Main Office
23456 Hawthorne Blvd.
Suite 300
Torrance, CA 90505
(310) 539-2055

Endoscopy Center
23560 Madison St. Suite
109 Torrance, CA 90505
(310) 325-6331

Jerome Cohen, M.D.
Oren Zaidel, M.D.
Daniel D. Cho, M.D.
Minh Q. Nguyen, M.D.
Tonny Lee, M.D.
Gloria Sze, M.D.
Mary Ahmadian, N.P.
Melissa Munsell, M.D.
Tram Tran, M.D.
Jung Li, N.P.

Patient Information

Please complete this form in its entirety to allow us to serve your health care needs. The information is strictly confidential and will not be released unless you authorized us to do so or if required by law.

Name _____ Date of Birth _____

Social Security #* _____ Sex ☐ M ☐ F Marital Status ☐ S ☐ M ☐ D ☐ W

Address _____ Home Phone _____

City _____ State ____ Zip _____ Work Phone _____

Email Address _____ Cell Phone _____

Preferred method of contact: ☐ Email ☐ Cell ☐ Home ☐ Text

Referring Physician _____ Phone _____

Primary Care Physician _____ Phone _____

Reason for Referral _____

Emergency Contact _____ Relation _____ Phone _____

Name of Primary Insurance _____

Insurance Address (from card) _____

Subscriber Name _____ Subscriber Date of Birth _____

Subscriber Social Security #* _____ Relationship to You _____

ID# (from card) _____ Group # (from card) _____

Employer (of insured if it is not you) _____

Name of Secondary Insurance _____

Insurance Address (from card) _____

Subscriber Name _____ Subscriber Date of Birth _____

Subscriber Social Security #* _____ Relationship to You _____

ID# (from card) _____ Group # (from card) _____

RACE: ☐ WHITE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ OTHER

ETHNICITY: ☐ HISPANIC OR LATINO ☐ NON-HISPANIC OR LATINO

Preferred Language: ☐ ENGLISH ☐ OTHER _____

Signature of Patient _____ Date _____

As a Centers for Medicare/Medicaid Services and Electronic Health Records certified user, South Bay Gastroenterology is required to collect federal data on race and ethnicity, Statistical Policy Directive No. 15, as revised October 30, 1997 (see "Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity" available at http://www.whitehouse.gov/omb/fedreg_1997standards).

*The collection of Social Security number information is to assist with positive identification of patients and to assist with billing and billing to insurance.

PATIENT HISTORY FORM

Patient Name: _____ **Phone #:** _____

Date of Birth: _____ Age: _____

Occupation: _____

Marital Status: _____

Weight: _____ lbs Height: _____ ft _____ in

Reason for visit today: _____

Family History of cancer and hereditary disorders:

Father _____ age diagnosed or if deceased _____

Mother _____ age diagnosed or if deceased _____

Brother/Sister _____ age diagnosed or if deceased _____

Son/Daughter _____ age diagnosed or if deceased _____

Tobacco ☐ Never used tobacco

Current use: _____ packs per day

Prior use: Quit _____ months / years ago?

Alcohol ☐ Never used alcohol

Current use: _____ drinks per day _____ drinks per week

Prior use: Quit _____ months / years ago? ____ drinks per week

Recreational/Illegal Drugs ☐ Never used recreational/illegal drugs

Currently using: _____ How often? _____ Last used: _____

Previously used: _____ When? _____

Past Medical History: Illness / Surgeries

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

Past colonoscopy ☐ Yes ☐ No Results: _____, last colonoscopy date: _____

Past endoscopy ☐ Yes ☐ No Results: _____, last endoscopy date: _____

Current Medications including Drug Name, dosage and how often taken

Medication Name	Dose	Frequency	Reason	Last Taken	Instructions
1.					
2.					
3.					
4.					
5.					
6.					

Pharmacy Name: Address: Phone #:

Allergic reaction to medication and other substances such as food and latex, include name and reaction:

1. _____
2. _____
3. _____

HEALTH QUESTIONNAIRE

Please complete both sides of this form and return it to our office. We appreciate your timeliness in this matter, as it will help ensure an efficient visit with our physician.

Patient Name: _____ Date of Birth: _____

Primary Physician: _____ Phone #: _____ Last Physical: _____

Do you see a specialist? ☐ Cardiologist ☐ Pulmonologist ☐ Nephrologist ☐ Oncologist ☐ Hematologist ☐ Other: _____

Name: _____ Phone #: _____ Last Visit: _____

HR Cardiac:

☐ Yes ☐ No Heart attack. Date _____
☐ Yes ☐ No Bypass surgery. Date _____
☐ Yes ☐ No Heart Stents. Date _____
☐ Yes ☐ No Cardiac arrhythmia
(If yes see questions on page 3)
Type _____
☐ Yes ☐ No Heart valve disease/surgery. Date _____
☐ Yes ☐ No Aortic Aneurysm ☐ Monitoring
☐ Surgery Date _____
☐ Yes ☐ No Chest pain/Angina
(If yes see questions on page 3)
☐ Yes ☐ No Blood thinners
☐ Yes ☐ No Congestive heart failure
☐ Yes ☐ No Congenital heart problems
☐ Yes ☐ No Cardiomyopathy
☐ Yes ☐ No Heart valve disease
☐ Yes ☐ No Pacemaker
☐ Yes ☐ No Defibrillator/AICD
☐ Yes ☐ No Become significantly short of breath when I walk a block.
Why? _____

HR Pulmonary:

☐ Yes ☐ No Shortness of breath
(If yes see questions on page 3)
☐ Yes ☐ No COPD
☐ Yes ☐ No Bronchitis/respiratory infection (pneumonia/flu)
☐ Yes ☐ No Emphysema
☐ Yes ☐ No Chronic lung disorder _____
☐ Yes ☐ No Oxygen home use
☐ Yes ☐ No Pulmonary hypertension (lungs)

HR Neurology:

☐ Yes ☐ No Stroke. Date _____
☐ Yes ☐ No Paralysis/residual deficits
☐ Yes ☐ No TIA. Date _____
☐ Yes ☐ No Brain surgery. Date _____
☐ Yes ☐ No Cerebral aneurysms
☐ Yes ☐ No Seizure
☐ Yes ☐ No Dementia/Alzheimer's
☐ Yes ☐ No Power of attorney
☐ Yes ☐ No Conservatorship

HR Hematology/Oncology:

☐ Yes ☐ No DVT/Pulmonary embolism
☐ Yes ☐ No Chronic low/high platelets
☐ Yes ☐ No Current chemotherapy/radiation
☐ Yes ☐ No Hemophilia or other bleeding disorder
Type _____
☐ Yes ☐ No Blood clotting disorder
Type _____
☐ Yes ☐ No History of cancer. Date _____
Type _____
☐ Yes ☐ No Chronic anemia
☐ Yes ☐ No Previous blood transfusion

HR Renal:

☐ Yes ☐ No Chronic kidney disease
Type _____
☐ Yes ☐ No Dialysis. Type _____ Frequency _____
☐ Yes ☐ No Kidney transplant

Cardiac:

☐ Yes ☐ No Coronary artery disease
☐ Yes ☐ No High Cholesterol
☐ Yes ☐ No Hypertension
☐ Yes ☐ No Peripheral vascular disease

Pulmonary:

☐ Yes ☐ No Asthma
☐ Yes ☐ No Obstructive sleep apnea
☐ Yes ☐ No CPAP machine
☐ Yes ☐ No Wheezing
☐ Yes ☐ No Chronic cough

Neurology:

Other neurologic diagnosis:
☐ Yes ☐ No Neuropathy
☐ Yes ☐ No Vertigo
☐ Yes ☐ No Migraines
☐ Yes ☐ No Parkinson's
☐ Yes ☐ No Multiple sclerosis
☐ Yes ☐ No Confusion
☐ Yes ☐ No Neuromuscular disease
☐ Yes ☐ No Memory loss

Constitutional:

☐ Yes ☐ No Fever
☐ Yes ☐ No Fatigue
☐ Yes ☐ No Chronic rash or itching
☐ Yes ☐ No Recent weight change

Renal:

☐ Yes ☐ No Kidney stones
☐ Yes ☐ No Kidney surgery
☐ Yes ☐ No Prostate problems

Endocrine:

☐ Yes ☐ No Diabetes
☐ Yes ☐ No Insulin pump
☐ Yes ☐ No Gout
☐ Yes ☐ No Lupus/SLE
☐ Yes ☐ No Hypothyroidism
☐ Yes ☐ No Hyperthyroidism
☐ Yes ☐ No Recent steroid use

Gastrointestinal:

☐ Yes ☐ No Cirrhosis
☐ Yes ☐ No Previous gastric bypass
☐ Yes ☐ No Any abdominal surgery
☐ Yes ☐ No Liver transplant
☐ Yes ☐ No Constipation
☐ Yes ☐ No Diarrhea
☐ Yes ☐ No Diverticular disease
☐ Yes ☐ No Change in bowel habits
☐ Yes ☐ No GI bleeding
☐ Yes ☐ No Melena
☐ Yes ☐ No Rectal bleeding
☐ Yes ☐ No Occult blood in stool
☐ Yes ☐ No Crohn's disease
☐ Yes ☐ No Ulcerative colitis
☐ Yes ☐ No Hemorrhoid surgery
☐ Yes ☐ No Personal history of colon cancer
☐ Yes ☐ No Personal history of polyps
☐ Yes ☐ No Family history of polyps
☐ Yes ☐ No Gallbladder disease
☐ Yes ☐ No Jaundice
☐ Yes ☐ No Difficulty swallowing
☐ Yes ☐ No Heartburn and indigestion
☐ Yes ☐ No Hiatal Hernia
☐ Yes ☐ No Nausea and vomiting
☐ Yes ☐ No Bloating and belching
☐ Yes ☐ No Change in appetite
☐ Yes ☐ No Abdominal pain
☐ Yes ☐ No Unexplained weight loss
☐ Yes ☐ No Abnormal CT scan
☐ Yes ☐ No Epigastric pain
☐ Yes ☐ No Barretts
☐ Yes ☐ No Gastric reflux/GERD
☐ Yes ☐ No Family history of esophageal cancer/ stomach cancer

Eyes, Ears, Nose, Throat:

☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Blindness
☐ Yes ☐ No Macular degeneration
☐ Yes ☐ No Retinal detachment
☐ Yes ☐ No Hearing loss
☐ Yes ☐ No Tinnitus
☐ Yes ☐ No Meniere's disease
☐ Yes ☐ No Sinus problems
☐ Yes ☐ No Hoarseness
☐ Yes ☐ No Recurrent mouth sores
☐ Yes ☐ No Recurrent nose bleeds

Infectious Disease:

☐ Yes ☐ No HIV/AIDs
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Herpes Simplex Virus
☐ Yes ☐ No Frequent urine infections
☐ Yes ☐ No C difficile
☐ Yes ☐ No Current communicable disease
☐ Yes ☐ No Other _____
☐ Yes ☐ No Hepatitis ☐ A ☐ B ☐ C
Date diagnosed _____

Psychiatric:

☐ Yes ☐ No Schizophrenia
☐ Yes ☐ No Bipolar
☐ Yes ☐ No Anxiety disorder
☐ Yes ☐ No Panic attacks
☐ Yes ☐ No Depression

Musculoskeletal:

☐ Yes ☐ No Rheumatoid arthritis
☐ Yes ☐ No Other arthritis
☐ Yes ☐ No Joint pain or swelling
☐ Yes ☐ No Chronic Neck/Back pain
☐ Yes ☐ No Fibromyalgia
☐ Yes ☐ No TMJ
☐ Yes ☐ No Carpal Tunnel
☐ Yes ☐ No Amputation/prosthesis
☐ Yes ☐ No Limited range of motion of your neck up and down or limited mouth opening

☐ Yes ☐ No Do you currently have any Cardiac, Respiratory, Neurologic conditions that are going to be evaluated? i.e.: ☐ Treadmill Stress Test ☐ Echocardiogram ☐ Holter Monitor ☐ Carotid U/S ☐ Pulmonary Function Test ☐ MRI ☐ CT of Brain ☐ Other _____

☐ Yes ☐ No Do you have any special medical or physical need we should know before we schedule your appointment? _____

Patient Signature: _____ Date: _____

FOLLOW UP QUESTIONS

Shortness of Breath If you answered yes to Shortness of Breath (Please Complete)

When you walk a block or climb a flight of stairs, do you have to stop and rest to catch your breath? ☐ Yes ☐ No

Please explain: _____

_____

Chest Pain If you answered yes to Chest Pain (Please Complete)

When was the last episode of chest pain? _____

Which best describes your chest pain. ☐ Pressure/Compression. ☐ Burning. ☐ Sharp Pain.

☐ Other: _____

_____

Do you have a family history of heart disease? _____

How often does your chest pain occur? _____

When did your chest pain first occur? _____ Last occur _____

Where is the pain? ☐ Midline in chest. ☐ Radiating down either arm. ☐ Radiating to neck or jaw.

☐ Left chest. ☐ Right chest. ☐ Other _____

When does the chest pain occur? ☐ During exercise. ☐ After eating. ☐ Randomly.

☐ Other _____

How long does the chest pain last? ☐ Less than one minute. ☐ 1 to 20 minutes. ☐ More than 20 minutes.

☐ Other _____

Associated factors with the chest pain. ☐ Shortness of breath. ☐ Nausea/vomiting. ☐ Weakness. ☐ Fatigue.

☐ Dizziness/syncope. ☐ Cold and clammy. ☐ Sweating. ☐ Other _____

Relieving factors. ☐ Rest. ☐ Antacids. ☐ Position change/sitting forward. ☐ Nitroglycerin.

☐ Other _____

Severity of the pain 1 to 10. (1 no pain - 10 worst pain imaginable) _____

Is your primary care provider aware of your chest pain? _____

Have you had your chest pain evaluated by a cardiologist? _____

Are you planning to have your chest pain evaluated by a cardiologist? _____

Have you had cardiac tests done (☐ Stress test, ☐ Echocardiogram, ☐ Holter monitor)? Date: _____

Do you have any upcoming cardiac tests scheduled? When _____

When was your last visit to your cardiologist? _____

What exercise are you able to do? _____

_____

Any other description of your chest pain? _____

_____

_____

Arrhythmia If you answered yes to Arrhythmia (Please Complete)

What arrhythmia do you have?

☐ Atrial fibrillation. ☐ PVC's. ☐ PAC's. ☐ SVT. ☐ V-Tach. ☐ Other _____

If A-fib, is it ☐ constant or ☐ occasional? Have you had an ablation? ☐ Yes ☐ No

Additional Notes (Anything else you want to explain) _____

_____

_____

_____

_____

SOUTH BAY GASTROENTEROLOGY
MEDICAL GROUP
AND
The Endoscopy Center of the South Bay

OFFICE POLICY FOR
INSURANCE BILLING

South Bay Gastroenterology Medical Group & Endoscopy Center of the South Bay have enrolled in numerous managed care insurance programs to accommodate the needs of our patients.

With each insurance program, there are many individual requirements of the plans having different stipulations regarding what services are covered and how often they may be performed. These plans differ depending on what type of contract your employer has negotiated.

Because we do not have access to each employers guidelines and stipulations; we must rely on you, the patient, to inform us EACH time of services exactly what those guidelines and stipulations are.

Unfortunately, if you do not inform us of special requirements in your insurance contract such as **lab work, screening / preventative care, hospitalization, and/or out-patient procedures** that are non-covered or must go to a specific location, or the need for a referral from your primary care physician, we have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

Please check with your insurance if you have any questions relating to the services we provide. We want you to receive all of the benefits offered to you.

. . . . . .

I have read and understand the office policy stated above and agree to accept responsibility as described.

_____ _____

Signature Date

The Endoscopy Center of the South Bay
And
South Bay Gastroenterology Medical Group

Authorization to Leave Message:

I hereby authorize **SBGMG/ECSB** to leave a message regarding pending appointments or tests at the following:

Home : ☐ Yes ☐ No Phone Number: _____

Cell Phone : ☐ Yes ☐ No Phone Number: _____

Work : ☐ Yes ☐ No Phone Number: _____

You may contact me via my Email : ☐ **Yes** ☐ **No** **Email Address:** _____

You may leave a message with any of the individuals listed below:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Print Patient Name: _____

Patient, Parent or Guardian _____ **Date:** _____

(Signature)

Endoscopy Center of the South Bay

FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's and/or physician's and/or anesthesia charges, the Center and/or physicians which render service to me are authorized to submit a claim for payment to my insurance carrier. The Center, physician's office, anesthesia and/or pathology providers are not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. We will expect payment of deductibles, co-pays and co-insurance at the time of service. Self-pay patients are expected to pay the agreed upon balance at the time of service. I am aware that I may receive a separate bill for any physician, anesthesia or pathology services performed from their respective companies

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to Endoscopy Center of the South Bay, my admitting physician or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balances due after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician or other physicians who render service to charges not paid for within a reasonable period of time by insurance or third-party payer. I certify that the information given with regard to insurance coverage is correct.

RELEASE OF MEDICAL RECORDS

I authorize the Center, my admitting physician or other physicians who render service to release all or part of my medical records where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior to my surgery/procedure that the physicians who perform procedures/services at Endoscopy Center of the South Bay may have an ownership interest in Endoscopy Center of the South Bay. I have been provided a list of physicians who have a financial interest or ownership in the Center. The physician has given me the option to be treated at another facility/Center, which I have declined. I wish to have my procedure/services performed at Endoscopy Center of the South Bay.

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my demographic and insurance information on this date and verify that all information reported to the center is correct.

Email/Text/Automated Communication Informed Consent

I hereby consent and authorize Endoscopy Center of the South Bay, any associated physician or other caregiver, as well as any of their related entities, agents, or contractors, including but not limited to schedulers, billing services, debt collectors, and other contracted parties, to use automated telephone dialing systems, text messaging systems, and electronic mail to provide messages (including pre-recorded or synthetic messages, text messages and voicemail messages) to me about my account, payment due dates, missed payments, information for or related to medical goods and/or services provided, exchange information, health care coverage, care follow-up, and other healthcare information.

Patient Signature Date Signed Printed Name

Parent/Guardian Signature (if patient is a minor) Date Signed Printed Name

Contact Information:
Mobile Phone Number: _____ Email address: _____

To revoke your consent to receive text messages or electronic mail from Endoscopy Center of the South Bay, you may unsubscribe by replying and entering "Unsubscribe." If you would like to revoke other portions of this Consent to Contact Form, please contact the center directly in writing or by telephone.

PATIENT RIGHTS/ADVANCED DIRECTIVES INFORMATION

I have received written and verbal notification regarding my Patient Rights prior to my surgery/procedure. I have also received information regarding policies pertaining to ADVANCED DIRECTIVES prior to the procedure. Information regarding Advance Directives along with official State documents have been offered to me upon request.
Do you have an Advanced Directive for healthcare? Yes or No (circle) If No, would you like any information? Yes or No (circle)
Did the patient bring a copy to the Center? Yes or No (circle) If provided, a copy is placed in patient's medical record.

The undersigned certifies that he/she has read and understands the foregoing and fully accepts all terms specified above.

_____ _____
Signature of Patient or Responsible Party Print Name

_____ _____
Relationship to Patient Date Signed

I hereby authorize the Endoscopy Center of the South Bay and/or the physician performing my procedure today to communicate information regarding my procedure/results of my procedure/billing to/with:
My spouse/family member/other Name(s): _____ _____Initials

Leave a message on my answering machine: Yes_____ No_____ _____Initials

The undersigned certifies that he/she has read and understands the foregoing and full accepts all terms specified above.

_____ _____
Signature of Patient or Responsible Party Print Name

_____ _____
Relationship to Patient Date Signed

ENDOSCOPY CENTER OF THE SOUTH BAY - NOTICE OF PRIVACY PRACTICES

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 applies to ("Center") and health professionals when they provide services at the Center. Under federal law, your health information (known as "PHI") is protected and confidential. PHI includes information about your symptoms, test results, diagnosis, treatment, and related medical information and payment, billing, and insurance information. Your PHI may be stored and disclosed electronically.

How We Use & Disclose Your PHI

Treatment: We will use and disclose your PHI for treatment purposes. For example, nurses, physicians, and other members of your treatment team use PHI to determine the most appropriate course of care. We may also disclose PHI to other health providers who participate in your care.

Payment: We will use and disclose PHI for payment purposes. For example, we may need to obtain authorization from your insurance company before providing treatment, determine whether you are enrolled or eligible for benefits and submit bills to your health plan.

Health Care Operations: We will use and disclose your PHI to conduct our standard internal operations, including administration of records, credentialing, evaluation of the quality of treatment, arranging for legal services and assessing the care and outcomes of your case and others like it.

The Center and professionals covered by this Notice will share PHI with each other as permitted by law for treatment, for payment, and for the Center's health care operations.

Other Uses and Disclosures We May Make

Family/Friends/Disasters: We may disclose limited PHI to family members or friends who are helping with your care or payment for your care and to those assisting in disaster relief efforts. For example, following a procedure, we will disclose your discharge instructions and PHI related to your care to the individual who is driving you home or who is otherwise assisting in your post-procedure care.

Required by Law: We may disclose your PHI as required by law , such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events. For example, we may disclose your PHI to the U.S. Department of Health and Human Services if it requests PHI to determine that we are complying with federal law.

Research: We may use or disclose PHI for approved medical research.

Public health activities: We may disclose vital statistics, disease information, information related to recalls of dangerous products, and similar information to public health authorities.

Health oversight: We may disclose PHI to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and administrative proceedings: We may disclose PHI in response to an appropriate subpoena, discovery request or court order.

Law enforcement purposes: We may disclose PHI to law enforcement officials as permitted by law, such as to report a crime on our premises.

Deaths: We may disclose PHI regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious threat to health or safety: We may use and disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and special government functions: If you are a member of the armed forces, we may release PHI as required by military command authorities. We may also disclose PHI to correctional institutions or for national security purposes.

Workers compensation: We may release PHI for workers compensation or similar programs providing benefits for work-related injuries or illness.

Business associates: We may disclose PHI to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.

De-identification. We may use and disclose your PHI to create information that is de-identified. In other words, we may remove identifiers in order to create information that is no longer individually identifiable as defined by law. We may also remove most PHI that identifies you from a set of data and use and disclose this data set for research, public health and health care operations, provided the recipients of the data set agree to keep it confidential.

Health information exchanges. We may participate in one or more health information exchanges ("HIEs") and with your consent may electronically share your PHI for treatment and other permitted purposes with other HIE participants. HIEs allow your providers to efficiently access and use your PHI for treatment and other lawful purposes unless you opt out.

In any other case, we will ask for your written authorization before using or disclosing your PHI. If you sign an authorization, you can later revoke that authorization to stop any future uses and disclosures by contacting the Contact Person listed below. Subject to limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your PHI for marketing purposes or sell your PHI, unless you have signed an authorization.

If we receive records from substance use disorder treatment programs subject to federal privacy rules (42 CFR Part 2) such records or testimony about their content cannot be used or disclosed in civil, criminal, administrative, or legislative proceedings against the individual unless based on written consent or a court order entered after notice and an opportunity to be heard is provided to the individual or us, as provided by 42 CFR Part 2. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested substance use disorder record is used or disclosed.

We may use Artificial Intelligence or (AI) tools, for purposes described in this Notice and as permitted by the HIPAA Rules. For example, we may use tools that record your interactions with our providers and staff to assist with drafting notes or scheduling appointments.

Individual Rights

You have the following rights with regard to your PHI. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights. If you have given another individual a medical power of attorney, if another individual is appointed as your legal guardian or is authorized by law to make healthcare decisions for you (known as a "personal representative"), that individual may exercise any of the rights listed below on your behalf.

□ You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by the request and when the uses or disclosures are not required by law.

□ You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

□ You have the right to look at or get a copy of your PHI. There may be a reasonable cost-based charge for copies.

□ You have the right to request that we amend your PHI.

□ You may request a list of disclosures of PHI about you except for disclosures made with your authorization and other exceptions.

□ You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

Our Legal Duties/Changes to this Notice

We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured PHI.

We may change this Notice at any time and make the new terms effective for all PHI we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the Contact Person listed below.

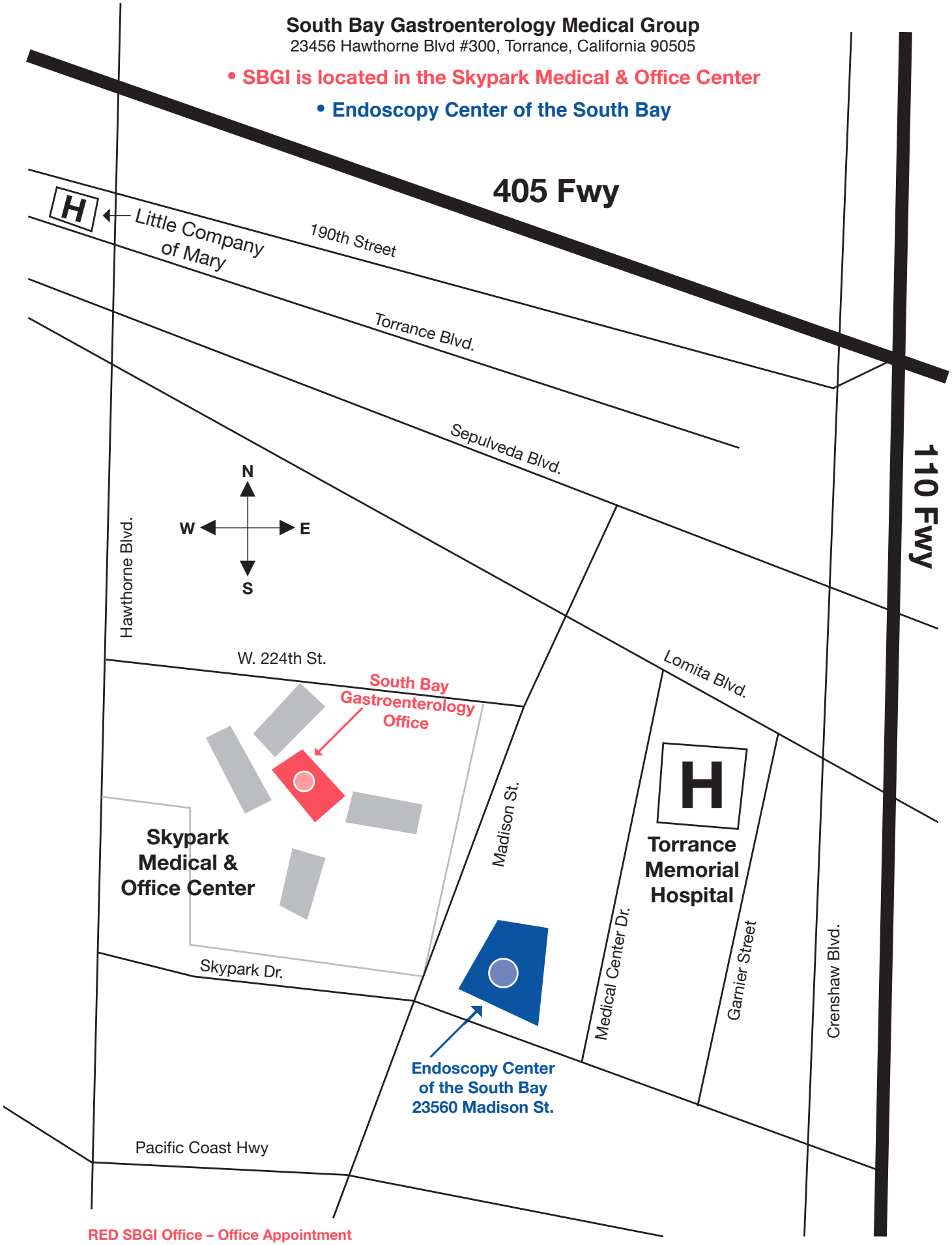
Complaints/Contact Person

If you are concerned that we have violated your privacy rights, you may contact the Contact Person listed below. You also complain to the U.S. Department of Health and Human Services. The Contact Person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint. If you have any questions, requests, or complaints, please contact:

Center Privacy Officer (310-325-6331)

South Bay Gastroenterology Medical Group
23456 Hawthorne Blvd #300, Torrance, California 90505

- **SBGI is located in the Skypark Medical & Office Center**
- **Endoscopy Center of the South Bay**



RED SBGI Office – Office Appointment
BLUE Endoscopy Center SB – Procedure Appointment

South Bay Gastroenterology Medical Group
And
The Endoscopy Center of the South Bay

Patient Consent Form (Must Be Completed and Returned by Patient Prior To Treatment)

To the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____ , (Account Number: _____) understand that as part of my health care, South Bay Gastroenterology Medical Group and Endoscopy Center of the South Bay originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a **Notice of Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

Health Information Exchange (HIE):

I understand that South Bay Gastroenterology Medical Group and the Endoscopy Center of the South Bay may make my Individual health information available to a sponsored Health Information Exchange (HIE) and to a regional and or National Health Information Exchange and or state immunization registry.

I understand that the South Bay Gastroenterology Medical Group and the Endoscopy Center of the South Bay is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.520 of the Code of Federal Regulations. Should the south Bay Gastroenterology Medical Group and the Endoscopy Center of the South Bay change their notice, they will send a copy of any revised notice to the address I've provided (whether US mail or, if I agree, email).

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Can confidential messages be left on your answering machine or voicemail? ☐ YES ☐ NO

Please list, if any, person(s) whom we may inform about your medical condition, diagnosis, and/or financial account:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

I wish to have the following restrictions to the use or disclosure of my health Information: _____

_____

_____

I fully understand and ☐ accept ☐ decline the terms of this consent.

Patients Signature: _____ Date: _____

FOR OFFICE USE ONLY

☐ Consent received by _____ Date: _____

☐ Consent refused by patient, and treatment refused as permitted.

☐ Consent added to the patient's medical record on (Date) _____

AMSURG | ANESTHESIA SERVICES

Who We Are

We are the anesthesia clinician for your upcoming surgery / procedure. Your clinician may be an anesthesiologist, certified nurse anesthetist, and/or anesthesiologist assistant. We work with your provider in your care.

What is Anesthesia?

Anesthesia manages your comfort throughout your surgery/procedure. The type you receive (general, regional, or monitored anesthesia care) will be determined by your anesthesia clinician.

What to Expect from Anesthesia Services

Before

Your anesthesia clinician will ask you to stop eating and drinking before your surgery. Be sure to follow these instructions to avoid rescheduling.

After

You will be instructed not to consume alcohol or drive immediately after surgery. You will also be instructed to drink plenty of fluids and rest. Additionally, you will be contacted to complete a survey about your experience.

Side effects

Side effects may include difficulty concentrating, feeling groggy, and being nauseous. Your clinician will advise you on how to manage your pain after your surgery.

More details will be provided before and after your operation.

Billing

Unless your procedure is fully covered by your insurance, you will be billed. You can expect your bill 1-3 months after your procedure.

This bill may be separate from other bills you receive from your surgery center.

1. **If you are insured, we will bill your insurance provider for your anesthesia clinician.**
2. **Your insurance company will process your claim and determine the patient portion, for which we bill you.**
   - If your anesthesia clinician is not part of your insurance plan (out of network), but the center where you're having the procedure is in-network, then your insurance will process the service as in-network.
   - The bill will come from the clinical practice.
   - We may contact you by mail, text message, and/or email.
3. **Your bill will be due within 30 days of receiving it.**

We do not balance bill patients. Balance billing is when the provider bills for the difference between the provider's charge and the allowed amount.

We have made every reasonable effort to comply with the No Surprises Act regulations. However, in rare circumstances mistakes happen and a patient may have been billed in error. If this is the case, please reach out to our customer service team and we will review and correct the patient bill.