Encinitas Surgical Associates
Matthew Cooper, M.D.
303 Santa Fe Drive
Encinitas, CA 92024
Phone: (760) 635-9185 Fax: (760) 942-1359

Patient Information

Today's Date_____

Patient First/Middle Initial/Last Name:_____

Address: _____

Email:_____

Single_____ Married____ Divorced____ Widowed____ Domestic Partner _____

DOB: _____SSN: _____ Cell Phone: _____

Work Phone: _____ Home Phone: _____

Primary Care Doctor Name: _____

Primary Care Doctor Address: _____

Primary Care Phone: _____ Primary Care Doctor Fax: _____

Referring Doctor Name: _____ Ref: Doctor Phone: _____

Employer Name and Address: _____

_____

Occupation: _____ Work Phone: _____

Name of Spouse or Domestic Partner: _____

Spouse or Domestic Partner Phone: _____ Cell ___ Work ___

Name of person legally responsible if patient is a minor:

First and Last Name: _____ Relationship to Patient_____

Address: _____

Preferred Phone: _____ Cell ___ Work ___ Home ___

Name of Insurance: _____ HMO____ PPO ____ EPO____ Private ____

Insurance ID # _____ Group #_____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____ Cell___ Home___ Work ___

Patient Name: _____ Date: _____

Date of Birth: _____ Reason for visit: _____

Past Medical History Illness: _____

_____

_____

Current Medications: Please list all vitamins, supplements, and over the counter medications as some may need to be discontinued before a surgery.

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Allergies to Medications:

_____

Past Surgical History

Date	Surgery	Hospital Name	Complications

All Patients 50 y/o and over, date of last colonoscopy:_____

Females over 40 y/o, date of last mammogram: _____

Are you on a special diet? _____

Patient Name_____ DOB:_____

Social History:

Smoking- How many cigarettes or packs per day or week? _____

Alcohol- How many glasses of wine/ beer per day or week? _____

Caffeine- How many cups of coffee/ energy drinks per day or week? _____

Past medical History Check box if applicable.

- ❑ **Adhesions**
- ❑ **Anemia**
- ❑ **Arthritis**
- ❑ **Asthma**
- ❑ **Bleeding Disorders**
- ❑ **Breast Cancer/lumps**
- ❑ **Breast Implants**
- ❑ **Colon Cancer/Polyps**
- ❑ **Connective Tissue Disease**
- ❑ **Crohn's Disease**
- ❑ **Diabetes**
- ❑ **Diverticulitis**
- ❑ **Hay Fever**
- ❑ **Blood Transfusion-If yes, when?**
- ❑ **_____**
- ❑ **Heart Disease**
- ❑ **Hepatitis**
- ❑ **Hernia**
- ❑ **High Blood Pressure**
- ❑ **Hemorrhoids**
- ❑ **Kidney Disease**
- ❑ **Leukemia/ Lymphoma**
- ❑ **Lipoma**
- ❑ **Lung Disease**
- ❑ **Neurologic Disorder/Disease**
- ❑ **Pilonidal Cyst**
- ❑ **Sebaceous Cyst**
- ❑ **Stroke**
- ❑ **Sleep Apnea/02 Therapy**

Explain boxes checked and write in any diagnosis or symptoms not listed:

_____

_____

_____

Family History: Have any members of your family (including grandparents, parents, siblings, and children) had any serious illnesses such as Bleeding Disorders, Cancer, (Breast, Colon, Skin, other), Leukemia,/Lymphoma, Or Crohn's Disease/Ulcerative Colitis, etc?

If yes, please indicate relationship to you and illness:

_____

Encinitas Surgical Associates
Matthew D. Cooper, M.D., FACS
Board Certified General Surgeon

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company. There are many plans and our staff cannot guarantee what your plan covers. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.
- You are ultimately responsible for all payment obligations arising out of your treatment, care, and/or surgeries. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier, which are not otherwise covered by supplemental insurance.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- By signing below, you authorize **Encinitas Surgical Associates** to verify your insurance benefits and submit your claim for services rendered to your insurance carrier or other plan provider. If we have a contract with your insurance company, we will bill your insurance company first. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We can provide you with a statement that you can submit to your insurance company for reimbursement.
- **Payment by Check:** If payment is made by check and it is returned or declined for any reason, your account will be charged a surcharge of $30.00.
- **Payment by Credit Card/Debit Card:** You may pay with credit card or debit card, including Visa, Mastercard, and Discover (“credit card”). Your payment with a credit card may be made in person, by mail, or by calling the number provided on your billing statement.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services that are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient

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Encinitas Surgical Associates
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Authorization for Release of Information
(For Family, Caregivers, and/or Partners)

Patient Name:_____ Date of Birth: _____

Many of our patients allow family members such as their spouse, parents, and children over the age of 18, or others to call and request medical information. Under the requirements of HIPAA we are not allowed to give this information to anyone without patient consent, including but not limited to: scheduling/confirming/cancelling appointments, requesting or picking up prescriptions, requesting or picking up records or results etc.

If you wish to have your medical, or billing information discussed or released to family members, you must sign this form. Signing this form will only allow us to give information to the individuals listed below.

I authorize Encinitas Surgical Associates to release and/or discuss my medical and/or billing information to the following individual(s): ☐ Medical Information ☐ Billing Information

1._____Relationship to Patient: _____

2._____ Relationship to Patient: _____

Patient Information

This authorization is effective until:

Check one please:

- o I revoke it.
- o Only effective until this date : _____ ____

I understand I have the right to revoke this authorization at any time. If I wish to revoke this authorization, I need to submit a written request to do so. I have the right, upon request, to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any of the above recipient(s) is no longer protected by Encinitas Surgical Associates , federal or state law, as they cannot guarantee what the individuals I authorized as recipients, will do with my information.

Patient's Signature: _____ Today's Date: _____

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Notice of Privacy Practices Acknowledgment Form

Patient Name:_____ Date of Birth: _____

I have received a copy of the **Encinitas Surgical Associates** Notice of Privacy Practices.

Signature: _____ Date: _____
Individual or Personal Representative with legal authority to make healthcare decisions.

If Signed by a Personal Representative:

Print Name: _____ Role: _____
(Parent, Guardian, etc.)

Witness: _____ Date: _____

OFFICE USE ONLY:

If the individual has a personal representative with legal authority to make health care decisions on the individual's behalf, the notice must be given to and acknowledgment obtained from the personal representative. ***If the individual or Personal Representative did not sign above, staff must document when and how the notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.***

Notice of Privacy Practices given to the individual on: _____ by
Date

- □ Face to face meeting
- □ Mailing
- □ Email
- □ Other: _____

Reason Individual or Personal Representative did not sign this form:

- □ Individual or Personal Representative chose not to sign
- □ Individual or Personal Representative did not respond after more than **one** attempt.
- □ Email receipt verification
- □ Other: _____

Staff Signature: _____ Title: _____

Print Name: _____ Date: _____

Encinitas Surgical Associates

Matthew Cooper MD

303 Santa Fe Dr.
Encinitas, CA 92024
(760) 635-9185

Policy for Cancellation or Rescheduling of a surgery or procedure:

In the event that you would ever have surgery performed by the physician, it is important that when you schedule your surgery or procedure you have thoroughly checked your personal calendar to make sure that your scheduled date is ideal for you. Cancelling or rescheduling your surgery/procedure requires a lot of administrative coordination for the following reasons:

- **Cancel the hospital room** or outpatient facility. **Cancel the surgeon's time**.
- **Insurance company must re-authorize** a new date (even if you have a PPO).
- **If there was a doctor or a nurse assist scheduled, they must be cancelled**. At times a doctor or a nurse is specifically booked for your surgery.
- **There are days and hours spent on coordinating and authorizing your pre surgery testing and the surgery itself.**
- **Filling a cancelled surgery date/time with another patient** that has been awaiting their surgery date **is difficult and/or impossible** because we would need the exact same surgery to fit in your time slot as not all surgeries are allotted the same amount of time. This may require that we reschedule all surgeries planned for the day, or leave an empty surgery room, as there is a lot of pre-surgery testing and coordination involved.
- If you have to cancel due to illness, **please provide a doctor's note.**

There will be a $500.00 charge each time a surgery/procedure is rescheduled with less than a 7 working day notice. This fee will not be applied toward your surgery/procedure or deductible and will be added as a charge to your account, not billable to insurance. Fee must be paid prior to rescheduling surgery.

- This fee must be paid to Encinitas Surgical Associates prior to surgery or procedure being rescheduled.
- This fee will be billed to you personally even if you do not reschedule your appointment.

NO-SHOW POLICY

If you do not show up for a scheduled surgery/procedure you will be charged the FULL AMOUNT of your surgery cost.

I understand and agree to the cancellation and no-show policy described above.

Patient Name:_____ DOB:_____ Surgery Date:_____

_____ _____

Patient Signature **Date**