MVSA

Murrieta Valley Surgery Associates

GENERAL AND VASCULAR SURGERY

LAST: _____ FIRST: _____ MI: _____

GENDER: ____F ____M BIRTHDATE: ____/____/____ AGE: _____ SSN: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CELL PHONE: _____ HOME PHONE: _____

EMAIL: _____

EMERGENCY CONTACT INFORMATION:

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

PRIMARY PHYSICIAN: _____

PHARMACY: _____ CITY/CROSS STREET: _____

WHO REFERRED YOU FOR TODAY'S VISIT? _____

DO YOU CURRENTLY HAVE A CARDIOLOGIST: YES NO NAME: _____

DO YOU CURRENTLY HAVE A NEPHROLOGIST: YES NO NAME: _____

INSURANCE SUBSCRIBER INFORMATION:

**(ONLY COMPLETE IF THE SUBSCRIBER IS SOMEONE OTHER THAN YOURSELF)**

LAST: _____ FIRST: _____ MI: _____

BIRTHDATE: ____/____/____ RELATIONSHIP: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____

# MEDICAL HISTORY FORM

REASON FOR VISIT:_____

HEIGHT:_____ WEIGHT:_____

ANY ALLERGIES TO MEDICATIONS: NO / YES

IF YES, PLEASE LIST MEDICATION AND REACTION:_____

_____

ALLERGY TO (CIRCLE ALL THAT APPLY): LATEX TAPE IV DYE SOY

DO YOU CURRENTLY TAKE ASPIRIN OR BLOOD THINNERS? NO / YES

IF YES, PLEASE LIST:_____

PLEASE LIST ANY MEDICATIONS AND DOSAGE THAT YOU ARE TAKING CURRENTLY:_____

_____

_____

NON-PRESCRIPTION OR HERBAL REMEDIES:_____

_____

ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING PRESCRIPTION WEIGHTLOSS MEDICATIONS?

- ☐ OZEMPIC
- ☐ WEGOVY
- ☐ TRULICITY
- ☐ BYETTA
- ☐ VICTOZA
- ☐ MOUNJARO

CHECK ALL THAT APPLY TO YOU:

- ☐ HIGH BLOOD PRESSURE
- ☐ BLOOD CLOTS
- ☐ KIDNEY DISEASE
- ☐ RENAL DISEASE
- ☐ THYROID PROBLEMS
- ☐ STROKE/TIA
- ☐ MINI STROKE
- ☐ PACEMAKER
- ☐ DEFIBRILLATOR
- ☐ HEART MURMUR
- ☐ TUBERCULOSIS
- ☐ ELEVATED CHOLESTEROL
- ☐ ASTHMA
- ☐ COLITIS/POLYPS
- ☐ CONGESTIVE HEART FAILURE
- ☐ ARRHYTHMIAS
- ☐ BACK INJURY
- ☐ BACK INJECTIONS
- ☐ COPD
- ☐ HEART ATTACK/FAILURE
- ☐ HEPATITIS
- ☐ CANCER
- ☐ DIABETES

IF HEPATITIS OR CANCER APPLIES TO YOU, PLEASE STATE THE TYPE AND WHEN YOU WERE DIAGNOSED:

_____

PLEASE LIST ANY OTHER SERIOUS ILLNESS THAT **DID NOT** REQUIRE SURGERY:

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PREVIOUS SURGERIES:

☐ CAROTID ☐ LEG BYPASS ☐ BACK SURGERY

☐ CARDIAC ☐ STENT ANGIOPLASTY ☐ VARICOSE VEIN SURGERY

PLEASE LIST ANY OTHER SURGERIES:

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DO YOU USE:

TOBACCO? NO YES If yes, or if you have quit, how many packs per day?_____# of years_____

ALCOHOL NO YES If yes, how many drinks per week?_____

ILLICIT DRUGS? NO YES If yes, please explain type, duration and frequency:_____

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**FAMILY HISTORY**

CHECK ALL THAT APPLY TO YOUR MATERNAL FAMILY: (Mother's side)

- ☐ Abdominal Aortic Aneurysm
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Bleeding Tendencies
- ☐ Cancer
- ☐ Renal Insufficiency
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Diabetes

WHAT TYPE OF CANCER?

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CHECK ALL THAT APPLY TO YOUR PATERNAL FAMILY: (Father's side)

- ☐ Abdominal Aortic Aneurysm
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Bleeding Tendencies
- ☐ Cancer
- ☐ Renal Insufficiency
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Diabetes

WHAT TYPE OF CANCER?

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## Attention all patients receiving imaging orders:

**(this section is regarding future appointments with MVSA)**

- Once your imaging has been completed, it is your responsibility, as the patient, to call our office to schedule a follow-up appointment to review the results.

- Patients having **CT scans**, **CTA**, or **MRI/MRA:** YOU MUST bring a copy of the images on a disc to your appointment for review.

  If you are unable to obtain the disc prior to your appointment, you will need to reschedule.

  Patient's signature is his/hers acknowledgement of the above stated responsibility:

  Signature: _____

**RELEASE OF MEDICAL INFORMATION**

I wish for the following people to have access to all my medical records (Family, friends, caretakers, other physicians, etc.):

_____

_____

I, _____have had an opportunity to review the Notice of Privacy Practices which is attached to this registration packet. I understand that I may request a copy of this form for my personal use at any time. I have also reviewed the attached Office Policies for Murrieta Valley Surgery Associates.

Patient Signature: _____ Date: _____

## ASSIGNMENT OF BENEFITS

I, the undersigned, have insurance coverage and directly assign all medical benefits to Murrieta Valley Surgery Associates for services rendered. I hereby authorize Murrieta Valley Surgery Associates and/or their representatives to release all information necessary to obtain payment of insurance benefits. I authorize the use of this signature on all insurance claims submitted on my behalf. I consent for care and treatment as required by the physician. Once my signature is obtained, Murrieta Valley Surgery Associates may submit any later medical claims without obtaining additional signatures. All claims submitted on my behalf from this date forward will indicate "Signature on File" in the space provided on the claim form.

Patient Name (print): _____ Date: _____

Patient or Parent/Guardian Signature: _____

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you acknowledge that Murrieta Valley Surgery Associates, Inc. (MVSA) has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

CHECK ALL THAT ARE TRUE:

- ☐ I have read the MVSA Privacy Notice
- ☐ I have requested and have been provided with a copy.
- ☐ MVSA has given me the chance to discuss my concerns and questions about the privacy of my health information.

Patient Signature: _____ Date: _____

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The Murrieta Valley Surgery Associates, Inc. staff should complete if Acknowledgement Form is not signed:

Does the patient have a copy of the Privacy Notice?

☐ YES ☐ NO

Please explain why the patient was unable to sign an acknowledgement form and the efforts in trying to obtain the patient's signature:

_____

# FINANCIAL POLICY

We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and agree to prior to any treatment. **WE ACCEPT CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS.**

We will bill your insurance company as a courtesy. Your insurance policy is a contract between you and your insurance company. It is your responsibility to know your benefits and how they will apply to your treatment by the doctor. We are not a party to that contract. If your insurance company has not paid your account in full within 60 days, the balance will be transferred to you and/or the guarantor listed on the Patient Information form. If unable to make the payment in full, contact the billing department immediately to make payment arrangements. In the event that the account is referred for collections, you will be responsible for the balance of your account plus a collection agency charge of 25% of the balance and reasonable attorney fees. If your account becomes delinquent or is referred for collections, your provider has authorization to obtain your credit report to assist them in the collection of your bill.

**HMO Plans** (with which we are contracted): All co-pays must be satisfied at every visit. Due to contractual and uniform compliance issues with your insurance company, there are no exceptions to the policy of collecting co-pays at every visit. You are responsible for obtaining authorization and approval for treatment with your Medical Group or PCP prior to treatment.

**PPO Plans** (with which we are contracted): We have negotiated rates with your insurance company. Your co-insurance and unmet deductible is your responsibility and payment is due at the time of your treatment or upon receiving notification from your insurance of the amount owed by you.

In the event that your insurance coverage changes to a plan where we are not a participating provider, you will be responsible for any out of network deductible or coinsurance amounts.

**Medicare:** We accept assignment with Medicare. Medicare pays 80% of the allowed amount after satisfaction of the annual deductible. We will bill your secondary insurance for the remaining 20% of the Medicare allowed payment as a courtesy; however, you are responsible for any remaining balance regardless of payment from a secondary insurance.

**Usual and Customary Rates:** Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

**Cash patients** are accepted on an individual basis. All services must be paid in full at the time of your treatment. Our office can provide you with an estimate of the cost of treatment prior to your visit with the physician. We are willing to extend a discount of 25% off our usual and customary fees for full payment at the time the services are rendered. The discounted price for your initial consultation (new patient visit) is $250.00 and follow-up visits (established patient visit) are $150.00. Again, these services must be paid for at the time of the services being rendered or the discount is not applicable. The fees without the discount are $380.00 and $100.

**Returned Checks:** A $25.00 fee will be charged for any returned checks. We will be unable to accept your check for any services thereafter. If any discount was applied to the pricing of the service(s) the discount will be revoked and you will pay the full price of the service(s) rendered in addition to the fee.

**Medical Records:** All Medical Record requests are subject to a clinical preparation fee of $25.00 for legal cases, personal injuries and other matters that involve your attorney requesting your records.

**Paperwork Fees:** We do charge for completing paperwork on your behalf. This fee covers our costs and time involved in accessing your medical records, reviewing the documents, completing, and signing the forms. We require a $40.00 fee. These fees must be paid prior to the forms being completed. Paperwork can take 3-5 business days to complete.

I have read and understand the policies and fees, and I agree to these terms. I hereby give a lifetime authorization for payment of insurance benefits made directly to Murrieta Valley Surgery Associates. Inc. (MVSA). I understand that I am financially responsible for all charges and fees whether or not they are covered by insurance. I hereby authorize MVSA Inc. to release all information and medical records necessary to secure payment for my services. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient Signature: _____ Date: _____