SILLECT
CENTER FOR SURGERY
3545 San Dimas St.
Bakersfield, CA 93301
661-323-1947

Date: _____ **Time In:** _____

Patient Name: _____ ☐F ☐M
Last Middle First

DOB: _____ Age: _____ Social Security: _____

Driver's License: _____ Race: _____ Ethnicity: _____

Cell Phone: _____ Home: _____ Email: _____

Address: _____
City State Zip

Employer: _____ Phone: _____ Occupation:_____

Next of Kin: _____ Phone: _____ Relationship: _____

Best form of communication: ☐Home Phone ☐Mobile Phone ☐Email ☐Mail ☐Other _____

Emergency Contact: _____ Phone:_____ Relationship to Patient:_____

Insurance:

Primary insurance: _____ Secondary insurance: _____

Policy # _____ Policy # _____

Group # _____ Group # _____

Acknowledgement of receipt of privacy notice
I acknowledge that I have access to the Privacy Notice. In order to maintain healthcare costs, copies of the Privacy Notice are distributed in the patient waiting area for my viewing. I may obtain a copy upon request.

Financial Agreement

1. **In consideration of the services to be rendered to me, I HEREBY INDIVIDUALLY OBLIGATE MYSELF TO PAY THE ACCOUNT OF THE SURGERY CENTER IN ACCORDANCE WITH THE REGULAR RATES AND TERMS OF THE SURGERY CENTER.** Should the account be referred to an attorney or licensed collection. I shall pay reasonable attorney's fees and collection expenses. All delinquent accounts (those not paid within 60 days from date of service) shall bear interest at the legal rate.
2. I hereby authorize direct payment to the surgery center of any insurance benefits otherwise payable to me for this admission at a rate not insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. I understand that I am financially responsible for charges not covered by this assignment.
3. A photo static copy of this assignment shall be considered effective and valid as the original.

I understand that the Surgery Center shall have the right at any time to refuse to admit me or to provide medical care or treatment for me.

I certify that I am the patient or am duly authorized by the patient's general agent to execute this document and accept its terms.

I understand that, as a courtesy, the Center will file my primary insurance. After 60 days for the date of surgery, the total balance will be considered due and payable.

Signature: _____ Date: _____ Witness: _____

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Health History Questionnaire

Name: _____ ☐**M/F**☐ Age:____ Wt(lbs.):____ Ht(ft/in):_____

Do you wear?
Contacts: Y N **Dentures:** Y N **Hearing Aids**: Y N Left/Right/Both

Allergies to Medications and Reactions: _____
(Please list)
Allergies to Foods, Tape, Soap, LATEX, etc._____
(Please list)
Who will take you home? _____Relationship:_____ Phone#_____

Current Medications (Prescription/Over-the-Counter/Herbal)– *(please attach list if necessary)*

Medication	Dose/Mg	X per day	Medication	Dose/Mg	X per day
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Have you or a blood relative ever had a complication with anesthesia? ☐ Yes ☐ No
If yes, describe_____

Previous Surgeries/dates _____

Medical History *(Check all that apply to you)*

Cardiac
☐ Angina/Chest Pain
☐ Congestive Heart Failure
☐ Irreg. Heart Beats
☐ Coronary Bypass #___
☐ High Blood Pressure
☐ Pacemaker

Lungs
☐ Asthma/Use Inhalers
☐ Emphysema
☐ COPD/Use Oxygen at home?
☐ Bronchitis
☐ Allergies
☐ Sleep Apnea/Wear CPAP?
☐ Smoker, # Packs per Day

Thyroid
☐ Hyperthyroid
☐ Hypothyroid

Eyes
☐ Glaucoma ☐ Cataract surgery
☐ Retina surgery

Kidney
☐ Chronic Urinary Tract Inf.
☐ Dialysis, When_____
☐ Voiding at Night #_____

Liver
☐ Hepatitis A,B,or C
☐ Cirrhosis

Diabetics
☐ Oral Meds
☐ Insulin Reg/NPH
☐ Diet Controlled

Central Nervous System
☐ Stroke/TIA's
☐ Seizures/Migraines

Pregnancy Screen
☐ Possibility that you might be pregnant? If yes, please speak with your surgeon

Other
☐ Alcohol Use
☐ How Often_____
☐ Drug Use
Specify_____
☐ Bleeding Disorders
☐ History of Mental Illness
☐ **Take/Have taken FLOMAX**

Please list any previous serious illness or current chronic illness:

_____
_____
_____
_____
_____

Patient/Guardian Signature:_____ **Date:**_____

For subsequent surgeries, there have been no changes to the above:

_____ _____
Patient Signature Date

Place Patient Label Here

Patient Notification and Acknowledgement

Notice of Rights
Sillect Surgery Group, LLC has established a Patient's Bill of Rights, which is provided verbally and in writing in a language and manner the patient or patient's representative understands prior to the date of the procedure. Sillect Surgery Group, LLC expects that observance of these rights will contribute to more effective patient care and greater satisfaction for patients, physicians and the facility.

Financial Disclosure
Sillect Surgery Group, LLC is privately owned and has informed the patient prior to the date of the procedure that their physician may have a proprietary interest in this facility. The patient has the right to choose the facility of his/her choice for health related services.

Advance Directives
It is the policy of Sillect Surgery Group, LLC, regardless of any advance directives or instructions from a health care surrogate or power of attorney, that an unexpected medical emergency, which occurs during treatment at this facility, will be aggressively managed with resuscitative or other stabilizing measures followed by emergency transfer to the closest emergency room. The receiving hospital will implement further treatment or withdrawal of treatment measures already begun in accordance with patient wishes, advance directive or health care power of attorney. Acknowledgement of this policy does not revoke or invalidate any current health care directive or health care power of attorney.

Please check the appropriate box. Have you executed an advance health care directive, a living will and/or a power of attorney that authorizes someone to make health care decisions for you?

☐ **Yes**, I have an advance health care directive, living will and/or a power of attorney.

☐ I have provided my advance health care directive, living will and/or a power of attorney to SSI.

☐ **No**, I do not have an advance health care directive, living will and/or a power of attorney.

☐ I would like additional information on advance health care directives
(PLEASE ASK RECEPTIONIST FOR PAMPHLET)

By signing this document, I acknowledge that the above information was given to me prior to my day of surgery, and that I have read and understand the information on notice of patient rights, financial disclosure and advance directives. I agree to the policies of Sillect Surgery Group, LLC. If I have indicated I would like additional information, I acknowledge receipt of that information.

_____ _____
Patient Signature (If patient is unable to sign, please indicate relationship) **Date**

_____ _____
Witness Signature **Date**

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Patient Sticker

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received Sillect Surgery Group, LLC's Privacy Notice.

_____ _____

Patient or Personal Representative Signature **Date**

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____

_____

Witness Signature:

Patient Label

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Patient Financial Policy

Thank you for choosing Sillect Surgery Group as your healthcare provider. The Surgery Center realizes that the cost of healthcare is a concern for our patients. We offer the following information to help you understand our financial policies and aid you in planning for payment. Your clear understanding of our Policy is important to our professional relationship. Carefully review the following information and please feel free to ask if you have any questions about our fees, our policies or your responsibility.

With the information provided by your physician's office the Surgery Center will estimate the charges for your scheduled procedure or surgery. An exact fee cannot be quoted before surgery, since it is unpredictable what the findings may be at the time of surgery and what specific procedures may be billed. We will estimate the portion your insurance will cover and estimate your patient responsibility.

Prior to your surgery, A staff member will explain our charges and confirm with you what your insurance is expected to pay for these charges. You will be given the estimated patient responsibility at that time. If you have not received a call by the day before your surgery, please call the business office at (661) 489-4543.

Insurance:
Your insurance policy is a contract between you and your insurance company. As a courtesy, we will help you receive maximum benefits by promptly filing your claim and supplying information as required by the insurance company for claim processing. In order for your claim to be filed in a timely manner we require that you provide patient and insurance information at each visit. Please remember to bring your current insurance cards and a photo ID with you to the Surgery Center.

If your insurance company contacts you for information or completion of a form, please respond immediately. Your untimely response could cause a delay or a denial of your claim. If the Insurance Company does not pay within 90 days, you may be held responsible for the timely payment of your account. Sillect Surgery Group will not become involved in disputes between you and your insurance company.

If your insurance carrier reimburses you directly for our services, we expect you to send or bring the signed insurance check and EOB to Sillect Surgery Group within 7 days. If the Surgery Center has not received the full amount of the insurance check within 30 days, your account will be sent for collection action.

Copayments:
All copayments must be paid at the time of service. A ***copayment***, or ***copay***, is a capped contribution paid by the patient each time a medical service is rendered. It must be paid before any policy benefit is payable by an insurance company.

Deductibles and Coinsurances:
Your estimated deductible and coinsurance amount is due at the time of service. Your ***deductible*** is the amount you have to pay out-of-pocket for services before your insurance company will begin to pay. ***Coinsurance*** is a co- sharing agreement between you and your insurance company which provides that your insurance will cover a set percentage of the covered costs after the deductible has been paid. If you have a high deductible plan, be prepared to pay for your services in full on the date of service. After your insurance has paid, any remaining patient responsibility will be billed to you. If our original estimate was too high, you will be refunded your overpayment in a timely manner.

Method of Payment:
For your convenience Sillect Surgery Group accepts cash (US dollars), local personal checks, cashiers check, debit cards, Visa®, MasterCard®, Discover®, American Express® and CareCredit®.

Payment Arrangements:
Full payment of the estimated patient balance is required at the time of service unless prior arrangements have been made. In the event the total patient balance is more than you are able to pay, contact the Surgery Center Business Office to make payment arrangements.

The Surgery Center does not routinely offer payment plans longer than 6 months. If you need a longer time to pay your balance you will need to contact CareCredit® for financing. For CareCredit® Financing call the toll free number 1-800-677-0718 or go to www.carecredit.com and complete an application. Always provide the Surgery Center's name and phone number when applying to assure the application is processed correctly.

If you are having financial difficulty, our business office will work with you to get your account paid. It is your responsibility to inform us of any such concerns **before** your surgery.

Minor Patients (under age 18):
Any patient under the age of 18 must be accompanied by a Parent or Guardian. The person who accompanies the minor will be responsible for providing current information and payment of the patient responsibility. The Surgery Center does not recognize any family relationship contract or settlement.

Medicare Patients:
The Surgery Center does not accept Medicare. If you are a Medicare patient and you still wish to have your services done at Sillect Surgery Group, a cash rate will be offered to you.

Worker's Compensation:
If you are having a procedure/surgery because of a work-related injury, the Surgery Center will need your employer's worker's compensation insurance information and your personal health insurance information. Your employer should supply you the name and phone number of their Worker's Compensation Insurance, a contact person and claim number for your surgical visit. This information is needed so the Surgery Center can obtain prior approval from your workers' compensation carrier for your services. Worker's compensation claims denied by the carrier will become your responsibility.

Cosmetic Procedures:
Payment for cosmetic surgery is due in full on or before the date of service. No personal checks will be accepted for cosmetic procedures, unless received 10 business days prior to services being rendered.

Self-Pay Accounts:
Patient's that are not covered by insurance are expected to pay the surgical charges in full on or before the date of service. If you are unable to make payment in full, please call the Billing Office prior to your surgery to discuss financial arrangements.

Returned Checks:
The charge for a returned check is $25.00. If a check is returned for insufficient funds, the Surgery Center requires that you make a payment equal to the returned check plus the $25.00 charge within 15 business days of bank notification. The Surgery Center will not accept a check for payment of a check that was returned for insufficient funds.

Collection of Unpaid Accounts:
If your account becomes delinquent it will be turned over to a collection agency. A delinquent account is an account that has had no payments in 60 days, sporadic payments or nonpayment of a check returned for insufficient funds. You will be responsible for all costs, including agency fees, attorney fees, court costs and other related expenses incurred in collecting the delinquent amount.

Separate Billing:
You will receive a separate bill from your physician for his professional services at the Surgery Center. In addition, if you require anesthesia, the contracted anesthesia group will bill you for their services. If your physician orders pathology or blood work while at the Surgery Center the laboratory will bill you directly for their services. If you require implants or high dollar devices for your surgery, you may be billed by Implantable Provider Group (IPG) who provided the implant or device. The Surgery Center provides insurance and billing information to these providers, so they can file a claim on your behalf. The Surgery Center will make every effort to utilize network providers for your ancillary services.

Property Release:
Sillect Surgery Group will make every effort to protect your possessions while you are under our care. Please leave all valuables with your family or friends. The Surgery Center cannot be held responsible for loss or damage of my personal property.

Acknowledgement:
By signing below, each of the undersigned acknowledges that: (i) I have been provided a copy of the Medical Associates Clinic, P.C. PATIENT FINANCIAL RESPONSIBILITY STATEMENT; (ii) I have read, understand, and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due (or to become due) to Medical Associates for the below Patient's care and treatment, including copayments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any, paid by a third-party will be credited on the Patient account; (v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered; (vi) if I failed to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including court costs, collection agency fees, and attorneys' fees (to the extent allowed by law); and (vii) failure to pay when due may subject me to late payment charges and can adversely affect my credit report.
I further agree that a photocopy of this Patient Responsibility Financial Statement shall be as valid as the original.

ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC (".PDF") SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

_____	_____	_____
Patient/Responsibility Party/Guardian Signature	Date	Date of Birth

_____
Witness

HIPAA NOTICE OF PRIVACY PRACTICES
As required by the Privacy Regulations Promulgated Pursuant to the
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our President in person or by phone at 252-744-2426.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

The American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

PATIENT RIGHTS & RESPONSIBILITIES

This accredited facility presents these Patient Rights and Patient Responsibilities to reflect the commitment to providing quality patient care, facilitating dialogue between patients, their physicians, and the facility management, and promoting satisfaction among the patients and their designated support person(s), physicians, and health professionals who collaborate in the provision of care. This facility recognizes that a personal relationship between the physician and the patient is an essential component for the provision of proper medical care. When the medical care is rendered within an organizational structure, the facility itself has a responsibility to the patient to advocate for expanded personal relationships and open communications between patients and their designated support persons, physicians and the organization's staff members. This facility has many functions to perform, including but not limited to, preventing and treating medical conditions, providing education to health professionals and patients, and conducting clinical research. All these activities must be conducted with an overriding concern for the patient and above all the recognition of his or her dignity as a human being. Although no catalogue of rights can provide a guarantee that the patient will receive the kind of treatment he or she has a right to expect, these patient rights are affirmed and actively incorporated into the care provided in this facility.

1. The patient has the right to receive considerate and respectful care in a safe setting.

2. The patient has the right to know the name of the physician responsible for coordinating his/her care.

3. The patient has the right to obtain information from his or her physician in terms that can be reasonably understood. Information may include, but is not limited to his or her diagnosis, treatment, prognosis, and medically significant alternatives for care or treatment that may be available. When it is not medically advisable to share specific information with the patient, the information should be made available to an appropriate person in his or her behalf. When medical alternatives are to be incorporated into the plan of care, the patient has the right to know the name of the person(s) responsible for the procedures and/or treatments.

4. The patient has the right to obtain the necessary information from his or her physician to give informed consent before the start of any procedure and/or treatment. Necessary information includes, but is not limited to, the specific procedure and/or treatment, the probable duration of incapacitation, the medically significant risks involved, and provisions for emergency care.

5. The patient has the right to expect this accredited ambulatory surgery facility will provide evaluation, services and/or referrals as indicated for urgent situations. When medically permissible, the patient or designated support person(s) will receive complete information and explanation about the need for and alternatives to transferring to another facility. The facility to which the patient is to be transferred must first have accepted the patient for transfer.

6. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his or her action.

7. The patient has the right to obtain information about any financial and/or professional relationship that exists between this facility and other health care and educational institutions insofar as his or her care is concerned. The patient has the right to obtain information about any professional relationships that exist among individuals who are involved in his or her procedure or treatment.

8. The patient has a right to be advised if this accredited ambulatory surgery facility proposes to engage in or perform human experimentation affecting his or her care or treatment. The patient has the right to refuse to participate in research projects.

9. The patient has the right to every consideration for privacy throughout his or her medical care experience, including but not limited to, the following. Confidentiality and discreet conduct during case discussions, consultations, examinations, and treatments. Those not directly involved in his or her care must have the permission of the patient to be present. All communications and records pertaining to the patient's care will be treated as confidential.

10. The patient has the right to expect reasonable continuity of care, including, but not limited to the following. The right to know in advance what appointment times and physicians are available and where. The right to have access to information from his or her physician regarding continuing health care requirements following discharge. The number to call for questions or emergency care

11. The patient has the right to access and examine an explanation of his or her bill regardless of the source of payment.

12. The patient and designated support person(s) have the right to know what facility rules and regulations apply to their conduct as a patient and guest during all phases of treatment.

13. The patient has the right to be free from all forms of abuse, neglect, or harassment

14. The patient has the right to exercise his or her rights without being subjected to discrimination or reprisal.

Patient Responsibilities

It is the patient's responsibility to participate fully in decisions involving his or her own health care and to accept the consequences of these decisions if complications occur.

It is the patient's responsibility to follow up on his or her physician's instructions, take medications when prescribed, and ask questions that immerge concerning his or her own health care.

It is the patient's responsibility to provide name of support person in case of emergency, and have this support person available when advised to do so.

Direct any care concerns or complaints to:

Facility Director:____VIPUL R. DEV, M.D.____
Phone: 661-327-2101

Director of Clinical Compliance of AAAASF
Ilana Wolff
Phone: (888) 545-5222
Email: info@aaaasf.org

Department of Health: CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
Phone: (916) 558-1784

Office of the Medicare Beneficiary Ombudsman
Phone: 1-800-MEDICARE (1-800-633-4227)
Website:http://www.medicare.gov/*claims-and-appeals/medicare-rights/get-help/ombudsman.html*