Buena Vista
SURGERY CENTER

Patient Name: _____

Case No. _____

PATIENT INFORMATION

Patient Name | SSN

Address | City | State | Zip

Driver License# | State | Gender ❍ Male ❍ Female | Date of Birth

Email Address

Home Phone ( ) - | Cell Phone ( ) - | Occupation

Employer ❍ Full Time ❍ Part Time ❍ Unemployed ❍ Self Employed ❍ Disabled ❍ Retired

Work Address | City | State | Zip

Work Phone ( ) - | Marital Status ❍ Single ❍ Married ❍ Widowed ❍ Divorced ❍ Domestic Partner

Spouse/Parent Name | SSN

Spouse/Parent Address | City | State | Zip

Spouse/Parent Home Phone ( ) - | Parent Driver License # *(if patient is minor)*

Spouse/Parent Employer | Work Phone ( ) -

EMERGENCY CONTACT

Contact Phone ( ) - | Name | Relationship

Please provide a contact number where we may reach you to check in either the evening of, or day after, your procedure? ( ) -

INSURANCE / PAYMENT INFORMATION

Type of Payment ❍ Insurance *(please attach a photocopy of insurance information)* ❍ Cash ❍ Lien *(please attach Lien document*

Primary Insurance | Policy # | Policy Holder

Secondary Insurance | Policy # | Policy Holder

Patient/Responsible Adult Signature | Date

Patient/Responsible Adult Name *(printed)* | *Relationship to Patient

**if signed by person other than patient*

Interpreter Printed Name *(if required)*

Interpreter Signature *(if applicable)* | Interpreter Relationship *(if applicable)*

Fill out the below section ONLY if you accept terms below and the financial responsibility for the patient for whom you have NO legal responsibility.

I, the undersigned person, hereby certify that I have accepted total financial responsibility for the above patient, for the care/treatments rendered to the patient by the Center and all their providers including but not limited to: surgeons, anesthesiologists, radiology, laboratories, and clinical care workers. I understand that I do not currently have any legal responsibility to provide financial support for this patient. I also understand that, by signing below, I agree to personally accept full responsibility for all financial costs associated with the care/treatments/services provided to the patient by Center. Furthermore, I certify that I have had the opportunity to ask all questions related to this matter and was given adequate answers. **Please fill in all sections below and sign where indicated.**

Last Name | First | M.I. | SSN

Relationship to Patient | Home Phone ( ) - | Date of Birth

Address | City | State | Zip

Driver License *OR* other photo ID# | Type of ID | State Issued

Occupation | Employer | Work Phone ( ) -

2701 West Alameda Avenue, Suite 401B • Burbank, CA 91505 • 818.563.6757• fax 818.563.6755 • BuenaVistaSurgeryCenter.com

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SURGERY CENTER

Patient Name: _____

Case No. _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner ***(please check ALL that apply):***

❍ **Home Phone ( ) -**

- ❍ OK to speak with _____
- ❍ OK to a leave message with detailed information
- ❍ Leave message with call back number only

❍ **Work Phone ( ) -**

- ❍ OK to a leave message with detailed information
- ❍ Leave message with call back number only

❍ **Written Communication**

- ❍ OK to mail to my home address
- ❍ OK to mail my work/office address
- ❍ OK to fax to ( ) -
- ❍ Other _____

X

PATIENT SIGNATURE **DATE**

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the disclosure of, and requests for, PHI to the minimum to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to the authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information listed below, if completed properly, will constitute an adequate record. Uses and disclosures for TPO (treatment, payment, operations) may be permitted without prior consent in an emergency.

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RECORD OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

Date	Disclosed to Whom *(address or fax#)*	(1)	Description of Disclosure Purpose of Disclosure	By Whom Disclosed	(2)	(3)

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read, or have had the opportunity to read, this Notice and I understand the Notice.

Patient Name *(please print)*	Date
Authorized Representative *(if applicable, please print)*	Relationship to Patient

X

PATIENT SIGNATURE *(or Authorized Representative)* **DATE**

NOTICE OF ADVANCE DIRECTIVES POLICY

Medicare standards, the State of California, and our Accreditation agency, Accreditation Association for Ambulatory Health Care, Inc (AAAHC), require the surgery center to notify you of our Advance Directive policy prior to the start of your procedure.

Our policy is that Buena Vista Surgery Center does NOT honor the DNR portion of your Advance Directives. However, if you would like to bring an Advance Directive with you on your day of surgery, we will forward it to the hospital in the unexpected event you are transferred for further care.

- ❍ I have an Advance Directive.
- ❍ I do not have an Advance Directive.
- ❍ I would like to have information regarding Advance Directives.

X

PATIENT SIGNATURE *(or Authorized Representative)* **DATE**

X

WITNESS SIGNATURE **DATE**

X

GUARDIAN/RESPONSIBLE PERSON SIGNATURE *(if applicable)* **RELATIONSHIP TO PATIENT** **DATE**

NOTICE OF PHYSICIAN DISCLOSURE

California Law imposes disclosure requirements for Physicians that have a financial interest in a facility to which they refer patients. In compliance with these laws, please be advised that your doctor may have partial ownership in Buena Vista Surgery Center where your surgery is scheduled to be performed. If you have any questions regarding the law, desire confirmation of your physician's ownership, or if you would prefer that your surgery not be performed at Buena Vista Surgery Center, please let us know so we can provide answers to your questions or, if necessary, make other arrangements for you.

I understand the above and have been given an opportunity to ask questions about my physician's part ownership in this Ambulatory Surgery Center.

X

PATIENT SIGNATURE *(or Authorized Representative)* **DATE**

X

GUARDIAN/RESPONSIBLE PERSON SIGNATURE *(if applicable)* **RELATIONSHIP TO PATIENT** **DATE**

Buena Vista
SURGERY CENTER

Patient Name: _____

Case No. _____

ASSIGNMENT OF BENEFITS - *CENTER*

I hereby authorize my Insurance Company to pay by check made payable and mailed directly to:

BUENA VISTA SURGERY CENTER
2701 WEST ALAMEDA AVE SUITE 401
BURBANK CA 91505

for the medical and surgical benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for the services rendered. I understand that as a courtesy to me, the Buena Vista Surgery Center will file a claim with my insurance company on my behalf. However, I am financially responsible for, and hereby do agree to pay, in a current manner, any charges not covered by the insurance payment. If my insurance company sends me, my partner or the financially responsible person any checks for services provided at the Center, I will immediately bring or mail the check to the Center. Be sure to endorse the check and annotate "Pay to the Order of Buena Vista Surgery Center" or deposit the check, then send a personal or cashiers check. If it is necessary to file a formal collection action, I agree to pay all costs, including reasonable attorney's fees incurred by the outpatient medical center in the collection of the outstanding fees.

Actual Plan Benefits can not be determined until the claim is received by your insurance company and is based upon their determination of medical necessity. The information received from the above stated is not a guarantee of payment.

X

GUARDIAN/RESPONSIBLE PERSON SIGNATURE *(if applicable)* | **RELATIONSHIP TO PATIENT** | **DATE**

ASSIGNMENT OF BENEFITS - *ANESTHESIA*

For ANESTHESIA SERVICES rendered, I hereby authorize my Insurance Company to pay by check made payable and mailed directly to:

_____

_____

for the anesthesia benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for the services rendered. I understand that as a courtesy to me, my anesthesia provider will file a claim with my insurance company on my behalf. However, I am financially responsible for, and hereby do agree to pay, in a current manner, any charges not covered by the insurance payment. If it is necessary to file a formal collection action, I agree to pay all costs, including reasonable attorney's fees incurred by the outpatient medical center in the collection of the outstanding fees.

Actual Plan Benefits cannot be determined until the claim is received by your insurance company and is based upon their determination of medical necessity. The information received from the above stated is not a guarantee of payment.

X

GUARDIAN/RESPONSIBLE PERSON SIGNATURE *(if applicable)* | **RELATIONSHIP TO PATIENT** | **DATE**

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