Minimally Invasive Surgeons of North County
2385 S. Melrose Drive
Vista, CA 92081
760-300-3647

Adam Fierer, M.D. FACS Karen Hanna, M.D. FACS Jay R. Grove, M.D. FACS

PATIENT INFORMATION – PLEASE PRINT

Patient's Name: (Last) _____(First) _____(M.I) _____

Home Address: _____(City)_____(Zip)_____

Phone#: Home: _____Work: _____

Cell: _____Email Address: _____

Birth date: _____ Age: _____ SS#: _____Sex: ☐Male ☐Female

Status: ☐Married ☐Single ☐Widowed ☐Divorced *Ethnicity*: ☐Hispanic or Latino ☐Not Hispanic or Latino
Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐White ☐Decline to report
Primary Language Spoken: ☐English ☐Spanish ☐Other: _____
Primary Care Doctor (First and Last Name): _____
Referring Doctor (First and Last Name): _____
Employer Name: _____ Occupation: _____
Do you work ☐Full-time ☐Part-time ☐Retired Is this a Worker's Compensation Injury? ☐Yes ☐No

Communication Preference
You will receive communications from our office for various functions such as appointment confirmations, appointment recalls, reminders when test results are received. How would you like our staff to communicate with you? ☐Text ☐Phone Message ☐Letter ☐In-person ☐Email: _____

EMERGENCY CONTACT

Name: _____Relationship: _____
Home Address: _____(City)_____(State/Zip)_____
Phone#: Home: _____Work: _____
Cell: _____Email Address: _____

INSURANCE INFORMATION

Please provide us with your insurance card so that we can make a photocopy
Primary Insurance Name: _____☐HMO ☐PPO
Name of Medical Group: _____
Member ID#: _____Group#: _____
Subscriber Name: (Last) _____(First)_____(M.I.)_____
Subscriber Birth date: _____Subscriber SSN#: _____
Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other

ADDITIONAL INSURANCE INFORMATION

Please provide us with your insurance card so that we can make a photocopy
Insurance Name: _____☐HMO ☐PPO
Name of Medical Group: _____
Member ID#: _____ Group#: _____
Subscriber Name: (Last) _____(First)_____(M.I.)_____
Subscriber Birth date: _____Subscriber SSN#: _____
Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to Minimally Invasive Surgeons of North County for medical or surgical services or items rendered to me or my dependent by Minimally Invasive Surgeons of North County. Should my insurance carrier deny Minimally Invasive Surgeons of North County payment, I understand that I am financially responsible for the charges.

I authorize Minimally Invasive Surgeons of North County to release any and all of my records to my insurer, or any other third-party payer, legally responsible for the payment of medical expenses.

I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance and health information.

Name (Please print)	Signature	Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to
Dr. _____for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the 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 in item 9 of the HCFA 1500 form, or elsewhere other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare insurance and the deductible as based upon the charge determination of the Medicare carrier.

Name (Please print)	Signature	Date

Minimally Invasive Surgeons of North County
DBA "Premier Weight Loss Center"
2385 S. Melrose Drive
Vista, CA 92081
760-300-3647

Adam Fierer, M.D. FACS Karen Hanna, M.D. FACS Jay R. Grove, M.D. FACS

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and in directly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operation such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses of disclosures of my healthy information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only
I attempted to obtain the patient's signature is acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so documented below:

Date:	Initials:	Reasons:

PATIENT MEDICAL HISTORY

Kindly answer all questions. Our knowledge of your medical status will help us provide quality care.

Reason for today's visit: _____

Primary Care Doctor: _____

Referring Doctor: _____

Other treating MD's (last 5 yrs): _____

_____

_____

Pregnant? ☐Yes ☐No

Due date: _____

Do you smoke? ☐Yes ☐No

How often? _____

☐Heavy smoker ☐Light smoker

Do you / did you drink alcohol? ☐Yes ☐No

How much? _____ ☐Beer☐Liquor☐Wine

☐Socially☐Minimally ☐Infrequently ☐ Frequently

Drug Use? ☐Yes ☐No

Type: _____

Do you have any allergies to report? ☐Yes ☐No If so, please list.

Allergies:

Allergies (Please list)	Reaction

Medical Conditions:

Medical Condition	When did this start?	Doctor

Family Medical History: _____

_____

Surgeries/procedures:

Surgery/Procedure	Date	Doctor

Pharmacy Information:

Pharmacy Name: _____ ☐ Retail ☐Mail Order

City: _____ State: _____ Zip: _____

Phone Number: _____

Medication:

Medication	**Dosage**	**Frequency**	**Comments**	**Update**

Please attach medication list if applicable

Minimally Invasive Surgeons of North County
2385 S. Melrose Drive
Vista, CA 92081
760-300-3647

STATEMENT OF FINANCIAL POLICY

It is the intent of Minimally Invasive Surgeons of North County (MISNC) to provide quality surgical care and treatment in a cost-effective manner. Therefore, the following notice is necessary to ensure that all patients are informed of the financial policy of MISNC. It is never our intention to cause hardship to our patients, only to provide you with the best care possible and the least amount of stress.

Insurance Billing Information

Your insurance policy (this includes Medi-cal and Medicare) is a contract between you and your insurance company. MISNC submits claims to insurance companies as a courtesy to you. It is the patient's responsibility to provide current insurance information to the practice. If your insurance company has not paid your account in full within sixty (60) days, payment of the balance is due upon receipt of statement. For assistance or to discuss payment arrangements, call the Billing Department at 760-300-3647.

General Payment Policies

- Full payment or accurate insurance information is due at time of service. Patients must present a current insurance card at every visit. ***We will kindly reschedule your appointment if you do not have your co-payment or any past due balances.***
- Co-payments, Co-insurance and deductibles are due at time of service. If applicable, a pre-surgical deposit (deductible) will be collected prior to scheduling surgery. ***Our office must collect the co-pay from each and every patient. Physicians are bound by the Office of Inspector General laws and regulations as well as private contractual obligations to collect co-pays. Failure to collect co-pays is a violation of the False Claims Act.***
- We accept cash, MasterCard, Visa, and American Express. MISNC accepts personal or business checks however if returned there is a $25.00 returned check bank fee.
- All claims will be submitted to the contracted insurance companies under the name of Minimally Invasive Surgeons of North County, Inc.
- Payment of bills is expected upon receipt of our statement. Accounts become delinquent after thirty (30) days unless alternative arrangements have been made through the billing office.
- Delinquent accounts over 60 days will be sent to collections for processing.
- There is an upfront $25.00 service fee for State Disability or FMLA Family forms due prior to completion.
- There will be a $25.00 service fee for no-show appointments and rescheduled late appointments.
- If you do not cancel your scheduled surgery within 72 hours, there will be a $150.00 cancellation service fee. Cancellation fee must be paid prior to next scheduled surgery.

Usual and Customary Rates

MISNC is committed to providing the best treatment for our patient, and we charge what is usual and customary for our area.

Self-pay/Cash-Pay Accounts

Self-pay/Cash-Pay accounts are patients without insurance coverage or patients covered by insurance plans in which the office does not participate, it is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Self-pay patients will be required to bring in full payment at each office visit.

Minimally Invasive Surgeons of North County
2385 S. Melrose Drive
Vista, CA 92081
760-300-3647

STATEMENT OF FINANCIAL POLICY

Credit Card On File (CCOF)
At MISNC, we may require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. A billing service fee of $10.00 will be added to your account for any balances that we must attempt to collect through mailing monthly statement. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

Contracted Insurance Payment Policies
All patients are expected to pay any required co-payments and/or deductible at time of services. For medical services covered by their contract, no additional payments are required.

Medicare
MISNC accepts Medicare assignment. All patients without a secondary insurance will be responsible to pay the remaining balance after Medicare payment. All patients are required to sign an Advance Beneficiary Notice (ABN) for all non-covered items. Medicare HMO managed care co-payments and deductibles are due at the time of service.

Medi-Cal
MISNC **does not** accept Medi-Cal assignment at this time. If you have Emergency/Pregnancy Medi-Cal you may be responsible for services rendered.

VA Health Care
VA health care is NOT considered a health insurance plan. VA health benefits are established by Federal law and regulations and funded through appropriations. They are not the same as an insurance contract. An authorization may be granted when it has been determined that direct VA services are either geographically inaccessible or VA facilities are not available to meet a Veteran's needs. All community services must be preapproved before a Veteran receives treatment. VA enrollee specialty care co-payment is $50.00 and is due at the time services are rendered. For more information about VA health care, please visit, https://www.va.gov/health/index.asp
MISNC recommends VA health care enrollees provide a primary insurance or/and a secondary insurance coverage.

Minors – Accompanied and Unaccompanied
The adult accompanying a minor (parents, guardian, custodians, etc.) are responsible for full payment.

Collecting your patient responsibility amount is critical in allowing our doctors to continue providing quality care to you as a patient and is a legal requirement based on your contract that you have signed with the insurance provider. Please be advised that you are responsible for any balance due to the practice regardless of your contract with your insurance company.

By signing this form, I have read and understand the Statement of Financial Policy and I agree to the terms.

Printed name: _____

Signature: _____ Date: _____

☐Patient received copy ☐Patient declined copy

Minimally Invasive Surgeons of North County

UNDERSTANDING YOUR BILL

As a courtesy to our patients, our billing office will bill your primary and secondary insurance carriers if you have provided us with the appropriate insurance information.

You or your insurance carrier will receive bills from your surgeon, the facility, your anesthesiologist and if applicable the assistant surgeon.

Surgery
If your physician recommends surgery, your surgery will be scheduled by our surgery scheduler. She will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it. You may be required a ***pre-surgical deposit*** to go towards your surgery co-payment, deductible or any other amount deemed the patient's responsibility by your insurance carrier. After your insurance company has processed your surgery claim, any outstanding balance will be billed to you and any amount remaining as a credit balance will be refunded to you.

As you prepare for your surgery, we want to make sure you understand how you will be billed for the services you receive. **You may receive up to three separate bills.** The success of your treatment depends on a team effort by many dedicated professionals. Due to government and insurance rules each facility of our team must send you a separate bill and collect payment for you separately.

Here is an explanation of the bills you may receive:

Minimally Invasive Surgeons of North County-PHYSICIAN'S BILL Initials: _____
Your initial consultation, surgery, follow-ups will be performed by MISNC Physician. At each office visit your co-pay and/or estimated in-network co-insurance/deductible will be collected at the time of service. Your patient statement will be sent from the physician's office – Minimally Invasive Surgeons of North County. Questions and payments regarding your statement should be addressed to our office at 760-300-3647.

Facility-HOSPITAL/SURGERY CENTER BILL Initials: _____
When your surgery is performed at a hospital or surgery center facility. The facility will contact you prior to your surgery to make necessary arrangements. Questions and payments regarding your hospital statements should be address directly to that facility.

Anesthesiologist-PHYSICIAN'S BILL Initials: _____
The anesthesiology will bill you directly for services performed at the hospital or surgery center. Questions and payment regarding this statement should be address directly to office sending out the statement.

For questions about your insurance plan, call the member services number on the back of your insurance card.

We realize that these multiple bills can be confusing. Our staff will do their very best to help you with questions and guide you to the proper source of information.

By signing this form, you acknowledge that you have read and understand the "Understanding Your Billing" form.

Patients signature: _____ Date: _____

☐Patient received copy ☐Patient declined copy

HOW DO DEDUCTIBLES, COINSURANCE AND COPAYS WORK?

When both you and your health insurance company pay part of your medical expense, it's called cost sharing. Deductibles, coinsurance and copays are all examples. Understanding how they work will help you know when and how much you have to pay for care.

Deductible

A deductible is the amount you pay for health care services before your health insurance begins to pay.
Let's say your plan's deductible is $1,500. That means for most services, you'll pay **100 percent** of your medical and pharmacy bills until the amount you pay reaches $1,500. After that, you share the cost with your plan by paying coinsurance and copays.
If your plan does not waive your deductible for office visits, you will pay the cost of your deductible at your office visit.

Coinsurance

Coinsurance is your share of the costs of a health care service. It's usually figured as a percentage of the amount we allow to be charged for services. You start paying coinsurance after you've paid your plan's deductible.
Here's how it works. Lisa has allergies, so she sees a doctor regularly. She just paid her $1,500 deductible. Now her plan will cover 70 percent of the cost of her allergy shots. Lisa pays the other 30 percent; that's her coinsurance (70/30 or 80/20 or 90/10). If her treatment costs $150, her plan will pay $105 and she'll pay $45.

If Lisa has a PPO plan, she has the option to see any doctor she wants. If she goes to an out-of-network doctor, her plan will still share the cost, but her percentage of coinsurance will be higher. And, if the medical service she gets is more than what her plan would pay for an in-network doctor, she'll have to pay the difference.

Copay

A copay is a fixed amount you pay for a health care service, usually when you receive the service. The amount can vary by the type of service. You may also have a copay when you get a prescription filled.
For example, a doctor's office visit might have a copay of $30. The copay for an emergency room visit will usually cost more, such as $250. For some services, you may have both a copay and coinsurance.

FOR QUESTION ABOUT YOUR INSURANCE PLAN, CALL THE MEMBER SERVICES NUMBER ON THE BACK OF YOUR INSURANCE CARD.

Review of Systems

To be completed at each visit

Patient Name: _____ DOB: _____ Date: _____

Please check any of the following that you currently have:

General:
☐Fevers
☐ Chills
☐ Sweats
☐ Anorexia
☐ Fatigue
☐ Sleepiness
☐ Sleep Problems
☐ Malaise
☐ Weight Gain/Loss

Eyes:
☐ Pain
☐ Vision Loss
☐ Excessive Tears
☐ Blurred Vision
☐ Double Vision
☐ Irritation
☐ Discharge
☐ Photophobia

Ears/Nose/Throat:
☐ Ear pain/Infection
☐ Discharge
☐ Decreased hearing
☐ Nasal obstruction
☐ Nasal discharge
☐ Nosebleeds
☐ Sore Throat

Cardiovascular:
☐ Chest pain
☐ Palpitations
☐ High Blood Pressure
☐ Heart Murmur
☐ Irregular Heartbeat
☐ Swelling of Legs
☐ Use of Oxygen

Respiratory:
☐ Cough
☐ Dyspnea
☐ Excessive Sputum
☐ Wheezing
☐ Shortness of Breath

Gastrointestinal
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Change in bowel habits
☐ Abdominal pain
☐ Constipation

Genitourinary
☐ Urinary Symptoms
☐ Painful Urination
☐ Urinary Frequency
☐ Discharge
☐ Sores
☐ Menstrual Irregularity

Musculoskeletal
☐ Back Pain
☐ Joint Pain
☐ Joint Swelling
☐ Muscle Cramps
☐ Muscle Weakness
☐ Stiffness

Skin
☐ Rash
☐ Itching
☐ Ulcers/growths
☐ Excess Scarring
☐ Bleeding Problem
☐ Dryness
☐ Suspicious Lesions

Neurologic
☐ Transient Paralysis
☐ Weakness
☐ Seizures
☐ Tremors
☐ Vertigo
☐ Frequency or Severe Headaches

Psychiatric:
☐ Depression
☐ Anxiety
☐ Memory Loss
☐ Mental Disturbance
☐ Suicidal Ideation
☐ Hallucinations
☐ Paranoia

Endocrine
☐ Cold Intolerance
☐ Heat Intolerance
☐ Excessive/Increased Thirst
☐ Tired/Sluggish

Hematologic/Lymphatics
☐ Abnormal Bruising
☐ Bleeding
☐ Enlarged Lymph nodes
☐ Blood Clotting Problems
☐ Anemia

Allergic/Immunologic:
☐ Hay Fever
☐ Persistent Infections
☐ Drug Allergies

Health Screening:
☐ Mammogram (past year)
☐ Pap Smear(past year)
☐ Colonoscopy (past year)
☐ Other: _____
_____

Additional comments:____
_____
_____

☐ NONE of the above apply to my present condition.