Crown Valley
OUTPATIENT
SURGICAL CENTER

Patient Name:
Surgeon:
Date of Service
Medical Record:
Date of Birth:

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Patient Name: | | | SS# |
| Address: | | City: | State: Zip: |
| Driver License #: | State: | Gender: ☐ Male ☐ Female | |
| Date of Birth: Age: | Marital Status: | Home Phone: ( ) | |
| Allergies/Drug Hypersensitivities: | | | |
| Employer: | | Business Phone: ( ) | |
| Business Address | | City: | State: Zip: |
| Name of Spouse/Parent: | | | SS# |
| Spouse/Parent Address: | | City: | State: Zip: |
| Spouse/Parent Home Phone: ( ) | *(if patient is minor)* Parent Driver License# | | State |
| Spouse/Parent Employer: | | Business Phone: ( ) | |

## EMERGENCY CONTACT

Contact Telephone #: ( ) Name Relationship:

***We will be contacting you after your procedure to check on your recovery. Where can we reach you the evening of or day after your procedure?*** (_____) _____--_____

**INSURANCE/PAYMENT INFORMATION:**

Type of Payment: ☐ Insurance *(attach photocopy of information)* ☐ Cash ☐ Lien *(attach Lien document)*

Primary Insurance _____ Policy #:_____ Policy Holder: _____

Secondary Insurance Policy #: Policy Holder:

Patient/Responsible Adult Signature: Date:

Patient/Responsible Adult Print Name: *Relationship to Patient

**If signed by person other than patient*

Interpreter (If required) Signature: Print Name

Interpreter relationship to patient (if applicable)

**Fill out this section ONLY if you accept 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. | SS#: |
| 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: | | Bus Phone: |

Signature of Responsible Party Print Name:

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## ASSIGNMENT OF BENEFITS- CENTER

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

**Crown Valley Outpatient Surgical Center**
**26921 Crown Valley Parkway Suite 110**
**Mission Viejo, CA 92691**

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, Crown Valley Outpatient Surgical 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/partner any checks for services provided at the Center, I will immediately bring or mail the check to Crown Valley Outpatient Surgical Center. I will endorse the check and annotate "Pay to the Order of "Crown Valley Outpatient Surgical 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 incurred by the outpatient 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 on their determination of medical necessity. The information received from the above stated is not a guarantee of payment. I agree that I am responsible for annual deductibles or services not covered by my insurance company(s), regardless of whether my insurance is Medicare, Private or HMO. Physician, Laboratory and Pathology services are billed separately from the Center. Cash patients are required to pay the Center at the time of service.

**X** _____

Patient Signature or Financially Responsible Party | Relationship to patient if not 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** _____

Patient Signature or Financially Responsible Party | Relationship to patient if not patient | Date

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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's or Authorized Representative's Signature Date

Authorized Representative (Please print if applicable) Relationship to Patient Date

### 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 (check ALL that apply):

☐ Home telephone: _____ Written Communication

☐ OK to speak to :_____

☐ OK to leave message with detailed information ☐ OK to mail to my home address

☐ Leave message with call back number only ☐ OK to mail my work/office address

☐ Work telephone: _____ ☐ OK to fax to _____

☐ OK to leave message with detailed information

☐ Leave message with call back number only ☐ Other

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.**

**Record of Disclosures of Protected Health Information**

| Date | **Disclosed to Whom (address or fax number)** | (1) | **Description of Disclosure Purpose of Disclosure** | **By Whom Disclosed** | (2) | (3) |
|---|---|---|---|---|---|---|
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## PRE-OPERATIVE PHONE CALL

| Patient Phone #: | Time | Procedure Date: |
|---|---|---|
| Procedure(s) | | |
| | | |
| Allergies/Abnormal Reactions: ❑ NKA or abnormal reactions OR: | | |
| Anesthesia Type: ❑General ❑IV/Moderate Sedation ❑MAC ❑ Local ❑ Block-Type: _____ | | |
| Ride Home/Aftercare: | Post-Op Contact #: | |

| *Question/Instruction* | **Done** |
|---|---|
| DO NOT EAT OR DRINK ANYTHING AFTER MIDNIGHT: If you have had anything to eat or drink after midnight the night before your surgery, your surgery may have to be cancelled. | |
| CLEANSING: Shower and wash the surgical areas with anti-bacterial soap (such as Phisoderm Dial of Lever 2000). Wash your face well and do not wear any kind of moisturizer, lotion, eye or facial make-up. Do not use moisturizer or body lotion 24 hours before surgery. | |
| ORAL HYGEINE: It is fine to brush your teeth the morning of your procedure, but DO NOT swallows the water. | |
| PRESCRIPTIONS: If currently taking medications, please bring a list of your prescriptions with you the day of surgery including the name of the medication, its strength/dosage and frequency. | |
| Name _____ Strength _____ Frequency _____ Name _____ Strength _____ Frequency _____<br>_____ _____ _____ _____ _____ _____ | |
| CLOTHING: Wear buttoning shirt, slacks and flat slip-on tennis shoes. Do NOT wear pantyhose or a pull-over top. Contact lens wearers should bring glasses. Please bring a sweater or a jacket in case you are cold after surgery. | |
| LEAVE ALL VALUABLES AT HOME: this includes handbags, jewelry including watches, earrings, wristbands and necklaces. | |
| ARRIVE ON TIME: It is extremely important that you arrive at the Center at the time given to you. CONFIRM the time. | |
| CONTACT AFTER SURGERY: You must provide us with a telephone number where you can be reached for 24 hours after your surgery. (Enter the number above) | |
| IN CASE OF A TRAFFIC HOLD-UP OR OTHER INCIDENT BEFORE OR AFTER NORMAL BUSINESS HOURS (9am-5pm) Contact our Nurse by calling | |
| IN CASE OF AN EMERGENCY AFTER YOUR SURGERY contact your physician or go to the nearest Emergency Room. (Confirm that they have the surgeon's office phone number) | |
| DO NOT SCHEDULE any business or social activity directly following your surgery. After surgery, we strongly suggest you REST COMPLETELY and follow your post-surgical instructions carefully. Do not make any important personal or business decisions directly following your surgery and do not return to work until approved by your surgeon. | |
| PRE-OPERATIVE WORK-UP: Did your doctor order blood work? Chest x-ray? EKG? Did you have it/them done? | |

| Interviewed by: | Date: |
|---|---|