PACIFIC THORACIC
SURGERY

Office Hours
Monday through Friday: 8:00 am -12:00 pm and 1:00 pm – 4:00 pm

After Office Hours
For urgent medical issues after regular office hours, please call our office number to be connected to the on-call doctor's paging service. For all other issues, please call us during our regular office hours.

Same Day / Urgent Appointments
We understand that sometimes medical problems come up and you would like to be evaluated sooner than the next available appointment. Please let us know and we will try to accommodate you on the same or following day.

Emergencies
Call 911 for medical emergencies.

Medication Refills
We do not want you to run out of your medications. We recommend that you notify the pharmacist to send us a "refill request" when you are picking up your last refill. If you prefer to call us, please call us during our regular office hours and allow 3-4 working days for us to refill your medications.

Forms
Please make an appointment if you have any forms that will require our doctors to fill out. Most forms require an evaluation and possible laboratory testing to complete.

Medical Care
We are concerned about your health. In order for us to provide the best possible quality of care for you, we will need your cooperation in keeping your scheduled appointments, making follow up appointments, scheduling annual physical exams, and completing tests ordered for you.

Canceling Appointments
If for any reason you will not be able to keep your appointment, we ask that you notify us to reschedule at least 24 hours prior to your appointment.

Other Physicians or Heath Care Specialists
If you are seeking healthcare from other physicians in the community, we would like you to ask their office to send us a copy of their notes and studies.

Communication
We believe in having good communication between our office staff and our patients. We encourage you express any questions or concerns to us so we may better serve you.

**All New Patient Forms must be completed and signed at or prior to your first appointment.*

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.	NAME YOU PREFER TO BE CALLED	SEX

ADDRESS	APT #	CITY	STATE	ZIP

SOCIAL SECURITY #	BIRTHDATE	HOME TELEPHONE #	CELL PHONE #

WORK TELEPHONE #	E-MAIL ADDRESS

EMPLOYER	EMPLOYER ADDRESS	POSITION/ TITLE

HOW DID YOU HEAR ABOUT US?

EMERGENCY CONTACT NAME & TELEPHONE NUMBERS

WHO IS YOUR PRIMARY PHYSICIAN? TELEPHONE #

PHYSICIAN ADDRESS

GUARANTOR/ POLICY HOLDER INFORMATION

LAST	FIRST NAME	M.I.	RELATIONSHIP TO PATIENT
			SPOUSE PARENT OTHER:

ADDRESSS IF DIFFERENT FROM PATIENT

BIRTH DATE	SOCIAL SECURITY #

GUARANTOR/ POLICY HOLDER'S EMPLOYER	EMPLOYERS ADDRESS	CITY	STATE	ZIP

INSURANCE INFORMATION

1.PRIMARY INSURANCE PLAN	GROUP NUMBER	POLICY NUMBER

TYPE OF PLAN OR COVERAGE

HMO PPO EPO MEDI-CAL MEDICARE MEDICARE SUPPLEMENT CASH OTHER

POLICY OWNERS NAME (GUARANTOR)	IPA	PRIMARY CARE PROVIDER

2.SECONDARY INSURANCE PLAN	GROUP NUMBER	POLICY NUMBER

TYPE OF PLAN OR COVERAGE

HMO PPO EPO MEDI-CAL MEDICARE MEDICARE SUPPLEMENT CASH OTHER

POLICY OWNERS NAME (GUARANTOR)	IPA	PRIMARY CARE PROVIDER

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. Once the insurance company is billed we allow 60 days for the balance to be paid by your insurance carrier. If the insurance carrier does not remit payment in 60 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance, we will gladly refund the overpayment to you within 30 days, providing that you do not have any outstanding accounts with our office. It is also customary to pay for professional services when rendered unless prior arrangements are made. I request that payment of authorized Medicare/other insurance company benefits be made on my behalf to Pacific Thoracic Surgery. Inc. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the social security administration and healthcare financing administration or its intermediaries or carriers, any information needed for this or a related Medicare claim or other insurance claim. I permit a copy of this authorization to be used in place of the original and request that payment of medical insurance benefits be made payable to Pacific Thoracic Surgery. Inc. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.(section 1128b of the social security act and 31 u.s.c 3801-3812 provides penalties for withholding this information.) There is a $25.00 charge for all returned checks. All unpaid balances are subject to 1.5% interest or minimum $6.00 service charge after 90 days. If your account must be forwarded to a collection service and/or an attorney because of nonpayment, you will be responsible for all collection fees and/or attorney fees charged by these services.

PATIENTS SIGNATURE_____GUARANTORS SIGNATURE_____DATE_____

HEALTH HISTORY FORM

Patient Name: _____ **Date of Birth:** _____

Personal Medical History: **Have you ever had (please circle all answers Yes or No)**

High Blood Pressure	No	Yes	Anxiety	No	Yes	Pneumonia	No	Yes
Heart Disease	No	Yes	Depression	No	Yes	Meningitis	No	Yes
Heart Murmur	No	Yes	Epilepsy	No	Yes	Gonorrhea	No	Yes
High Cholesterol	No	Yes	Osteoporosis	No	Yes	Chlamydia	No	Yes
Diabetes	No	Yes	Thyroid Disease	No	Yes	Syphilis	No	Yes
Anemia	No	Yes	Asthma	No	Yes	Genital Herpes	No	Yes
Stomach pain or Reflux	No	Yes	Hives or Eczema	No	Yes	Genital Warts	No	Yes
Arthritis or Rheumatism	No	Yes	Migraines	No	Yes	Tuberculosis	No	Yes
Kidney disease	No	Yes	Gallbladder Disease	No	Yes	AIDS/HIV	No	Yes
Neuritis or Neuralgia	No	Yes	Colitis or other Bowel Disease	No	Yes			
Bone or Joint disease	No	Yes	Jaundice or Liver Disease	No	Yes			
Sciatica, Back pain	No	Yes	Cancer *	No	Yes	* Type of Cancer:_____		

If "yes" to any of the above, please describe further: _____

If you have, or have had, any symptoms in the following areas to a <u>significant degree</u>, please briefly explain.

Skin:	Back/Joints:	*Recent Changes in the following:*
Head/Neck:	Intestinal:	Weight:
Ears/Nose/Throat:	Bladder:	Energy level:
Lungs:	Menstruation:	Mood:
Chest/Heart:	Circulation:	Other pain or discomfort:

Other Medical Problems & Surgeries:

_____

_____

List All Current Medication and Dosages: (include non-prescription)

_____

_____

Allergies to medications or food:

_____

Describe the allergic reaction:

_____

Do you drink alcohol?	No	Yes	Number of drinks _____ per week	Quit date: _____
Do you or have you ever smoked?	No	Yes	How many cigarettes per day:_____ Quit date: _____	How many years: _____
Do you use drugs?	No	Yes	What kind:_____	How many years: _____

Are you currently(circle one): Married Single Divorced Widowed

How many children do you have? _____ Ages: _____

Occupation:_____ Employer: _____ Highest level of education: _____

Please list the last date you had any of the following:

Pap Smear _____ Mammogram _____ Prostate Exam _____ Colonoscopy _____

Family Medical History: *example: cancer (type), diabetes, heart disease, mental illness, stroke, seizure, etc.*

Father: _____ Paternal grandfather:_____

Mother: _____ Paternal grandmother:_____

Siblings: _____ Maternal grandfather:_____

_____ Maternal grandmother:_____

PATIENT RESPONSIBILITIES

As a partner in your healthcare, you have the following responsibilities:

1. I will provide accurate health information to your doctor and update us with any health changes.
2. I will follow treatment plans recommended to me by my physician, including completing testing, making an appointment with a specialist, and taking my medications. I will be sure to clearly comprehend any treatment plan and ask questions when I do not understand. I understand that *not* following my treatment plans may put my health at risk.
3. I will keep my appointments and reschedule any missed appointments. I understand that my doctor schedules these appointments to follow up on my response to treatment and to monitor my medical conditions. If I do not follow up, I may put my health at risk and may have medical conditions go undetected.
4. I understand that the goal of the office is to provide me with test results in a timely fashion. If I do not hear from the office, I will call the office for test results. I understand that not hearing from the office about a particular test does not necessary mean that the test result is normal.
5. I will inform my doctor if my medical condition changes, does not improve, or worsens. This will allow my doctor to re-evaluate my condition and make changes in treatment. If I do not inform my doctor, I may put my health at risk.
6. I will take charge of my health and make positive choices for my health including not smoking, not using illegal drugs, eating a healthy diet, and getting appropriate exercises.
7. I will treat all providers and office staff respectfully and courteously.
8. I will fulfill my financial obligations for care provided to me in a timely manner.
9. I will keep my scheduled appointments and give adequate notice of rescheduling or cancellation.
10. I will take responsibility to understand my Health Plan and be aware of my benefits, deductibles, and Health Plan limitations. I will ask my Health Plan if I have any questions regarding my health coverage.
11. If you need information or inquiring about Advance Directives (Durable Power of Attorney for Health Care, Natural Death Act Declaration or Living Will,) please call the Member Services Department of your Health Plan.

I have been informed of my responsibilities and I understand them fully.

Print Name: _____ Date: _____

Signature: _____

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the Pacific Thoracic Surgery Notice of Privacy Practices and that I have read (or had the opportunity to read, if I so do chose) and understood the Notice.

_____ _____

Patient Name (please print.) Date

_____

Parent or Authorized Representative

(if applicable)

_____

Signature