that of their legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be informed.

The patient has the right to know who is responsible for authorizing and performing the procedure or treatment.

The patient shall be informed if the facility proposed to engage in or perform human experimentation or other research/educational projects affecting their care or treatment, and the patient has the right to refuse to participate in any such activity.

Pain
The patient has the right to have appropriate assessment and management of pain.

Consultation
The patient, at his/her own expense, has the right to consult with a specialist.

Refusal of Treatment
The patient may refuse treatment to the extent permitted by law. When refusal of treatment by the patient or his/her legally authorized representative prevents the provision of appropriate care in accordance with ethical and professional standards, the

PATIENT NOTIFICATION

relationship with the patient may be terminated upon reasonable notice.

The patient has the right to change primary or specialty physicians if other qualified physicians are available.

Transfer and Continuity of Care
A patient may not be transferred to another facility unless they have received a complete explanation of the need for the transfer and the alternative to such a transfer, and unless the transfer is acceptable to the other facility. The patient has the right to be informed by the responsible practitioner or their delegate of any continuing health care requirements following discharge from the facility.

Facility Charges
Regarding of source of payment for his/her healthcare, the patient has the right to request and receive an explanation of their total bill for services rendered in the facility. The patient has the right to timely notice prior to termination of his/her eligibility for reimbursement by any third party for the cost of their care.

Facility Rules and Regulations
The patient should be informed of the facility rules and regulations applicable to their conduct as a patient. Patients are entitled to information about the facility's mechanisms for the initiation, review and resolution of patient complaints.

PATIENT RESPONSIBILITIES

Provisions of Information
A patient has the responsibility to provide, to the best of his knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her health. They have the responsibility to report unexpected changes in their condition(s) to the responsible practitioner. A patient is responsible for making known whether they clear comprehend a contemplated course of action and what is expected of them.

Compliance with Instruction
A patient is responsible for following the treatment plan recommended by the practitioner primarily responsible for their care. This may include following the instructions of nurses and allied health personnel as they carry out the coordinated plan of care and implement the responsible practitioners orders, and as they enforce the applicable facility rules and regulations. The patient is responsible for keeping appointments and when is unable to do so for any reason, for notifying the practitioner or facility.

Refusal of Treatment
The patient is responsible for their action if they refuse treatment or do not follow the practitioner's instructions.

Facility Charges
The patient is responsible for assuring the financial obligations of his/her health care are fulfilled as promptly as possible.

Facility Rules and Regulations
The patient is responsible for following rules and regulations affecting patient care and conduct.

Respect and Consideration
The patient is responsible for being considerate of the rights of other patients and facility personnel and for assisting in the control of noise, smoking and the number of visitors. The patient is responsible for being respectful of the property of other persons and of the facility.

ADVANCE DIRECTIVE NOTIFICATION

In the state of California, all patients have the right to participate in their own health care decisions and to make Advance Healthcare Directives or to execute Power of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes and when the patient is unable to make decisions or unable to communicate decisions. San Joaquin Laser & Surgery Center upholds and respects those rights.

SAN JOAQUIN LASER & SURGERY CENTER
1805 N. California Street, Suite 101A, Stockton, CA 95204
(209) 948-3241

PATIENT NOTIFICATION

However, unlike an acute care hospital setting, the San Joaquin Laser & Surgery Center does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered "minimal risk". Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risk, your expected recovery, and care after surgery.

Therefore, it is our policy, regardless of contents of any Advance Directive or instructions from a health care surrogate or attorney-n-fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or health care Power of Attorney. Your agreement with this facilities policy will not revoke or invalidate any current health care directive or health care power of attorney.

If you wish to complete an Advance Directive, information will be provided to you.

If you do not agree with the facility's policy, we will be pleased to assist you in rescheduling your procedure.

PATIENT COMPLAINT OF GRIEVANCE

Patient complaints of grievances may be reported to:

Quality Management Department/Susan Ford, COE, Administrator:
1805 N. California Street, Suite 101A
Stockton, CA 95204
209-948-3241

Department of Health Services
Department of Licensing and Certification
3901 Lennane Drive, Suite 210
Sacramento, CA 95834-1922
916-229-3400
Or 800-554-0354

All Medicare beneficiaries may also file a complaint or grievance with the Medicare Beneficiary Ombudsman. Visit the Ombudsman webpage on the web at: www.cms.hhs.gov/center/ombudsman.asp

San Joaquin Laser & Surgery Center
1805 N. California Street, Suite 101A, Stockton, CA 95204
209-948-3241

PATIENT NOTIFICATION ACKNOWLEDGEMENT

❑

By signing this document I acknowledge that I have received and reviewed the "Patient Notification", which includes Disclosure of Ownership, Patient's Rights, Patient's Responsibilities, Advance Directive Notification , and Patient Complaint procedures, prior to the date of my surgical procedure:

By:_____ Date:_____
(Patient's Signature)

Witness:_____ Date:_____

❑

By signing this document I acknowledge that I had an emergency procedure and received and reviewed this "Patient Notification", which includes Disclosure of Ownership, Patient's Rights, Patient's Responsibilities, Advance Directive Notification , and Patient Complaint procedures the same day as my surgical procedure:

By:_____ Date:_____
(Patient's Signature)

Witness:_____ Date:_____

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 READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests 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, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse protected health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

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

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

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 may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI by alterative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of October 1, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing.

WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of San Joaquin Laser & Surgery Center.

I hereby acknowledge receipt of San Joaquin Laser & Surgery Center's Notice of Privacy Practices.

Name [please print]:_____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of San Joaquin Laser & Surgery Center's Notice of Privacy Practices with respect to the patient.

Name [please print]:_____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____