



## Office Policies

1. At Surgical Associates of La Jolla, Inc, our goal is to provide excellence in surgery with the individualized and personalized approach of private practice. Surgical Associates of La Jolla is deeply committed to your health and well-being. The following policies have been adopted to try to avoid any patient care confusion and minimize billing questions.

PLEASE READ CAREFULLY THROUGH ITEMS #2 - #12. WHEN YOU HAVE NO FURTHER QUESTIONS,  
PLEASE SIGN AT THE BOTTOM OF THE PAGE. THANK YOU.

2. **Consent to Medical Treatment:** I consent to any medical treatment or physical examination required for myself or for the minor for whom I am legally responsible.
3. **Contracted Insurance Plans:** It is my responsibility to supply the appropriate billing information. This includes current insurance identification, billing address, and any additional information required by my insurance carrier for payment of claim. I will be required to pay any co-payment, deductible, and/or non-covered services that are considered “non-covered benefits” by my insurer. If my insurance plan does not pay my account, I will be responsible for payment of charges for my medical services, including any denied disputed claims.
4. **Non-Contracted / Foreign Insurance Plans:** Surgical Associates of La Jolla will bill my insurance as a courtesy. Payment in full is expected at the time of service for international carriers. Upon request, I will be given a copy of my bill that includes the information necessary to bill my insurance carrier. Unpaid accounts will accrue interest at the rate of 1.5% monthly for balances over 60 days.
5. **Private/Self Pay:** Payment is expected at the time of service. We accept payment in the form of cash, check, or all forms of credit cards. If I am unable to pay at the time of service, I must make arrangements in advance.
6. **Returned Checks:** If my check is returned, I will be liable for \$25.00 plus face value of the check. I may be asked to pay cash for returned checks.
7. **Films / Outside Records:** When arriving to my appointment it is my responsibility to try to ensure that I have a disc containing any images/scans that have been performed. I will make every effort to be sure that I have paper copies of the reports for those images.
8. **High Deductible:** If Surgical Associates of La Jolla discovers that my deductible has not been satisfied I will pay the contracted rate allowed by my health plan prior to checking out at my appointment. If I have more than \$750.00 remaining on my deductible Surgical Associates of La Jolla will call prior to my surgery being scheduled to pre-collect payment for my upcoming operation/procedure.
9. **Copying of Charts:** When requesting a copy of my records. The first 10 pages will be at no cost with additional pages charged at a rate of 10 cents per page plus the cost of postage.
10. **Release of Medical Information:** All records released will need to be accompanied with a signed medical records release. This document can be found on our website under the “Your Visit” section.
11. **Disability Paperwork :** We understand the importance and urgency of this documentation. We will make reasonable efforts to have submitted forms completed within 2-3 days of receipt. Documentation will not be completed the same day that it is submitted.

**Notice to Patients:** Medical doctors are licensed and regulated by the Medical Board of California. I can find more information at (800) 633-2322 or [www.mbc.ca.gov](http://www.mbc.ca.gov).

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_



- Paul V.B. Hyde, MD
- Mark Sherman, MD
- Cheryl L. Olson, MD

**PATIENT INFORMATION**

Patient's Last Name:		First Name:	Middle Initial:
Mailing Address:		City:	State:      Zip:
E-mail Address:			
Home Phone: (      )	Mobile Phone: (      )	Work Phone and Extension: (      )	
Patient DOB:	Age:	Sex:	
Ethnicity: <input type="checkbox"/> Hispanic / Latin <input type="checkbox"/> Not Hispanic or Latin <input type="checkbox"/> Decline to State	Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Other Pacific <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Other Race <input type="checkbox"/> Decline to State		
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____		Social Security Number:	
Primary Care Physician:		Primary Care Physician Phone:	
How Did You Hear About Our Office?		Next of Kin:	

**IN CASE OF EMERGENCY**

Name of Emergency Contact Person:	Relationship to Patient:	Home Phone: (      )	Cell Phone: (      )
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**RESPONSIBLE PARTY (GUARANTOR) (if patient is spouse, dependent, or student)**

Guarantor's Last Name:		Guarantor's First Name:	Guarantor's Middle Name:
Mailing Address:		City:	State:      Zip:

**PRIMARY INSURANCE (please present new insurance card to our office staff)**

<input type="checkbox"/> Self-Pay / No Insurance <input type="checkbox"/> Patient is the Insured Subscriber		Policy Subscriber's Name (if not patient):	Policy Subscriber's DOB (if not patient):
Name of Primary Insurance:	Primary Insurance Address:	Policy Subscriber's Phone: (      )	
Patient's Relation to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other, please specify:		Policy Subscriber's Social Security #:	
Subscriber Number:	Group Number:	Specialist Co-Pay: \$	

**SECONDARY INSURANCE (please present new insurance card to our office staff)**

<input type="checkbox"/> Self-Pay / No Insurance <input type="checkbox"/> Patient is the Insured Subscriber		Policy Subscriber's Name (if not patient):	Policy Subscriber's DOB (if not patient):
Name of Primary Insurance:	Primary Insurance Address:	Policy Subscriber's Phone: (      )	
Patient's Relation to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other, please specify:		Policy Subscriber's Social Security #:	
Subscriber Number:	Group Number:	Specialist Co-Pay: \$	



**Surgical Associates of La Jolla  
Personal History**

Patient's Name:	Date of Birth:	Today's Date:		
Occupation:	Marital Status:			
Pharmacy:	Pharmacy Phone #:			
Referring Provider:				
<b>CHIEF COMPLAINT - Please describe the reason for your visit today:</b>				
<b>MEDICATIONS - Please list the name, strength, and number of times taken daily:</b>				
		Do you take Aspirin every day?		
<b>ALLERGIES - Include all allergies:</b>				
Do you have any allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, please list:			
Other:	Iodine?	Shellfish?		
<b>SURGICAL HISTORY - Please list any prior surgeries chronologically (include year):</b>				
1.	4.	7.		
2.	5.	8.		
3.	6.	9.		
<b>MEDICAL HISTORY - Have you ever had any of the following? When?</b>				
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	Strokes <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid disorder <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes      If yes, what type? <input type="checkbox"/> No				
Please list any other illness or hospitalizations:				

**\*\*\* (Please see reverse to complete additional information) \*\*\***

**PERSONAL HABITS:**

Do you currently smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, for how long? _____ packs/day _____
Did you smoke in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when did you discontinue?	If yes, for how long? _____ packs/day _____
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No		Drinks per week? _____
Do you use drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what type? _____

**Do you consume caffeine in the following?**

Coffee? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, cups per day _____
Tea? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, cups per day _____
Soda? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, cups per day _____
Chocolate? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**FAMILY HISTORY:**

<u>Relation</u>	<u>Age</u>	<u>Age at death</u>	<u>State of health / Cause of death</u>
Mother:			
Father:			
Siblings (Please specify gender):			
Children:			

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Doctor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Hereditary Cancer Questionnaire

## Personal Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Gender (M/F) \_\_\_\_\_ Today's Date (MM/DD/YY): \_\_\_\_\_ Healthcare Provider: \_\_\_\_\_

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

**You and the following close blood relatives should be considered:** *You, parents, brothers, sisters, sons, daughters, grandparents, grandchildren, aunts, uncles, nephews, nieces, half-siblings, first-cousins, great-grandparents, and great-grandchildren.*

### YOU and YOUR FAMILY'S Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU Age of diagnosis	PARENTS/SIBLINGS/ CHILDREN	Age of diagnosis	RELATIVES on your MOTHER'S SIDE	Age of diagnosis	RELATIVES on your FATHER'S SIDE	Age of diagnosis
<input checked="" type="checkbox"/> Y	<i>EXAMPLE:</i> BREAST CANCER	45	-----	-----	Aunt Cousin	45 61	Grandmother	53
<input type="checkbox"/> N	BREAST CANCER (Female of Male)							
<input type="checkbox"/> Y	OVARIAN CANCER (Peritoneal/Fallopian Tube)							
<input type="checkbox"/> N	UTERINE (ENDOMETRIAL) CANCER							
<input type="checkbox"/> Y	COLON/RECTAL CANCER							
<input type="checkbox"/> N	10 or more LIFETIME COLON POLYPS (specify #)							
<input type="checkbox"/> Y	OTHER CANCER(S) (Specify cancer type)	<i>Among others, consider the following cancers: Melanoma, pancreatic, stomach (gastric), brain, kidney, small bowel, sarcoma, thyroid, prostate</i>						
<input type="checkbox"/> N								
<input type="checkbox"/> Y	Are you of Ashkenazi Jewish descent?							
<input type="checkbox"/> N								
<input type="checkbox"/> Y	Are you concerned about your personal and/or family history of cancer?							
<input type="checkbox"/> N								
<input type="checkbox"/> Y	Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? (Please explain/include a copy of result if possible)							
<input type="checkbox"/> N								

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Healthcare Provider's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_