BASS
MEDICAL GROUP

www.bassmedicalgroup.com

IMPORTANT!!

It is critical that we know all medications that you are taking.

Please bring a complete list of your current medications (including strength and how many you take a day) to your appointment.

If you are unable to bring a list, then bring all of your medications in a bag and our staff will make a list for the doctor.

DO WE HAVE YOUR CURRENT BILLING INFORMATION?

Please make sure you have your current insurance cards with you at the time of check in.

BASS MEDICAL GROUP

NEW PATIENT REGISTRATION

Date: _____ **Social Security Number** _____ - _____- _____

Email Address_____ **Pharmacy** _____

Patient's Name: _____
Last Name **First** **MI**

Date of Birth: _____ ☐**Male** ☐**Female** **Marital Status:** Select **Age** _____

Race:_____ **Are you Hispanic?** ☐**Yes** ☐**No**

Language:_____ **Religion** _____ _**/or** ☐ Declines to specify

Street Address: _____ **City:**_____

State/zip code: _____ **Home Phone #: (**_____**)** _____ -- _____

Cell Phone #: (_____**)** _____ -- _____ **Driver's License#:**_____

Patient's Employer: _____ **Work Phone #: (**_____**)** _____ -- _____

Is this work-related? ☐ **Yes** ☐ **No** **If yes, date of injury:** _____ **Claim #:** _____

Spouse's Name: _____ **SS#** _____

PATIENT'S INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____

Insurance is through: ☐**Patient** ☐**Spouse** ☐**Parent** ☐**Other** **DOB of Insured:**_____

SECONDARY INSURANCE CARRIER: _____

Insurance is through: ☐**Patient** ☐**Spouse** ☐**Parent** ☐**Other** **DOB of Insured:**_____

<u>If patient is a Minor</u>, are parents ☐**Married,** ☐**Divorced? Custodial Parent** _____

Custodial Parent's Home Phone: (_____**)** _____ -- _____**Work Phone: (**_____**)** _____ -- _____

Custodial Parent's SS #: _____ **Date of Birth:** _____

PHYSICIAN INFORMATION

Referring Physician's Name:_____ **City:** _____

Primary Care Physician: _____ **City:** _____

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact: _____

Phone #: (_____**)** _____ -- _____ **Relationship to Patient:** _____

BASS
MEDICAL GROUP

PATIENT/RESPONSIBLE PARTY FINANCIAL AGREEMENT

I, the responsible party, certify that the above information is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges regardless of delays in insurance payment or denial of insurance coverage.

It is my responsibility to understand and have personally verified if my insurance is contracted with this practice and/or the doctor I am seeing.

I hereby authorize Bay Area Surgical Specialists, Inc. to apply for benefits and receive payments directly on my behalf for covered services rendered. They may also disclose any or all parts of my clinical record to any insurance company covering services for the purpose of satisfying charges billed.

I further agree to pay all collection costs, attorney fees and any other collection costs that may be incurred in the attempt to collect outstanding patient responsibility amounts.

I also understand, that if any insurance payments are sent directly to me, it is my responsibility to send these monies directly to Bay Area Surgical Specialists, Inc. immediately upon receipt.

I, the patient or the patient's representative, understand that all medical doctors at Bay Area Surgical Specialists, Inc. are licensed and regulated by the Medical Board of California. I can verify this by contacting the Medical Board at (800) 633-2322 or via the internet at their website: www.mbc.ca.gov.

_____	_____	_____
Signature of Patient, Parent or Legal Guardian	**Relationship to Patient**	**Date**

HIPAA / NOTICE OF PRIVACY PRACTICES – Page 1

In accordance with HIPAA laws, this notice describes how your health information may be used or disclosed and how you, the patient, can access this information. Please review the following carefully.

The law permits us to use or disclose your health information to the following:

- Another specialist or physician who is involved in your care.
- Your insurance company, for the purpose of obtaining payment for our services.
- Our staff, for the purpose of entering your information into our computerized system
- Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent via fax which is a permitted use allowed by law. We have on file with these sources verification for the confidentiality of the fax used and its limited access by authorized personnel.
- If this practice is sold, your health information will become the property of the new owner.
- We may release some or all of your health information when required by law. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

Federal and State law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations.

We also use a shared Electronic Medical Record that allows both our physicians and staff and certain of the participating physicians of the Muir Medical Group IPA and their staffs' access to our patients' health information. The purpose for this access is to expedite the referral of patients within the Muir Medical Group IPA systems and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the Muir Medical Group IPA system only with the patient's express authorization or as otherwise specifically permitted or required by law.

The law also establishes patient rights and our responsibility to inform you of those rights. These include:

- You have the right to request in writing any uses or disclosures we make with your health information beyond the normal uses referenced above.
- You have the right to limit the use or restrict the use disclosure of your health information. Our office will follow any restrictions notated by you on the reverse side of this form.
- You have the right to request in writing to inspect and/or receive a copy of your health information.* Our office may charge a reasonable fee to cover copying and mailing of these records to you.
- You have the right to request an alternate means or location to receive communications regarding your health information.*
- You have the right to request in writing an amendment or change to your health information. Our office may agree or disagree with your written request, but we will be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the reason for it and add it to your records.

* Conditions and limitations may apply; obtain additional information from our Privacy Officer.

HIPAA / NOTICE OF PRIVACY PRACTICES – Page 2

- We may use your information to contact you. For example, we may mail you an appointment reminder card or call you with information regarding your care. If you are not at home, this information may be left on your answering machine or with the person who answered the phone. In an emergency, we may disclose your health information to a family member or another person designated responsible for your care. **Please designate who our offices CAN disclose your health information to by checking the boxes below:**

☐ **OK to Spouse: _____**
☐ **OK to ALL family members: Please list names of family members:**
_____

☐ **OK to Other: _____**
☐ **OK to leave health information on answering machine or voice mail**

☐ **DO NOT RELEASE ANY INFORMATION to anyone other than myself (the patient).**
☐ **DO NOT RELEASE TO_____**

We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and our office will notify you of the changes in writing. You have the right to file a complaint with the Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, Washington, DC 20201. Our office will not retaliate against you for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office, at (925) 932-6330.

This notice goes into effect as of July 28, 2011.

ACKNOWLEDGEMENT

This acknowledges that you have received and read a copy of our Privacy Practices Notice. This document is not a contract, authorization, release, or consent form. This document will remain as part of your records.

Signed:_____ Date:_____

Patient's Name:_____ Date of Birth:_____

If person signing is not patient please provide:

Name:_____

Relationship to patient: _____

BILLING AND FINANCIAL POLICY – pg 1

The following sets forth the policies of Bay Area Surgical Specialists, Inc. Please review this information and sign where indicated below.

- I understand that it is my responsibility to furnish Bay Area Surgical Specialists, Inc. with current, accurate insurance information at the time services are rendered and/or notify us in a timely manner of any changes in coverage, which may affect the payment of services already rendered.

- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $50.00 NSF Fee. These amounts must be cleared with our financial office prior to your next appointment.

- I understand that a cancellation fee of $50.00 may be billed directly to myself if a 48 hour cancellation notice is not provided to our office. All cancellation fees must be cleared with our financial office prior to your next appointment. Specialty Ultrasound Appointments will have a $50.00 cancellation fee per test scheduled.

- I understand that a surgery cancellation fee of $500.00 may be billed directly to myself if a surgery is cancelled. This fee will also be assessed if cancellation has not been made 7 days prior to scheduled surgery date. This fee must be cleared with our financial office before surgery can be rescheduled.

- I understand that Bay Area Surgical Specialists, Inc. are not providers for any **HMO** insurances unless it is through John Muir Health or Sutter Delta Medical Group, Alta Bates, Hill Physicians, &Affinity.

- We are not **Medi-Cal** only providers. You will be responsible for all charges if you elect to see one of our physicians.

- It is the responsibility of each patient to verify with their insurance if this practice and the physician you are seeing is a contracted provider. BASS and/or its representatives will make every effort to assist you but BASS will not be held accountable for understanding every insurance plan.

- I understand that there is a $15.00 fee (per form) to complete disability paperwork associated with my care.

Updated 7/31/2025

BILLING AND FINANCIAL POLICY – pg 2

- I understand that the clinic will verify my insurance eligibility for surgery, but until claims are processed deductible amounts and co-insurance amounts prior to surgery cannot be determined. I further understand that a surgery co-pay may be collected upfront and applied to those fees. I further understand that ANY FEES I AM QUOTED ARE ESTIMATED based on 1) anticipated surgery to be performed and 2) current information provided to clinic by my insurance carrier.

- I understand that I will be billed for any amounts due by me (co-payments/co-insurance amounts/deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with three (3) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the third statement being mailed, the third statement will be marked as "Final Notice" and may result in my account being sent to an outside collection service if I still do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with those collection efforts.

- I understand that the clinic will obtain the necessary authorizations prior to surgery. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for all charges not paid by my insurance carrier. This also applies if your insurance company delays payment over 90 days after billing or denial of insurance coverage. If your insurance company demands a refund of any monies paid to us, you become financially responsible for those charges.

- I understand that the clinic may also take a verbal request by me over the phone to make a credit card payment on my account. I give authorization for the clinic to bill my card for the amount specified and acknowledge that verbal requests can only be made by the responsible party since no credit card information is kept on file.

My signature below confirms that I have read these billing policies and my financial obligations as pertains to the physicians of Bay Area Surgical Specialists, Inc..

_____ _____

Legal Signature Date

_____

Print Patient's Name

_____

Relationship to Patient **Updated 1/31/18**

PATIENT HISTORY FORM

DATE _____/_____/_____ **REFERRING DOCTOR**_____

NAME _____ **PRIMARY CARE DOCTOR** _____

DOB _____ **REASON FOR VISIT** _____

MEDICATIONS		
Please list all current medications, including vitamins:		
Name of medication	**Dose**	**Frequency**

ALLERGIES	
Please list all drug allergies:	
Drug	**Reaction**

PAST MEDICAL HISTORY

Please check whether you have or have had any of the following conditions:

Diabetes	☐ Yes	☐ No	High cholesterol	☐ Yes	☐ No
High blood pressure/Hypertension	☐ Yes	☐ No	COPD/emphysema	☐ Yes	☐ No
Coronary artery disease	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Congestive heart failure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Chronic renal failure	☐ Yes	☐ No	Dementia (e.g., Alzheimer's)	☐ Yes	☐ No
Atrial fibrillation	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hepatitis B	☐ Yes	☐ No
Type			Hepatitis C	☐ Yes	☐ No
_____			HIV	☐ Yes	☐ No
Type					
_____					

Others:

PAST SURGICAL HISTORY

Please list all prior surgeries:

Surgery	**Year**	**Surgery**	**Year**

NAME _____ **DOB** _____

FAMILY HISTORY			
Please answer the following questions about your family members:			
Father	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Medical problems:		
Mother	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Please list any significant medical problems:		
Sister	Please list any significant medical problems (if any):		
Brother	Please list any significant medical problems (if any):		
Family h/o	Please list any significant medical problems of other relatives (e.g., grandparents, uncles, aunts, etc.)		
Additional Space for Family History:			

SOCIAL HISTORY		
Drinks Alcohol	Do you drink alcohol? ☐ Yes ☐ No If yes how often? Select One	
	☐ Beer ☐ Wine ☐ Liquor Amount?	When was your last drink?
Tobacco Use	Do you smoke? ☐ Yes ☐ No If yes, how many packs per day?	
	How many years did you smoke?	What year did you quit?
Drug Use	Do you currently use recreational drugs? ☐ Yes ☐ No Have you in the past? ☐ Yes ☐ No	
	Have you ever used intravenous drugs? ☐ Yes ☐ No	
Caffeine Use	If yes, what kind? Select One How many cups? How many sodas?	
Employment	Occupation (past or present):	
Social History	Marital Status, please circle one: Select Who Lives in your home with you? _____ Do you have children? _____ If so how many _____	
Miscellaneous	Have you ever received a blood transfusion? ☐ Yes ☐ No	

NAME _____ **DOB**_____

REVIEW OF SYSTEMS

Please check whether you have any of the following problems, either CURRENTLY OR REPEATEDLY:

Constitutional

Fever	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Unexplained weight loss	☐ Yes	☐ No

Other: _____

Neurologic/Psychiatric

Numbness	☐ Yes	☐ No
Tingling	☐ Yes	☐ No
Weakness	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Memory loss	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Spinal cord injury	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Difficulty Sleeping	☐ Yes	☐ No

Other: _____

Respiratory

Shortness of breath	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Cough	☐ Yes	☐ No

Other:

_____

Cardiovascular

Chest pain	☐ Yes	☐ No
Irregular pulse	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No
Heart valve problem	☐ Yes	☐ No

Other: _____

Gastrointestinal

Abdominal pain	☐ Yes	☐ No
Nausea/vomiting	☐ Yes	☐ No
Indigestion/heartburn	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No

Other: _____

Vascular

Cool Extremity	☐ Yes	☐ No
Pain in limb	☐ Yes	☐ No
Varicose Veins	☐ Yes	☐ No

Other: _____

HEENT

Runny nose	☐ Yes	☐ No
Difficulty hearing	☐ Yes	☐ No

Other: _____

Metabolic/Endocrine

Excessive thirst	☐ Yes	☐ No
Too hot	☐ Yes	☐ No
Too cold	☐ Yes	☐ No

Other: _____

Immunologic

Hay fever	☐ Yes	☐ No
Food allergies	☐ Yes	☐ No

Other:

_____

Musculoskeletal

Joint pain	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Artificial joints	☐ Yes	☐ No

Other: _____

Hematologic

Easy bruising or bleeding	☐ Yes	☐ No
Blood clots in arms or legs	☐ Yes	☐ No
Anemia	☐ Yes	☐ No

Other: _____

Genitourinary

Back Pain	☐ Yes	☐ No
Cloudy Urine	☐ Yes	☐ No
Nausea		

Other: _____

Dermatologic

Rash	☐ Yes	☐ No
Boils/infections	☐ Yes	☐ No

Other: _____

CONSENT FOR ELECTRONIC COMMUNICATIONS

We at Bass Medical Group are committed to providing you with convenient and efficient healthcare services, including electronic communication options. Please read this form carefully and indicate your consent below.

Purpose:

This form outlines your agreement to receive electronic communications from Bass Medical Group and its affiliated healthcare providers, including but not limited to:

- Appointment Reminders
- Test Results (when appropriate and permitted by law, including California laws regarding disclosure of sensitive information).
- Billing Statements and Payment reminders
- Health information and educational materials
- General announcements and updates from practice
- Patient satisfaction surveys, including post-appointment feedback.
- Health screening reminders based on patient demographics.

These communications are supplemental to physician/patient encounters. BASS Medical Group will not provide diagnosis or treatment based solely on electronic communications.

Types of Electronic Communications:

We may use the following method to communicate with you Electronically:

- Email – Sent to email address you provide to us.
- SMS/Conversational Text Messages: Sent to the mobile phone number you provide to us.
- Patient Portal/Website: Secure online portal accessible through our website.

Risks of Electronic Communications:

While we take precautions to protect your privacy, there are inherent risks associated with electronic communications, including:

- Unauthorized Access: Although we use secure methods to communicate with you, there is a risk that unauthorized individuals or entities could access your information.
- Misdelivery: Emails or text messages could be sent to the wrong address or phone number if the number or email address we have in our file for you is incorrect or changed without giving notice to us.
- System Errors: Technical issues could prevent you from receiving or accessing electronic communications.

Your Responsibilities:

- Provide us with accurate and up-to-date contact information (email address and phone number).
- Promptly notify us of any changes to your contact information.
- Check your email, text messages, and patient portal regularly.
- Understand that electronic communication is not a substitute for in-person or phone communication in urgent situations. For urgent medical matters, please call our office directly and if you have an emergency medical situation, dial 911 or seek immediate medical attention at a nearby healthcare facility.
- Understand that you can withdraw this consent at any time and for questions or concerns, please contact our clinic.

California Privacy and Security:

- We are committed to protecting the privacy and security of your health information, including compliance with the California Confidentiality of Medical Information Act (CMIA) and HIPAA.
- We use secure methods to transmit and store electronic communications. We will not sell, rent, or lease your protected health information.

Certain health information is considered sensitive under California law (e.g., mental health records, substance abuse treatment, HIV/AIDS status, genetic testing). We will take extra precautions when communicating such information electronically, including obtaining specific authorization when required by law.

Withdrawal of Consent:

- You may withdraw your consent to receive electronic communications at any time by notifying us in writing or through the patient portal.
- Withdrawal of consent will not affect the lawfulness of processing based on consent before its withdrawal.
- Opting out will not affect your healthcare or your relationship with BASS Medical Group or your individual healthcare provider.
- You can opt out of these communications at any time using one of the following methods:
    - For text messages: Reply "STOP" to any message
    - For emails: Click the "OPT OUT" button at the bottom of any email
    - Send a letter via physical mail to:
      BASS Medical Group
      2637 Shadelands Drive
      Walnut Creek, CA 94598
    - For support, reply HELP or visit our website at bassmedicalgroup.com. Please see our Privacy Policy at https://www.bassmedicalgroup.com/privacy-policy for more information

Electronic Communications Consent:

I hereby consent to receiving electronic communications from Bass Medical Group, its affiliates and affiliated providers. These parties may use the provided information to contact or communicate with me by e-mail, live agent, voice mail, SMS text messages, conversational text message or pre-recorded message, including by using an auto-dialer or other computer assisted technology, patient portal, or by any other electronic communication for purposes that include appointment and follow-up health care reminders, pre-registration, surveys, prescription information, health-related products or services that may be of interest, my account(s), assignment of benefits, and financial responsibility. I understand that depending on my phone plan, I could be charged for these calls or text messages. I also understand that providing this contact information and consent are not conditions for receiving health care services. With respect to text messages, I understand that messaging frequency may vary, and message and data rates may apply, and I can opt-out at any time by replying “STOP” to the text message from my mobile device.

This consent applies to communications from BASS Medical Group and its affiliated healthcare providers, regardless of your primary care provider.

By signing below, you acknowledge that you have read and understand this consent form, including the potential risks and limitations of electronic communication

Print Name: _____

Signature: _____

Date: _____