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.

12. **Patient Forms:** EDD forms will be completed at no charge to the patient. Any other forms submitted to the office will incur a fee. Payment must be received prior to the forms being completed.
    1-2 Forms: $25.00 Fee
    3 or more: Additional $25.00 Fee (Fee not to exceed $50.00 for all forms 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.

Signature: _____ Date: _____

Patient Name: _____

Surgical Associates of La Jolla

☐ 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: ☐ Hispanic / Latin ☐ Not Hispanic or Latin ☐ Decline to State	Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian / Other Pacific ☐ Black or African American ☐ White ☐ Hispanic ☐ Other Race ☐ Decline to State		
Preferred Language: ☐ English ☐ 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: ( )

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)*		
☐ Self-Pay / No Insurance ☐ 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: ☐ Self ☐ Spouse ☐ Child ☐ 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)*		
☐ Self-Pay / No Insurance ☐ 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: ☐ Self ☐ Spouse ☐ Child ☐ 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:		

CHIEF COMPLAINT – Please describe the reason for your visit today:

MEDICATIONS – Please list the name, strength, and number of times taken daily:

		Do you take Aspirin every day?

ALLERGIES – Include all allergies:

Do you have any allergies to medications? ☐ Yes ☐ No	If so, please list:	
Other:	Iodine?	Shellfish?

SURGICAL HISTORY – Please list any prior surgeries chronologically (include year):

1.	4.	7.
2.	5.	8.
3.	6.	9.

MEDICAL HISTORY – Have you ever had any of the following? When?

Asthma ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Heart attack ☐ Yes ☐ No	High blood pressure ☐ Yes ☐ No	Pneumonia ☐ Yes ☐ No
Rheumatic fever ☐ Yes ☐ No	Seizures ☐ Yes ☐ No	Strokes ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No	Thyroid disorder ☐ Yes ☐ No
Cancer ☐ Yes If yes, what type? ☐ No				
Please list any other illness or hospitalizations:				

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

PERSONAL HABITS:		
Do you currently smoke? ☐ Yes ☐ No		If yes, for how long? _____ packs/day _____
Did you smoke in the past? ☐ Yes ☐ No	If yes, when did you discontinue?	If yes, for how long? _____ packs/day _____
Do you drink alcohol? ☐ Yes ☐ No		Drinks per week? _____
Do you use drugs? ☐ Yes ☐ No		If yes, what type? _____
Do you consume caffeine in the following?		
Coffee? ☐ Yes ☐ No		If yes, cups per day _____
Tea? ☐ Yes ☐ No		If yes, cups per day _____
Soda? ☐ Yes ☐ No		If yes, cups per day _____
Chocolate? ☐ Yes ☐ No		

FAMILY HISTORY:			
Relation	**Age**	**Age at death**	**State of health / Cause of death**
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
✓ Y ☐ N	*EXAMPLE:* *BREAST CANCER*	*45*	-----	-----	*Aunt* *Cousin*	*45* *61*	*Grandmother*	*53*
☐ Y ☐ N	BREAST CANCER *(Female of Male)*							
☐ Y ☐ N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐ Y ☐ N	UTERINE (ENDOMETRIAL) CANCER							
☐ Y ☐ N	COLON/RECTAL CANCER							
☐ Y ☐ N	10 or more LIFETIME COLON POLYPS *(specify #)*							
☐ Y ☐ N	OTHER CANCER(S) *(Specify cancer type)*	*Among others, consider the following cancers: Melanoma, pancreatic, stomach (gastric), brain, kidney, small bowel, sarcoma, thyroid, prostate*						
☐ Y ☐ N	Are you of Ashkenazi Jewish descent?							
☐ Y ☐ N	Are you concerned about your personal and/or family history of cancer?							
☐ Y ☐ N	Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*							

Patient's Signature: _____ **Date:** _____

Healthcare Provider's Signature: _____ **Date:** _____