



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 and a picture ID** with you at the time of check
in.

2637 Shadelands Drive, Suite D Walnut Creek, CA 94598

Tel. (925) 930-9978 | Fax. (925) 930-9663

BASS MEDICAL GROUP

NEW PATIENT REGISTRATION

Date: _____ Social Security Number _____ - _____ - _____

Patient's Name: _____
Last Name First MI

Date of Birth: _____ ☐ Male ☐ Female Marital Status: S M W D Age _____

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

Street Address: _____ City: _____

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

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

EMAIL Address: _____

Patient's Employer: _____ Full Time ☐ Part Time ☐ or Student Full Time ☐ Part Time ☐

Religion: _____ Refused ☐ None ☐

PATIENT'S INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____

Date of birth of Insured: _____

Insurance is through: ☐ Patient ☐ Spouse Name: _____ ☐ Parent Name: _____ ☐ Other

SECONDARY INSURANCE CARRIER: _____

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

If patient is a minor, 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: _____

Neesha Pammi, M.D. Board Certified Internal Medicine

2637 Shadelands Drive, Suite D Walnut Creek, CA 94598

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BASS
MEDICAL GROUP

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.

Cont. ➡

Neesha Pammi, M.D. Board Certified Internal Medicine

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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, and 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 Privacy Officer, Jenny Aivazian, 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: _____



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.

♦ MAIN OFFICE ♦

2637 Shadelands Drive, Walnut Creek, CA 94598 ♦ PHONE NUMBER ♦ 925-627-3424

FAX NUMBER ♦ 925-627-3560

**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: _____

♦ MAIN OFFICE ♦
2637 Shadelands Drive, Walnut Creek, CA 94598 ♦ PHONE NUMBER ♦ 925-627-3424
FAX NUMBER ♦ 925-627-3560

Neesha Pammi, M.D. Board Certified Internal Medicine
2637 Shadelands Drive, Suite D Walnut Creek, CA 94598
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BILLING AND FINANCIAL POLICY – pg 1

The following sets forth the policies of Neesha Pammi M.D. /BASS Medical Group please review this information and sign where indicated below.

- ❖ I understand that it is my responsibility to furnish Neesha Pammi M.D. /BASS Medical Group 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 \$25.00 NSF Fee. These amounts must be cleared with our financial office prior to your next appointment.
- ❖ I understand that a cancellation fee of \$25.00 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. Physical Exams, Pap Smears, and Pre-Operative Appointments will have a \$50.00 cancellation fee per missed appointments scheduled.
- ❖ I understand that BASS Medical Group are not providers for any HMO insurances unless it is through John Muir Health.
- ❖ We are not Medi-Cal 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. Neesha Pammi M.D./BASS and/or its representatives will make every effort to assist you but Neesha Pammi M.D./BASS will not be held accountable for understanding every insurance plan.
- ❖ I understand that there will be a Fee to complete Forms/Notes, Such as return to work notes, disability paperwork, school physicals, disability forms etc. associated with my care. * Charges will vary depending on the complexity of the note and/or form.

Cont. 

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BILLING AND FINANCIAL POLICY – pg 2

- ❖ I understand that the clinic will verify my insurance eligibility, but until claims are processed deductible amounts and co-insurance amounts prior to appointment cannot be determined. I further understand that an appointment 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 services 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. 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 BASS Medical Group.

Legal Signature

Date

Print Patient's Name

Relationship to Patient

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 BASS Medical Group and their billing company, Matrix, 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 BASS Medical Group 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



JOHN MUIR
HEALTH

John Muir Physician Network

HEALTH HISTORY FORM

Name:

Date of Birth:

Medical History

Question

Response

Date first noted
(approx)

Comments

Allergies

☐ Yes ☐ No

COPD/chronic bronchitis

☐ Yes ☐ No

Lung cancer

☐ Yes ☐ No

Anemia

☐ Yes ☐ No

Dementia

☐ Yes ☐ No

Migraines

☐ Yes ☐ No

Anxiety

☐ Yes ☐ No

Depression

☐ Yes ☐ No

Myocardial infarction

☐ Yes ☐ No

Arthritis

☐ Yes ☐ No

Diabetes mellitus

☐ Yes ☐ No

Nerve/muscle disease

☐ Yes ☐ No

Asthma

☐ Yes ☐ No

Eye Disease

☐ Yes ☐ No

Brittle bones

☐ Yes ☐ No

Autoimmune Disease

☐ Yes ☐ No

Acid reflux

☐ Yes ☐ No

Prostate cancer

☐ Yes ☐ No

Bipolar disorder

☐ Yes ☐ No

Glaucoma

☐ Yes ☐ No

Seizures

☐ Yes ☐ No

Breast cancer

☐ Yes ☐ No

Gout

☐ Yes ☐ No

Skin cancer

☐ Yes ☐ No



JOHN MUIR
HEALTH

John Muir Physician Network

HEALTH HISTORY FORM

Name:

Date of Birth:

Medical History (continued)

Question	Response	Date first noted (approx)	Comments
Cancer	☐ Yes ☐ No		
Heart Murmur	☐ Yes ☐ No		
Sleep apnea	☐ Yes ☐ No		
Cardiovascular other	☐ Yes ☐ No		
Hyperlipidemia	☐ Yes ☐ No		
Stroke/CVA	☐ Yes ☐ No		
Celiac disease	☐ Yes ☐ No		
High blood pressure	☐ Yes ☐ No		
Substance abuse	☐ Yes ☐ No		
Congestive heart failure	☐ Yes ☐ No		
Kidney disease	☐ Yes ☐ No		
Thyroid disease	☐ Yes ☐ No		
Bleeding problem	☐ Yes ☐ No		
Kidney stones	☐ Yes ☐ No		
Tremors	☐ Yes ☐ No		
Colon cancer	☐ Yes ☐ No		
Leukemia	☐ Yes ☐ No		
Ulcers	☐ Yes ☐ No		

Surgical History

Question	Response	Occurrence date (approx)	Comments
Appendectomy	☐ Yes ☐ No		
Dental surgery	☐ Yes ☐ No		
Prostate surgery	☐ Yes ☐ No		
Vasectomy	☐ Yes ☐ No		



JOHN MUIR
HEALTH

John Muir Physician Network

HEALTH HISTORY FORM

Name:

Date of Birth:

Surgical History (continued)

Question

Response

Occurrence
date (approx)

Comments

Brain surgery

☐ Yes ☐ No

Eye surgery

☐ Yes ☐ No

Small intestine surgery

☐ Yes ☐ No

Vein surgery

☐ Yes ☐ No

Breast surgery

☐ Yes ☐ No

Foot surgery

☐ Yes ☐ No

Spine surgery

☐ Yes ☐ No

Heart bypass

☐ Yes ☐ No

Fracture surgery

☐ Yes ☐ No

Thyroid surgery

☐ Yes ☐ No

Gall bladder removal

☐ Yes ☐ No

Hernia repair

☐ Yes ☐ No

Tonsillectomy

☐ Yes ☐ No

Colon/large intestine surgery

☐ Yes ☐ No

Hysterectomy

☐ Yes ☐ No

Tubes tied

☐ Yes ☐ No

Plastic surgery

☐ Yes ☐ No

Joint replacement

☐ Yes ☐ No

Ear tubes

☐ Yes ☐ No

C-Section

☐ Yes ☐ No

Ovary removal

☐ Yes ☐ No

Heart valve replacement

☐ Yes ☐ No



JOHN MUIR
HEALTH

John Muir Physician Network

HEALTH HISTORY FORM

Name:

Date of Birth:

Family History

Item	Family Member (i.e. mother, father)	Name	Comments
Allergies			
Anxiety/Depression			
Arthritis			
Asthma			
Breast cancer			
Clotting disorder			
Colon cancer			
COPD			
Crohn's/Ulcerative Colitis			
Dementia			
Diabetes			
Glaucoma			
Heart disease			
Hyperlipidemia			
Hypertension			
Kidney disease			
Learning disabilities			
Lung cancer			
Macular degeneration			
Mental retardation			
Migraines			
Osteoporosis			
Ovarian cancer			
Prostate cancer			



JOHN MUIR
HEALTH

John Muir Physician Network

HEALTH HISTORY FORM

Name:

Date of Birth:

Family History (continued)

Item	Family Member (i.e. mother, father)	Name	Comments
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Skin cancer

Stroke

Thyroid disease

Social History

Alcohol Use

☐ Yes ☐ No

Drinks/Week

Glasses of wine

Cans of beer

Shots of liquor

Drinks containing 0.5 oz of alcohol

Comments

Tobacco Use ☐ Current Everyday Smoker ☐ Current Some Day Smoker ☐ Never

☐ Former Smoker ☐ Passive

Packs/Day

0

0.25

0.5

1

1.5

2

3

Other (specify here)

Years

0

5

10

15

20

25

30

35

40

Other (specify here)

Quit Date

Comments on your
history with tobacco:

Drug Use

☐ Yes ☐ No