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

HUNTINGTON COLORECTAL SURGEONS

Howard S Kaufman, MD, FACS
Gabriel Akopian, MD, FACS
Juliane Y Golan, MD

686 S Fair Oaks
Pasadena, CA 91105
Phone: 626.397.5896
Fax: 626.397.5899

Registration Form

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

Date of Birth: _____ Age: _____ Sex: Select One Religion: _____

Race: Select One Ethnicity: Select One Preferred Language: Select One

SS#: _____ DL #: _____ Marital Status: Select One

Address: _____ City/State/Zip: _____

Home Tel: _____ Cellphone: _____ Home email: _____

Employer: _____ Occupation: _____ Employer Tel: _____

Employer Add: _____

Referring MD: _____ Referring Tel: _____

PHARMACY: _____ **PHARMACY TEL:** _____

Responsible Party (If different from above)

Name: _____ DOB: _____ Relation: _____

Address: _____ City/State/Zip: _____

Home #: _____ Cell #: _____ Home Email: _____

SSN: _____ DL #: _____ Employer: _____

Occupation: _____ Work #: _____ Address: _____

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

Name: _____ Relation: _____ Cell#: _____

Home#: _____ Work#: _____

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#: _____

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

SURGICAL HISTORY

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

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

YOUR FAMILY HISTORY

Has any immediate member of your family ever had:

- ☐ Colon or rectal cancer: Who? _____
- ☐ Colon or rectal polyps: Who? _____
- ☐ Gynecological cancers: Who? _____
- ☐ Other cancers: _____

PERSONAL HABITS/SOCIAL HISTORY

Marital Status: ☐ Married ☐ Divorced/separated ☐ Single ☐ Widowed

Do you smoke? ☐ No ☐ Yes How many packs per day? _____

Have you quit smoking? ☐ No ☐ Yes When did you quit? _____

Do you drink alcohol? ☐ No ☐ Yes How many drinks per week _____

Occupation: _____

MEDICATIONS

Which pharmacy do you use? _____ Address/city: _____

List all current medication below	Dose/how often	Purpose of medication

ALLERGIES

Do you have allergies to latex? ☐ No ☐ Yes Reaction: _____

Do you have allergies to contrast, iodine, shellfish? ☐ No ☐ Yes Reaction: _____

List all drug allergies and reaction below:	Reaction

REVIEW OF SYSTEMS

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

GENERAL:

- ☐ Deafness
- ☐ Change in vision
- ☐ Skin rash
- ☐ Weight loss
- ☐ Weakness
- ☐ Prolonged bleeding
- ☐ Swollen lymph nodes

CARDIORESPIRATORY:

- ☐ Cough
- ☐ Fainting
- ☐ Leg swelling
- ☐ Murmur
- ☐ Heart palpitations
- ☐ Shortness of breath
- ☐ Chest pain/angina

GASTROINTESTINAL

- ☐ Constipation
- ☐ Diarrhea
- ☐ Fecal urgency/frequency
- ☐ Incomplete evacuation
- ☐ Bloating
- ☐ Rectal or anal bleeding
- ☐ Perianal drainage/discharge
- ☐ Jaundice

GENITOURINARY

- ☐ Urinary frequency
- ☐ Urinary urgency
- ☐ Kidney stones
- ☐ Urinary incontinence
- ☐ Erectile dysfunction
- ☐ Genital lesions

NEUROPSYCHIATRIC

- ☐ Panic attack
- ☐ Suicidal thoughts
- ☐ Numbness
- ☐ Seizures

MUSCULOSKELETAL

- ☐ Physical disability
- ☐ Joint pain
- ☐ Joint swelling

OB/GYN

- ☐ Irregular menstruation
- ☐ Abnormal pap smear
- ☐ Pelvic organ prolapse
- ☐ Vaginal discharge
- ☐ Painful intercourse
- ☐ Pelvic pain

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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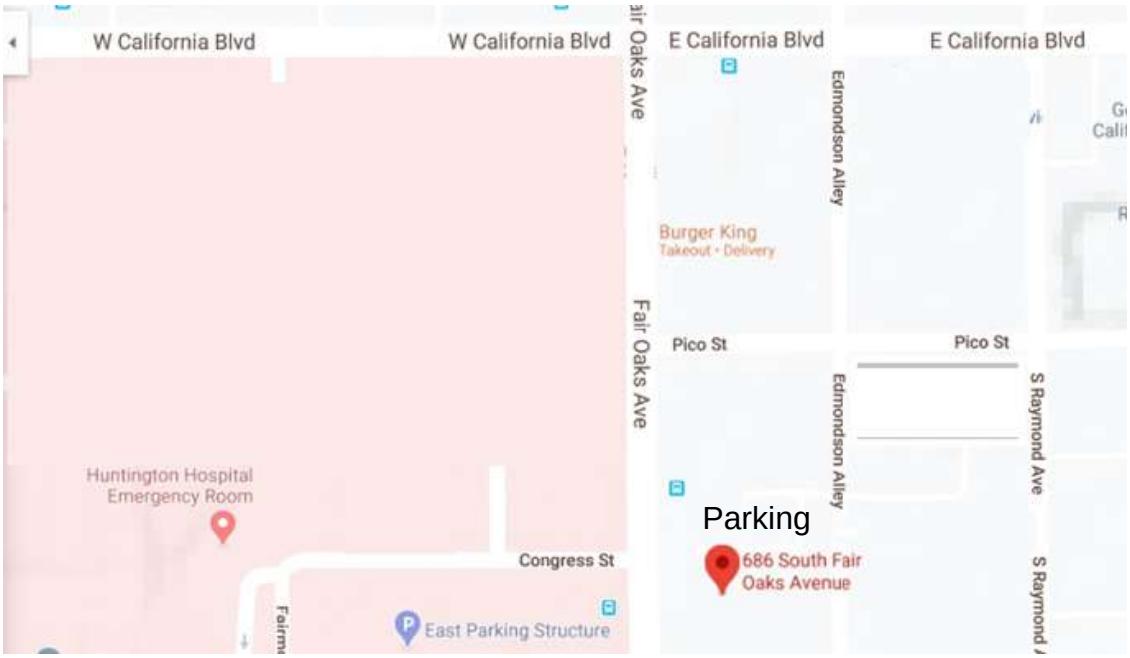

- Entrance to parking is through Edmondson Alley
- We are in the HMRI Building (All HMRI parking lots are an option)
- We are on the 1st Floor