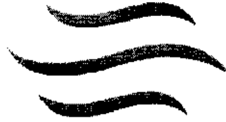
COASTAL VIEW GASTROENTEROLOGY
OF SOUTH BAY, INC

Sutha Sachar MD Double Board Certified Gastroenterologist
3440 Lomita Blvd, Suite 420,Torrance,CA 90505 T:424.250.9179 F:323.300.2021

PERSONAL INFORMATION	Name:________________________ (Last) (First) (Middle) Date of Birth (mm/dd/yyyy): __________ Sex:________ Home Address:____________________ City:____________ State:______ Zip Code:______ Home Phone:____________Cell Phone:____________ *Is it OK to text you appointment reminders? ( ) YES ( ) NO* *Is it OK to leave messages regarding your lab results? ( ) YES () NO* E-Mail Address:________________ *May we contact you via E-Mail? ( ) YES ( ) NO* Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widow ( ) Living with Partner Social Security Number:____________________ Driver's License Number:____________________
EMPLOYER INFORMATION	Company Name____________ Occupation____________ Address__________ City________ State____ Zip_____ Years Employed _____ Full Time___ Part Time ____
EMERGENCY CONTACT	Name__________ Relationship__________ Phone __________
PHARMACY INFORMATION	Name: ____________________ Location: ____________________ Phone number (required): ____________________

Who may we thank for your referral?	How did you hear about us? ____________________



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INSURANCE INFORMATION	Insurance____________________ ID#____________________ Policy/Group #____________ Effective Date: __________ Subscriber (Circle One): SELF OTHER If Other, Name:____________ Date of Birth:__________
SECONDARY INSURANCE INFORMATION	Insurance Company or Health Insurance Plan Name: ____________________ Name of Insured:____________ Subscriber:__________ ID#____________________ Policy/Group #____________ Effective Date: __________
Other Health Related Services	Please let us know if you would like to know more about our Weight Loss Program, Bio-identical Hormone Program, Genetic Cancer screening program, Fatty Liver Evaluation *If so, what service?*____________

As of February 1, 2023 we are Out Of Network with ALL insurances EXCEPT Aetna PPO, Regal HMO and Medicare PPO

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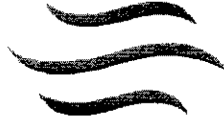
Legal Assignment of Benefits and Designation of an Authorized Representative	In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee healthcare benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance provider's managed care network participation status. I understand that I am financially responsible for all changes regardless of any applicable insurance or benefits payments. I understand I am responsible for checking eligibility at this office and hereby authorize the above names provider(s) to release all medical information necessary to process my claims under HIPPA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) in order to claim such medical benefits, reimbursement, or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submission.
PATIENT AGREEMENT & AUTHORIZATION FOR THE RELEASE OF MEDICAL AND HEALTH PLAN DOCUMENTS FOR THE CLAIMS PROCESSING & REIMBURSEMENTS AS REQUIRED BY FEDERAL	I hereby convey to the above named provider(s), to the full extent permissible under the law and under any applicable employee health group plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefit plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) about facts or law, (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or health group or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered valid as the original. I have read and fully understand this agreement. ____________________ **Signature of Insured/ Guardian** __________ **Date**



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MEDICAL HISTORY FORM

Name:____ Date Of Birth: ____________________

(Last)   (First)   (Middle)

YOUR MEDICAL HISTORY:

( ) Gallbladder Disease
( ) Ulcer
( ) Diabetes
( ) Osteoporosis
( ) Depression
( ) Asthma
( ) High Blood Pressure
( ) Hepatitis
( ) Anemia
( ) Heart Disease
( ) Allergies/Hay/Fever
( ) Cancer (If yes, what kind?)________________

ALLERGIES:

Are you allergic to latex?   YES   /   NO

Drug Allergies & Reactions: ____

Food Allergies & Reactions: ____

MEDICATIONS:

Please list dose and frequency:

1.____________________   5.____________________

2.____________________   6.____________________

3.____________________   7.____________________

4.____________________   8.____________________

Supplements/ Vitamins: ______________________________

SURGERIES:

Please list prior surgeries and dates: (including elective surgeries)

1.____________________   5.____________________

2.____________________   6.____________________

3.____________________   7.____________________

4.____________________   8.____________________

Hospitalizations: (Date/Reason) ____

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FAMILY HEALTH HISTORY: *(If Yes; Indicate Whom)*

( ) Colon Cancer ____________________

( ) Stomach Cancer ____________________

( ) Polyps in Colon ____________________

( ) Celiac Disease ____________________

( ) Pancreatic Cancer ____________________

( ) Diabetes ____________________

( ) Thyroid Disease ____________________

( ) High Blood Pressure ____________________

( ) Cancer ____________________

( ) Mental Illness ____________________

( ) Liver Disease ____________________

( ) Heart Disease ____________________

( ) Stroke ____________________

Medical History Continued

HAVE YOU EVER HAD:

Please list the dates and performing doctor:

Colonoscopy ____

Upper Endoscopy ____

HEPATITIS C RISK FACTORS: *(Circle One)*

Blood Transfusion Prior to 1992	Yes	/	No
Contact With Blood/Body Fluid	Yes	/	No
Shared Needles/Toothbrush	Yes	/	No
Body Piercing	Yes	/	No
IV Drug Use	Yes	/	No
WOULD YOU LIKE TO BE SCREENED TODAY (BLOOD TEST)?	Yes	/	No

SOCIAL:

Do you smoke?	Yes	/	No	(if yes how often: ____________________)
Do you drink Alcohol?	Yes	/	No	(if yes how often: ____________________)
Do you use/have used illicit drugs?	Yes	/	No	(if yes how often: ____________________)
Married?	Yes	/	No	
Children?	Yes	/	No	

Occupation: ____

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We are glad that you have chosen Dr. Sachar as your healthcare provider.
Please read the important notifications below to become familiar with our practice policies.

Appointments

If for some reason you are unable to keep your appointment, please let us know at least 24 hours in advance. If you are going to be late, we would appreciate a call. **However there will be a $25 charge to your account if you are a 'No show' or non-cancelled appointment. This will need to be collected prior to booking your next appointment. INITIAL ________**

Insurance Accepted

We are Out of Network with all insurances Accept Aetna PPO, Regal HMO and Medicare. If you with to continue, You are understanding that there may be added fees for going out of network. INITIAL _______

Procedures: Colonoscopy and EGD (Esophagogastroduodenoscopy)

There is a $99 charge if you cancel a colonoscopy or upper endoscopy without 48 hours notice. We have an extensive waiting list for these procedures and last minute cancellations affect our schedule and our ability to get other patients in without delay in their procedure and medical management. INITAL_______

Telephone Advice

If you are having a medical emergency, please call 911 before contacting our office. Our office personnel are trained to deal with questions regarding most minor ailments. **Non-urgent questions will be returned within 1-3 business days.** If the problem is more urgent the message will be relayed to Dr. Sachar and you should expect a call back within 24 hours. We may ask you to come in as some problems cannot be handled via phone. **Call visits and care will result in insurance billing. INITIAL______**

Pharmacy Prescriptions

You may be given a prescription for medication or medication refills in conjunction with your care. It is important to check with your pharmacist regarding potential interactions with other medications you are currently taking. Dr. Sachar recommends that you check with www. PrescribingReference.com to become aware of potential risks, benefits and interactions Refill requests are accepted Monday through Friday, but may take up to 48-72 hours. If a pre-authorization is needed for your medication (this is determined by your insurance company, not us) there is a $25.00 dollar processing fee (due to the amount of work involved, phone calls and time it takes to get it approved.) This may also cause substantial delay in receiving your medications . **INITIAL______**

Administrative Fees

There is a minimal clerical charge of $15 for any administrative form in the office including "back to work", "time off", or supplemental forms. There is also a minimal $15 clerical charge for medical records, up to five pages, that are copied in the office and/or sent to another party. As a courtesy, we will get prior authorizations for any procedures or radiology scans you may need. However if a "Peer to Peer" is needed, (a constraint your insurance imposes on your healthcare, not us) Dr. Sachar needs to block time out of her schedule to review your chart , medical diagnosis and justification to your insurance's reviewer MD or Nurse. This will result in a $35 fee for the immense amount of time and paperwork needed. INITIAL________

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Billing and Collections

I acknowledge that Coastal View Gastroenterology of South Bay Inc. is providing services in good faith that it will be appropriately compensated in a timely manner. If necessary, the patient and/or guarantor will be held liable for any late fees, interests, collection fees, and/or reasonable attorney's fees for the prosecution and/or collection of the patient amount owed. It is the patient's and/or guarantor's responsibility to provide Coastal View Gastroenterology of South Bay Inc. with updated billing and insurance information on each and every visit. **If your balance becomes more than 90 days old, our billing company will begin the collection process.**
INITIAL______

Financial Policy

Thank you for choosing us as your medical care facility. Our goal is to provide you with the highest quality medical care at an affordable cost. To make sure our services are available to as many patients as possible on an affordable basis, we have adopted the financial collection policy outlined below.

- All copays, deductibles and coinsurances are due at the time of service
- We may accept any assignable insurance with applicable coverage.
- We may offer financial assistance(discount,waiver or reduction of deductables, copays, and coinsurance)under our Idingency Policy to all eligible patients on a case by case basis. The Indigency
- Previous balances owed are due prior to ongoing treatment
- We accept cash and all major credit cards. We DO NOT accept personal checks.
- We accept patients without insurance on a 'cash "basis. Full payment is due at the time of service.

INITIAL ________

Regarding PPO and HMO Insurance

We work our best with you to verify your eligibility and benefits prior to your appointment. However, ultimately it is your responsibility to verify your insurance coverage, authorization, any pre-certfication and if we are contracted. Please understand that insurance verification is not a guarantee of payment. It is **your responsibility** to find out if we are contracted with your insurance for all balances owed. As you may know, you may have a choice to choose a surgeon or surgical facilities with or without PPO participation under different insurance coverage and benefit levels. We are dedicated to providing the highest quality care to every patient; however, we have no power to change your insurance coverage or network limitations. Most healthcare plans or insurance policies may provide surgical coverage to non-PPO providers and facilities, but at a lower percentage of insurance reimbursement. We will verify your insurance coverage and obtain pre-certification if applicable for all services as a courtesy to you before your surgery. An additional fee of $35 is required for "Peer to Peer" constraints placed by your insurance company. Please understand that insurance verification is not a guarantee of payment. **INITIAL________**

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Compliances & Disclosure under California Business and Professional Code

In compliance with California Business and Professions Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation of patient satisfaction, and my knowledge in my decision making in exercising my rights with respect to the in-network coverage and cost sharing,my attending doctor(s) and/or clinic (facility) have disclosed to me at the time of initial contact and and at the time of referral with respect to any significant beneficial interest and have advised me that I may choose any organization for the purpose of obtaining the services offered and requested by my attending physician, in connection with my choice of a doctor or a facility, solely in the interest of my healthcare quality and safety as a result of my informed consent and personal choice of doctor(s) and/or clinic (facility): (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he/she will receive, directly or indirectly, remuneration for referring upon my such request and exercising my rights of freedom or choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA, and the California Business and Professions Code.

Doctor or Facility with beneficial interest: Dr. Sutha Sachar M.D. Prime Surgical Center and Pacific Endo-Surgical Center.

INITIAL______

Your Responsibility for Cooperation

If we accept your insurance assignment as a payment form for your insurance reimbursement, you agree to timely cooperate with your insurance company or health plan in the course of insurance claim processing, such as insurance inquiries, requests for additional information claims status verification or any inquiries for the purpose of your claim processing. You also agree to notify us immediately of any insurance inquiry or request for additional information and provide us with a copy of any documentation received from the insurance company or submitted to the insurance company from you.

In the event that you receive insurance payment checks for your surgeries or services rendered by this doctor, you agree to submit such insurance reimbursement check to our office within five (5) business days after your receipt of insurance checks. In a failure or refusal to forward or send us the insurance reimbursement checks for the medical services from this provider, all of your discount arrangement will be voided, and the total balance is due immediately. **INITIAL ______**

If you have any questions regarding our office or financial policies, please do not hesitate to ask us at any time.

I have read and understood the above policies of Coastal View Gastroenterology of South Bay, Inc.

PRINT NAME/ Signature of Patient or Responsible Party **Date**

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

This notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Is there is a family member we can discuss your medical condition with, please list their name and relation:

____

(Please note we do not respond back regarding medical questions for this text feature. If you have a question regarding your medical condition, you must call the office or call 911 if it is an emergency. In addition, you may revoke the text reminders option at any time by notifying us.)

This consent was signed by: ____
(PRINT NAME PLEASE)

Signature: ____ Date: ________________

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PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether bron or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. Article 3: Procedures and Applicable Law: A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator. Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration. Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition. Article 6: Retroactive Effect: If the patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services. ______________________________ Patient's or Patient Representative's Initials If any provision if this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT. By: ______________________________ __________

Patient's or Patient Representative's Signature (Date)

By:______________________________ By:

____

Physician's or Authorized Representative's signature (Date) Print patients name (Date)

By::______________________________ By:______________________________

Print or Stamp Name of Physician, (If Representative, Print Name and Relationship to Patient) Medical Group or Association Name A signed copy of this document is to be given to Patient. Original is to be files in Patient's medical records.