PACIFIC THORACIC SURGERY

Overview of financial Responsibilities

Practice Responsibilities: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. We submit to your insurance as a curiosity to you the patient.

Patient/Parent/Guardian Responsibilities: To understand your own insurance network and benefits. To assure that our office is provided with the most current inforrnatic1n known about their insurance, and to inform us of any changes in insurance or demographics (address, phone numbers, etc). To within 30 days any Ila lance signed and patient responsibilities (e.g., co-pay, deductible, and coinsurance).

PATIENT INFORMATION

Patient Name (First, Middle, Last): _____

Date of Birth: _____

Insurance Subscriber Name (If not Patient): _____

Relationship to Patient: _____

Insurance Subscriber DOB: _____

Insurance Subscriber SS#: ___-_____

☐ Intial Here

Patient must understand their OWN network, plan benefits, Md plan limitations. Your health insurance is an agreement between you and your insurance. All charges are your responsibility, whether you have Insurance or not. Not all services are covered under all plans, regardless of whether our doctors consider the care medically necessary. Because there are so many plans, it is not possible for us to know the specific details of your coverage. By making a copy of your card, it does not confirm that we are part of your Network. We always do our best, but failure of our office staff to identify out-of-network plans do not not waive your responsibility for payment of services rendered.

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We are In network with most traditional PPO plans: O Our current accepted insurance plans are listed on our website. we are out of- network with: United Healthcare PPO, all HMOs, most State Exchanges plans, most Narrow PPOs, all HMO/IPA plans, Medicare Advantage HMOs, Medicaid / Medi-Cal / CalOptima, Worker's Compensation plans, and most Blue Shield and Anthem Blue Cross Individual/family plans purchased outside of employer group plans. Our recommendation is to call your insurance about a week before your appointment and ask if your plan's network includes our office, and what patient cost sharing may be applied. You authorize your insurance to pay us directly.

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Co-Pay, Self pay, and Cosmetic services are due at the time of Service. Patients with insurance are responsible for ensuring that our insurance records and other information are up to date. Patients who have not presented a valid active insurance card will be considered self-pay/cash-pay- and they must pay a minimum of$ 50 visit fee at arrival. Patients will have full responsibility for charges if we cannot process a claim due to incomplete, inaccurate or obsolete information. If your insurance changes, you must notify us immediately (even if you do not yet have your card); delays caused by patients can result in the claim being noncollectable from insurance, resulting in patient having full responsibility for all charges.

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ALL procedures and lab services have fees, In addition to the visit fee. Co-pay is usually for Office visit only, and does not typically cover procedures (e.g., any type of freeze, removal, incision, injection or other treatment) this will have a associated co-insurance or deductible that your insurance assigns to your plan. A co-insurance is different than a copay. Estimates for medical procedures are not typically given by the doctor; estimates can be provided, and is just a estimate based on your plan. Their can be additional fees your insurance places to your responsibility that will need to be paid. If you require a estimate before a procedures your procedure will typically need to be rescheduled for another day. Our policy is to act on Skin or tissue samples to be treated as if it could be cancerous, even if it is removed primarily at the patient's request, and will result in both excision/biopsy fees and pathology fees separate from our office fees. Labs, imaging, special stains, and other test sometimes must be ordered, and may be furnished by independent sources to complete a diagnosis. We are not responsible for those charges; Please contact those billing facilities for billing questions.

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Bills are DUE UPON RECEIPT. We are required by your insurance to collect CO-PAY, DEDUCTIBLE, AND CO-INSURANCE. Past due balances will be assessed *a* $.10 statement fee for each additional statement we must send. Any self pay, out of network, or other courtesy adjustments will be rescinded If account becomes over 30 days past due. We may charge 18% interest or *as* allowed by law for any delinquent payment. We exhaust efforts to resolve balances prior to use of a collection agency, however, additional fees up to 50% of your charges may accrue from collections activity. Returned checks will be assessed$ 25 fee,

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Credit Card On File: At Pacific thoracic surgery and out affiliated offices we frequently keeps CC on file to streamline the payment process. By initialing here you are authorizing our offices the option to utilize your CC on file to pay co-payments, coinsurance and other patient responsibilities.

☐ Intial Here

Appointment Cancellation Fees: We make numerous efforts to remind you of appointments. Out of courtesy to other patients that need appointments, please notify us if you need to cancel at least ONE (1) full business day prior. To encourage early notice, the following fees will apply for late cancellation or no shows. *$* 50 for a regular appointment and $100 for a medical procedure, surgery or cosmetic appointment.

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Your health Information Is protected: We must release patient health information to complete medical operations (e.g., to pharmacies, labs, insurances, other physicians, etc.) Any other release requires your written consent. Our Notice of Privacy Practices is available to you. By initialing here you are consenting to our office to leave a detailed message on your home or cell phone with information regarding your Health Information or treatment.

PLEASE LIST ANY OTHER INDIVIDUALS WITH WHOM WE CAN ALSO DISCUSS THE PATIENT'S CARE IN DETAIL (e.g., spouse, parent, child, etc,)

Name of Health Contact	Relationship to Patient	Primary Phone
Name of Health Contact	Relationship to Patient	Primary Phone
Name of Health Contact	Relationship to Patient	Primary Phone

Agreement by Patient (or Parent or Guardian). I have read each policy, I understand them and I agree,

Signature of Patient (or Parent or Guardian) _____ Date

Printed Name of Patient (or Parent or Gauardian) Date of Birth Social Security Number

Street Address (Street, City, State, ip)

Preferred Phone Number _____

Cell __Home ___Work

Email:_____
Please Provide a vaild email so we can set you your patient portal for documents, lab results, Appoinments.

Thank you for taking the time to understand our office Policies. Please contact our office with any questions. 949-716-2400 Email Billing@pacificthoracicsurgery.com

PACIFIC THORACIC SURGERY

REGISTRATION FORM

Today's Date: [Date]			PCP: [PCP]		
PATIENT INFORMATION					
Patient's last name: First:		Middle: [[Choose an item]		Marital status:	
Is this your legal name? ○ Yes ○ No	If not, what is your legal name? [Legal Name]	Former name: [Former Name]	Birth date: [Birthday]	Age: [Age]	Sex: ○ M ○ F
Address: [Address/ P.O Box, City, ST ZIP Code]					
Social Security no.: [SS#]	Home phone no.: [Phone]	Cell phone no.: [Phone]			
Occupation: [Occupation]	Employer: [Employer]	Employer phone no.: [Phone]			

WHO REFFERED YOU? Please choose one option):

○ DOCTOR:_____

○ CLINIC:_____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: [Birthday]	Address (if different):]	Home phone no.: [Phone]
Is this person a patient here?	○ Yes ○ No	Is this patient covered by insurance?	○ Yes ○ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance: [Choose an item] | Other: [Other insurance]

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:

Patient's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Pacific Thoracic Surgery to give my insurance company any information required to process my claims.
All professional services rendered are charged to the patient. We bill your insurance as a courtesy to you the patient therefore All unpaid balances submitted to insurance carriers that remain unpaid after 60 days will become the full responsibility of the patient. we will give you all the information you need to go after your insurance on your own. I understand it is my responsibility to notify the insurance of any changes or any other health care insurance or other party that is paying for my treatments. All unpaid payments will result in a 1.5% interest charge after 90 days. All returned checks will be a $35 charge.

Patient/Guardian signature:_____ Date:_____

HEALTH HISTORY FORM

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

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

High Blood Pressure	Yes NO	Anxiety	Yes NO	Pneumonia	No Yes
Heart Disease	Yes NO	Depression	Yes NO	Meningitis	No Yes
Heart Murmur	Yes NO	Epilepsy	Yes NO	Gonorrhea	No Yes
High Cholesterol	Yes NO	Osteoporosis	Yes NO	Chlamydia	No Yes
Diabetes	Yes NO	Thyroid Disease	Yes NO	Syphilis	No Yes
Anemia	Yes NO	Asthma	Yes NO	Genital Herpes	No Yes
Stomach pain or Reflux	Yes NO	Hives or Eczema	Yes NO	Genital Warts	No Yes
Arthritis or Rheumatism	Yes NO	Migraines	Yes NO	Tuberculosis	No Yes
Kidney disease	Yes NO	Gallbladder Disease	Yes NO	AIDS/HIV	No Yes
Neuritis or Neuralgia	Yes NO	Colitis or ot11er Bowel	Yes NO		
Bone or Joint disease	Yes NO	Disease ,Jaundice **or** Liver Disease	Yes NO		
Sciatica, Back pain	Yes NO				
		Cancer*	Yes NO	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:
Head/Neck:
Ears/Nose/Throat:
Lungs:
Chest/Heart:
Back/Joints:
Intestinal:
Bladder:
Menstruation:
Circulation:

Recent Changes in the following:
Weight:
Energy level:
Mood:
Other pain or discomfort:

Other Medical Problems & Surgeries:

Allergies to medications or Food: _____
_____
_____
_____

Do you drink alcohol? No Yes Number of drinks _____per week

Do you or have you ever smoked? No Yes How many years: ____

How many cigarettes per day:_____

Do you use drugs? No Yes Quit date:_____ How many years: _____

What kind:

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 _____

example: cancer (type), diabetes, heart disease, mental illnoss, stroke, seizure, etc.

Family Medical History:

Father: _____

Mother:_____

Siblings: _____

Paternal grandfather:_____

Paternal grandmother:_____

Maternal grandfather:_____

Maternal grandmother: _____

Patient Name: _____

Adult Medication Sheet

Date of Birth: _____

Medical Record Number: _____

Medication	Frequency	Dose	Date	Date (Re-new)	Precribed by
	daily bid tid qid nightly prn				
	daily bid tid qid nightly prn				
	daily bid tid qid nightly prn				
	daily bid tid qid nightly prn				
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Assignment of Benefits Form

Name of insured:

_____

Insurance LD. Number:

_____

I hereby assign all medical benefits to which I am entitled to Dr. Ledford Powell/ Pacific Thoracic Surgery, Inc. This applies for all insurance carriers, including Medicare, Private insurance, and any other health/medical plan, This form will be kept on file.

I understand it is my responsibility to report any changes in insurance coverage to the practice.

I authorize the release of any medical or pertinent information necessary to obtain these benefits to my insurance carrier or any other medical entity for continued medical care. I understand that I responsible for any amount not covered by insurance.

Signature:_____

Date:_____

Revised:01/10/2018

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 making 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 tin-1ely 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 rny 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:_____

ACKNOWLEDMENT 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 _____