

Huntington Colorectal Surgeons, Inc.

686 S. Fair Oaks Ave., Pasadena, Ca 91105

T: 626-397-5896

IMPORTANT PRE-VISIT INFORMATION

Welcome, you have an appointment on _____ at _____. **If you are more than 15 minutes late to your appointment, we may need to reschedule you.**

CANCELATION POICY: A \$75.00 fee will be charged to you for appointments canceled with less than 24 hours notice.

We look forward to seeing you, our office is located at:

HMRI Building

686 S. Fair Oaks Avenue

Pasadena, CA 91105

626-397-5896

During your visit, the doctor will discuss the nature of your problem, perform a rectal exam and if necessary, perform an additional diagnostic test called anoscope which is billed separately from your consult and subject to your deductible.

IMPORTANT PLEASE BRING THE FOLLOWING ITEMS WITH YOU

- Any prescription medications and or supplements that you are taking. Please bring the container or an itemized list.
- A translator if you are non-English speaking.
- The enclosed Patient Forms – please be sure to complete them before arriving to your appointment as this may delay or cause to reschedule your appointment.
- Insurance cards and Driver's License
- Pertinent operative, pathology and lab reports this includes your most recent colonoscopy report
- Pertinent imaging reports and CD with images
- Pathology slides from previous biopsy if applicable

Parking

Our parking lot entrance is off Raymond Ave. or Edmondson Alley (off Pico St.), see map enclosed.

Copayment

Your copayment is due at time of service

Method of Payments taken:

- Cash (we appreciate exact change)
- Check
- Credit Card

We look forward to serving you with clinical excellence and compassion.

Thank you

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Information For Your Appointment Related To COVID-19

Everyone must wear a face covering (**cloth or surgical mask**) when entering the building and walking through the building's public corridors throughout your appointment. **Bandanas, Gaiters, and one-way valve masks will not be permitted.**

- **Must arrive exactly at your appointment time.** If you arrive early, please wait at your car until your appointment time. We will NOT call you. You must simply wait at your car and come to the main entrance at your appointment time.
- We will check your temperature before you are brought in to the exam room
- **You must come alone unless assistance is required, we will allow one extra person for assistance only.**
- **Stay home/Cancel Your Appointment** if you or someone you share a dwelling with experiences any of the following symptoms:
 - Fever > 100.4°F
 - Cough
 - Shortness of breath or difficulty breathing
 - New Loss of taste or smell
 - Chills
 - Repeated shaking with chills
 - Muscle aches or pain
 - Headache
 - Sore throat
 - Diarrhea

HUNTINGTON COLORECTAL SURGEONS INC.
PATIENT REGISTRATION INFORMATION

Last Name: _____ First: _____ M.I.: _____

Date of Birth: _____ Age: _____ Religion: _____

Race (circle one): American Indian or Alaskan Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White, or Refuse to Report **Ethnicity (circle one):** Hispanic/Latino, Non Hispanic/Latino, or Refuse to Report

Preferred Language: _____

SS#: _____ Driver's License: _____ Sex: _____ Marital Status: _____

Address: _____ City & Zip Code: _____

Home Tel: (____) _____ Cell phone: (____) _____ Home email: _____

Employer: _____ Occupation: _____ Employer Tel: (____) _____

Employer Address: _____ City & Zip Code: _____

Referring Physician: _____ Referring Telephone: (____) _____

PHARMACY: _____ **PHARMACY#:** _____

Responsible Party (If different from above)

Name: _____

Date of Birth: _____ Age: _____

Address: _____

City & Zip Code: _____ Home Telephone: (____) _____

SS#: _____ Driver's License: _____ Cellphone: (____) _____

Sex: _____ Martial Status: _____ Home email: _____

Occupation: _____ Employer: _____

Employer Address: _____

City & Zip Code: _____ Work Telephone: (____) _____

Emergency Contact (relative or friend at an address different from above)

Name: _____ Relationship: _____

Home Telephone: (____) _____ Cell phone: (____) _____

Work Telephone: (____) _____

Insurance Information

Primary Insurance: _____ Ins. Co. Phone: _____

IPA/Medical Group (HMO only): _____

Subscriber Name: _____ ID#: _____

Subscriber Date of Birth: _____ Subscriber SS# _____

Secondary Insurance: _____ Ins. Co. Phone: _____

IPA (HMO only): _____

Subscriber Name: _____ ID#: _____

Appointment Date: _____

Name: _____ Age: _____ Sex: M F Date of Birth: _____

PHYSICIANS

Referring Physician Primary Care Doctor Cardiologist
Name: _____ Name: _____ Name: _____
Phone: _____ Phone: _____ Phone: _____
How were you referred to us? My doctor Online Family/friend Insurance group Speaking Engagement

TODAY'S CONCERNS

What problem are you being seen for today?

Are you experiencing any of the following symptoms? (check all that apply)

Rectal bleeding Fecal incontinence Anal itching Abdominal pain Change in bowel habits
 Hemorrhoids Anal pain Pelvic pain Other: _____
When was your last colonoscopy (date or year & GI doctor)? _____
Have you had any MRIs, CT or PET scans, ultrasounds? No Yes

MEDICAL HISTORY

Have you been diagnosed or treated for any of the following medical problems?

Colon or rectal cancer Ulcerative colitis Crohn's disease Irritable bowel syndrome Diverticulitis Pelvic organ prolapse Urinary incontinence Hepatitis Cirrhosis
 Diabetes High blood pressure High cholesterol Chest pain/angina Heart disease Heart attack Atrial fibrillation Irregular heartbeat Congestive heart failure
 Hernia Anxiety Depression HIV/AIDS HPV/Condyloma History of blood transfusion Anemia DVT/PE (blood clots) Bleeding disorder
 Thyroid disease Stroke/TIA Seizures Sleep apnea Asthma COPD Other STD: _____ Other cancer: _____ Other: _____

SURGICAL HISTORY

Colon or rectal surgery Hemorrhoid Fissure surgery Fistula surgery Anal/rectal abscess
 Coronary stent Heart bypass Heart valve replacement Pacemaker/defibrillator Weight loss surgery
 Gallbladder Appendectomy Hernia Joint replacement Other: _____
 Hysterectomy Removal of tubes/ovaries Vaginal/bladder surgery Prostate surgery

WOMEN ONLY

Are you pregnant? No Yes Number of: Pregnancies _____ C-sections _____ Vaginal deliveries _____
Did you ever experience any vaginal tears or an episiotomy during delivery? No Yes
How heavy was your child at birth? _____ Was your child's delivery vacuum or forceps assisted? No Yes

CONSENT FORM

1. CONSENT FOR TREATMENT

I hereby authorize my consent to be treated now and in the future by physicians providing services for Huntington Colorectal Surgeons, Inc.

2. ASSIGNMENT OF BENEFITS

I hereby authorize Huntington Colorectal Surgeons, Inc. to furnish information to insurance carrier concerning this illness. I hereby irrevocably assign to Huntington Colorectal Surgeons, Inc. all payments for medical services rendered and all major medical benefits.

3. MEDICRE AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for physician's services to the physician or organization furnishing the services.

4. RELEASE OF INFORMATION FOR BENEFITS

I authorize release of any information acquired in the course of my examination or treatment which may be needed for the payment of professional charges and related services.

5. FINANCIAL AGREEMENT

I understand that charges for any diagnostic tests will be in addition to the consultation fee, and that I am directly financially responsible for all charges incurred for medical services and/or surgical procedures rendered for myself and/or my dependents, which are not covered by valid insurance benefits. I agree to pay any legal interest, collection expense and attorney's fees or other costs incurred, should it become necessary to assign any amount I may owe for collection.

7. PERSONAL AFFIRMATION

I certify that all statements given to the physicians and personnel are complete and accurate to the best of my knowledge. A copy of this agreement shall be considered as effective and valid as the original. This agreement will continue until revoked by me in writing.

Patient Name

Date

Patient/Guarantor Signature

(Guarantor Relationship)

Date

Witness Signature

Remarks

8. PRE-AUTHORIZE

I hereby authorize Huntington Colorectal Surgeons, Inc. to automatically bill my credit card account for Huntington Colorectal Surgeons, Inc. fees that are not covered by my insurance. Huntington Colorectal Surgeons, Inc. is only authorized to bill my account for insurance balances not paid by my insurance company, or personal balances that are over 60 days.

Card Issuer Name: (Circle One) Visa MasterCard Amex Discover

Account #: _____ CVV Code: _____

Cardholder's Name: _____ Billing Zip Code: _____

Expiration Date: _____ Signature: _____

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Patient Record of Disclosure

The HIPAA privacy rule gives individuals the right to request restrictions on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communication of PHI if 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)

Mobile phone number _____

Ok to leave message with detailed information

Leave a message with call back number only

Home phone number _____

Ok to leave message with detailed information

Leave a message with call back number only

Work phone number _____

Ok to leave message with detailed information

Written Communication:

Ok to mail to home address

Ok to mail to work address

Ok to fax to this number _____

You may discuss my medical condition with:

_____	_____
_____	_____
_____	_____

Thank you for your assistance in this matter. If you have any questions, please do not hesitate to contact our office.

Patient Signature or Legal Representative Date

Print Patient Name or Legal Representative

Huntington Colorectal Surgeons, Inc.

Release of Information/Notice of Privacy Practices (HIPAA)

The circumstances under which Huntington Colorectal Surgeons, Inc. may use or disclose health information related to you concerning the care and including treatment information you receive here are described in the Notice of Privacy Practices, which is provided to you the first time you receive services from this provider and is otherwise available to you upon request. The Notice of Privacy Practices is incorporated into document by reference. The patient hereby acknowledges the receipt of the Notice of Privacy Practices.

The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, the provider may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable. For all or any portion of the providers charges, including, but not limited to insurance companies, health care service plans, or worker's Compensation carriers. Special permission is needed to release this information if the patient is treated for alcohol or drug abuse.

The undersigned certifies that he/she has read the foregoing, received a copy thereof and is the patient, the patient's legal representative, or is duly authorized by patient as the patient's general agent to execute the above, and accept its term, and agree that they are irrevocable.

Name: _____

Signature: _____ Date: _____

If signed by other than the patient, indicate relationship:

Huntington Colorectal Surgeons, Inc.

PATIENT EMAIL CONSENT FORM

To Address the risks of using email

Patient name _____

Email _____

1. RISK OF USING EMAIL

Transmitting patient information by email has a number of risks that patients should consider before using email. These include, but are not limited to, the following risks:

- a) Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- b) Email senders can easily misaddress an email.
- c) Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.
- d) Employers and on-line services have a right to inspect email transmitted through their systems.
- e) Email can be intercepted, altered, forwarded, or used without authorization or detection.
- f) Email can be used to introduce viruses into computer systems.
- g) Email can be used as evidence in court.
- h) Emails may not be secure, including at Huntington Colorectal Surgeons, Inc. and its affiliates, and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. CONDITIONS FOR THE USE OF EMAIL

Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Patients must acknowledge and consent to the following conditions:

- a) **Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email will be read and responded to within any particular period of time.**
- b) Email must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via email.
- c) **Email may be printed and filed in the patient's medical record or stored in the patient's electronic medical record.**
- d) Office staff may receive and read your messages.

- e) Provider will not forward patient identifiable emails outside of Huntington healthcare providers or other providers submitted as treating or referring physicians without the patient's prior written consent, except as authorized or required by law.
- f) The patient should not use email for communication regarding sensitive medical information.
- g) Provider is not liable for breaches of confidentiality caused by the patient or any third party.
- h) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. INSTRUCTIONS

To communicate by email, the patient shall:

- a) Avoid use of his/her employer's computer.
- b) Put the patient's name in the body of the email.
- c) Key in the topic (e.g., medical question, billing question) in the subject line.
- d) Inform Provider of changes in his/her email address.
- e) Acknowledge any email received from the Provider.
- f) Take precautions to preserve the confidentiality of email.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the Providers and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with patient by email. If I have any questions I may inquire with my treating physician's office.

Patient signature _____

Date _____

Witness signature _____

Date _____

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Request for Medical Records

Date: _____

Name: _____

Date of Birth: _____

I hereby authorize:

(Name of physician/hospital/agency)

Telephone No./Fax No.

Address

City

State

Zip code

To furnish:

Huntington Colorectal Surgeons, Inc.

- Howard S. Kaufman, MD
- Gabriel Akopian, MD
- Juliane Golan, MD

The following medical records: copies of the above-named patient's medical records including: operative reports, X-rays, labs, pathology reports, biopsy slides and blocks, etc.

Specifically: _____

Thank you for your assistance in this matter. If you have any questions, please do not hesitate to contact our office.

Patient Signature or Legal Representative

Date

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