

# Bay Area Colon & Rectal Surgeons

## A Division of BASS Medical Group

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### NEW PATIENT REGISTRATION

Date \_\_\_\_\_ Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Age \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_ SSN \_\_\_\_\_

Preferred Language \_\_\_\_\_ Email \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Other \_\_\_\_\_

Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

### PATIENT INSURANCE INFORMATION

Primary Insurance Carrier \_\_\_\_\_ Insurance is through \_\_\_\_\_

DOB of Insured \_\_\_\_\_ Secondary Insurance Carrier \_\_\_\_\_

Insurance is through \_\_\_\_\_ DOB of Insured \_\_\_\_\_

If patient is a Minor, parents are \_\_\_\_\_ Custodial Parent \_\_\_\_\_

### REFERRING PHYSICIAN INFORMATION

Referring Physician's Name \_\_\_\_\_ City \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ City \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Phone \_\_\_\_\_

## Bay Area Colon & Rectal Surgeons A Division of BASS Medical Group

**Reason for visit:** \_\_\_\_\_

## ALLERGIES

<u>Medication Allergy</u>	<u>Reactions</u>

## MEDICATION LIST

See attached

**Vaccinations:** *Flu*  *Pneumonia*  *COVID*  *Gardasil (HPV)*

## Preferred Pharmacy

## Pharmacy Address

Pharmacy City

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**MEDICAL HISTORY**

**Please circle any problem **YOU** have had or are being treated for.**

**ANAL/RECTAL**

Hemorrhoids  
Fissure  
Fistula  
Abscess

**BLOOD PROBLEMS**

Anemia  
Blood clots (DVT/Embolism)  
Bleeding disorder  
Clotting disorder

**CARDIOVASCULAR**

Angina (chest pain)  
Arrhythmia (heart rhythm problems)  
Heart failure  
Hyperlipidemia (high cholesterol)  
Hypertension (high blood pressure)

**GASTROINTESTINAL**

Accidental bowel leakage  
Celiac disease (gluten sensitivity)  
Colon/Rectal polyps  
Crohn's disease  
IBS (irritable bowel syndrome)  
Ulcerative colitis

**ENDOCRINE**

Diabetes  
Hyperthyroidism (high thyroid disease)  
Hypothyroidism (low thyroid disease)  
Uterine Endometriosis

**EYES**

Glaucoma  
Vision loss

**CANCER**

Anal cancer  
Bladder cancer  
Breast cancer  
Cervical cancer  
Colon cancer  
Kidney cancer  
Ovarian cancer  
Penile cancer  
Prostate cancer  
Rectal cancer  
Small bowel cancer  
Stomach cancer  
Uterine cancer  
Other cancer: \_\_\_\_\_

**KIDNEY/URINARY**

Poor kidney function  
Renal failure  
Urinary incontinence (leakage of urine)  
Kidney stones

**MENTAL HEALTH**

Anxiety  
Depression

**NEUROLOGICAL**

Stroke  
Neuropathy

**MUSCULOSKELETAL**

Arthritis  
Back problems  
Gout

**RESPIRATORY**

Asthma  
COPD/Emphysema

**INFECTIONS**

Hepatitis  
HIV  
HPV

Other not listed: \_\_\_\_\_

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**SURGICAL HISTORY**

<u>Surgery</u>	<u>Date</u>

Last Colonoscopy: \_\_\_\_\_  
 (date)

Last Endoscopy: \_\_\_\_\_  
 (date)

**TOBACCO USE**

Are you a current smoker: YES  NO  Former smoker: YES  NO

Types: *Cigarettes*  *Vaping*  *Cigar*  *Pipe*

Number of years smoked: \_\_\_\_\_ Packs per day: \_\_\_\_\_

Smokeless tobacco: YES  NO  Types: *Chew*  *Snuff*

**ALCOHOL USE**

Do you drink alcohol? YES  NO

If yes, how often? Daily  Weekly  Monthly  Socially  Rarely

Amount consumed: 1-3  3-5  5+

**DRUG USE**

Do you use recreational drugs? YES  NO  If yes, please list: \_\_\_\_\_

Have you in the past? YES  NO  \_\_\_\_\_

Have you ever used intravenous drugs? YES  NO  \_\_\_\_\_

**CAFFEINE USE**

Please circle all that apply: Coffee Soda Tea Chocolate Other

Number of cups: \_\_\_\_\_ Number of sodas: \_\_\_\_\_

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**FAMILY HISTORY**

	<u>Family Member</u>	<u>Maternal (M)</u> or <u>Paternal (P)</u>	<u>Comments</u>
Allergies			
Anxiety/Depression			
Arthritis			
Asthma			
Breast Cancer			
Clotting Disorder			
Colon/Rectal Cancer			
COPD			
Crohn's/Ulcerative Colitis			
Dementia			
Diabetes			
Glaucoma			
Heart Disease			
Hyperlipidemia (high cholesterol)			
Hypertension (high blood pressure)			
Kidney Disease			
Lung Cancer			
Migraines			
Osteoporosis			
Ovarian Cancer			
Prostate Cancer			
Stroke			
Thyroid Disease			
Uterine Endometrial			
Other:			

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**FINANCIAL POLICY**

1. A copy of your photo ID and insurance card is requested upon check-in.
2. Copayments and balances are due at the time of service.
3. Procedures done in the office including Anoscope's may be subject to annual deductible and will be billed separately once the claim is processed.
4. This office accept credit cards (VISA/MASTERCARD AND DISCOVER).
5. This office accepts checks with the proper identification.
6. There will be a fee of **\$25.00** for returned checks.
7. A 24-hour notice is required to cancel office appointments or there will be a fee of **\$50.00** charged to you. This charge is not billed to your insurance.
8. A 72- hour (business hours) notice is required to cancel/reschedule any surgery or procedure to be done in the hospital/ surgery center or there will be a fee of **\$200.00** charged to you.
9. There is a fee of **\$25.00** for the completion of forms such as EDD (state disability), FMLA, etc.
10. Any bills or balances are due within 30 days of final payment by insurance company.
11. Supplemental/ secondary insurance claims will be filed when appropriate.
12. For large balances payment arrangements can be made.
13. If you do not have insurance (CASH PAY PATIENTS) total payment is due at time of service.
14. Changes to insurance, home address, or phone number should be reported immediately to the office for billing and other purposes.
15. Telephone number to call with account questions is **925-627-3424**

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Name

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Signature

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Date

**Bay Area Colon & Rectal Surgeons  
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**ASSIGNMENT OF BENEFITS**

I hereby authorize BACRS a Division of BASS Medical Group to apply for benefits and receive payments on my behalf for covered services rendered. I agree that I am financially responsible to BACRS a Division of BASS Medical Group for charges not paid under my insurance policy. I agree that a photocopy of this form may be used in lieu of the original.

**Release of Information:**

I hereby authorize BACRS a Division of BASS Medical Group to disclose and all parts of my clinical records to any insurance company covering services for the purpose of satisfying charges billed.

**Medicare Patients:**

I request that payments of authorized Medicare benefits be made payable to BACRS a Division of BASS Medical Group on my behalf on any services furnished to me. I authorize any holder of medical information to release to the Health Care Financing Administration and its agent any information needed determined benefits of the payable of related services.

I understand that my signature request that payment be made and authorizes the release of medical information necessary to pay claims. My signature authorizes the release of information to the insurance agency covering services provided my BACRS a Division of Bass Medical Group. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as a full coverage, and I am responsible only for deductible, co-insurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

**THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND DOES UNDERSTAND THE ABOVE TERMS AND CONDITIONS.**

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Name

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Signature

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Date

## 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. While Bay Area Surgical Specialists, Inc. (BASS Medical Group) strives to provide the highest quality of care and a positive patient experience, I understand that I remain responsible for all charges for services rendered. I agree to promptly notify BASS Medical Group, the provider, or office staff at the time of service if I have any concerns, so that BASS Medical Group may address them in a timely manner. Dissatisfaction with services does not relieve me of my financial obligations.

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 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 BASS Medical Group 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](http://www.mbc.ca.gov).

I, the patient or the patient's representative, understand that BASS Medical Group adheres to Section 1785.27 of the Civil Code and will not furnish any information related to my medical debt to a consumer credit reporting agency.

Notice Required by California Law – Civil Code § 1785.27(c)(1):

“A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.”

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Signature of Patient, Parent or Legal Guardian

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Relationship to Patient

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Date

# Bay Area Colon & Rectal Surgeons

## A Division of BASS Medical Group

### HIPAA/NOTICE OF PRIVACY PRACTICE

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 permitted use allowed by law. We have on file with these sources' verification of confidentiality of the fax use and its limited access by authorized personnel.
- If this practice is sold your healthcare information will become 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 healthcare operations.

We also use a shared Electronic Medical Records system that allows both our physicians and staff and certain participating physicians of the Muir Medical Group IPA and their staff access to our patients' health information. The purpose of the access is to expedite the referral of patients within the Muir Medical Group IPA and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Records System can be released outside the Muir Medical Group IPA system only when the patient 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 normal uses referenced above.
- You have the right to limit the user 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.
- You have the right to request an alternative 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 request, but we'll be happy to include your statement as part of your records. If an agreement it 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 record.

**Bay Area Colon & Rectal Surgeons  
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**HIPAA/NOTICE OF PRIVACY PRACTICE**

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 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

Ok to speak with Spouse: \_\_\_\_\_

Ok to speak with family member(s) listed here: \_\_\_\_\_

Ok to leave health information on answering machine or voicemail.

DO NOT RELEASE ANY INFORMATION TO ANYONE OTHER THAN MYSELF (PATIENT)

DO NOT RELEASE TO: \_\_\_\_\_

We reserve the right to change our privacy practices and 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, 220 Independence 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 privacy officer, Lisa McGuinness, at (925) 274-9000.

This notice goes into effect as of January 10, 2017.

**ACKNOWLEDGEMENT**

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

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Patient Name

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Date of Birth

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Signature

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Date

If person signing is not patient, please provide name and identify the relationship to the patient and in what capacity you/they are signing (E.g.,-parent, guardian, conservator):

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Name

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Relationship to patient

**Bay Area Colon & Rectal Surgeons  
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**TELEHEALTH DISCLAIMER**

1. Please be advised that communicating via telehealth/telehealth video is not secure communication. By receipt of this telehealth/telehealth video disclaimer you understand the potential risk inherent with telehealth/telehealth video communication and agree to accept the possible risk and use telehealth/telehealth video communication as a way for you and this office to communicate.
2. I understand that BACRS a Division of BASS Medical Group does not and cannot guarantee the confidentiality of any telehealth/ telehealth video communications and will not be liable for improper disclosure of confidential information and/or breaches of confidentiality caused by me or a third party. I understand that BACRS, a Division of BASS Medical Group, has no control over the security or management of my individual internet service provider and cannot guarantee that information will not be intercepted, altered, or read by an unintended recipient.

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Name

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Signature

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Date



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**OPEN PAYMENTS DATABASE NOTICE**

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at [openpaymentsdata.cms.gov](http://openpaymentsdata.cms.gov)

The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars (\$10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals.

My signature below confirms that I have read and understand that notice above.

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Patient Name

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Patient Representative Name

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Signature

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Date



**Bay Area Colon &  
Rectal Surgeons**

A DIVISION OF BASS MEDICAL GROUP

BRIAN J. MCGUINNESS, MD, FACS  
NEGAR M. SALEHOMOUM, MD, FACS, FASCRS  
POORNIMA VANGURI, MD, FACS, FASCRS

## **Patient Consent Form for Use of Artificial Intelligence (AI) Technology-AI Scribe**

**Clinic Name:** Bay Area Colon & Rectal Surgeons, A Division of BASS Medical Group

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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### **Purpose**

Our clinic uses **artificial intelligence (AI) technology** to enhance the quality, accuracy, and efficiency of care. This technology may assist your healthcare provider in documentation, communication, language translation, or clinical decision support — helping your provider focus more attention on you during your visit.

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### **How the AI May Be Used**

- Assists in generating or summarizing clinical notes.
- May transcribe or analyze conversations between you and your healthcare provider.
- May support translation or interpretation during your visit.

#### **Please note:**

The AI tool does *not* diagnose conditions, make treatment decisions, or replace your healthcare provider's judgment. All information generated or suggested by the AI is reviewed and confirmed by your provider before becoming part of your medical record.

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### **Privacy and Data Protection**

- All AI systems used by this clinic follow HIPAA standards for privacy and data security.
- Any information processed by AI is encrypted, stored securely, and accessible only to authorized personnel.
- Your data will never be sold or used for marketing.
- You may request information about how your data is handled at any time.

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## Your Rights

- You have the right to ask questions about how AI is used in your care.
- You may decline or withdraw consent at any time without affecting your treatment.
- You may request a copy of your medical documentation or any AI-generated summaries.

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## Patient Acknowledgment

Please read and initial each statement:

- I understand that AI technology may assist my healthcare provider during my visit.
- I understand that the AI does not make independent medical decisions.
- I understand that my information will be protected in accordance with HIPAA and applicable privacy laws.
- I consent to the use of AI tools to support documentation, communication, or translation during my visits.

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Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Provider/Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_