Coastal View Gastroenterology of South Bay

3440 Lomita Blvd, Suite 420, Torrance CA 90505; Tel: (310)953-3269; Fax: (310) 933-0258

REGISTRATION

Date_______________ Home Phone_____________________ Work Phone_________________ Email______________________

Patient Last Name_________________________ First Name_______________________ Initial____________________________

Street Address____

City____ State__________________ Zip______________________

Sex M F Age______ Birth date____________ Single Married Widowed Separated Divorced

Social Security #______________________________________ Driver's License #________________________

Insured Name________________________________ How and where did you learn about this clinic?______________________

Last Name First Name Initial

Relationship To Insured Self Spouse Child Other

Condition/ Illness Related To Illness Employment Auto Other

EMPLOYER	Company Name____ Occupation__________________ Address____________________________________ Phone_______________ Full-time Part-time City _________________________ State _____________ Zip__________Years Employed______________
SPOUSE (PARENT)	Name_______________________________________ Birthdate____________SSN:____________________ Last Name First Name Initial Employer Name____ Years Employed__________________ Address_______________________Phone______________________ Occupation___________________ City_______________________ State ________ Zip________________ Full-time Part-time
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name____ Policy/Group #:______________________________________ Effective Date:________________________ Name of Insured:_______________________________________ID #:______________________________
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name____ Policy/Group #:______________________________________ Effective Date:________________________ Name of Insured:_______________________________________ID #:______________________________
MEDICAL AND LEGAL INFORMATION	**Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? Yes No** Your Initials:__________ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant Yes No Pacemaker Yes No Family Physician___________________________ Person to contact in emergency (Name and Phone #)____ Attorney____ Telephone:______________________ Address____
Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws	**Legal Assignment Of Benefits And Designation Of Authorized Representative** In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care 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 reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from 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 submissions. I hereby convey to the above named provider(s), to the full extent permissible under the law and under any applicable employee 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 benefits 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) obtaining information about the claim to the same extent as the assignor; (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 employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party 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 as valid as the original. I have read and fully understand this agreement. ____ _________________________ Signature of Insured / Guardian Date

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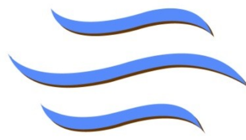

COASTAL VIEW GASTROENTEROLOGY, INC

Sutha Sachar, M.D.

Name________________________________ Date____________
Date of Birth______________________ Cell Phone___________________
Address____
Email__________________________
Is it okay to email or text you for appointment reminders? Y/N

Drug Allergies____
____
Are you allergic to Latex? Y/ N

Current Medications____
____

Family History	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐
Stomach Cancer	☐	☐	☐	☐	☐	☐

Hospitlization of Surgery
Reason____ Date__________
Reason____ Date__________

<u>Medical History</u>

Allergies/Hay Fever	Y/N	Ulcer	Y/N	Heart Disease	Y/N
Asthma	Y/N	Veneral Disease	Y/N	Depression	Y/N
Gallbladder Disease	Y/N	Hepatitis	Y/N	Power of Attorney	Y/N
Prostate Disease	Y/N	Anemia	Y/N	Living Will	Y/N
Hypertension	Y/N	Osteoporosis	Y/N	Influenza	Y/N

Habits
Tobacoo: Pack Daily________ Alcohol: Type________
How Long ________ Amount________

<u>Hepatitis C Risk Factors</u>
Blood Transfusion prior 1992 Contact with blood/body fluid Shared needles/ toothbrush

IV drug use Body Piercing

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FINANCIAL POLICY

Thank you for choosing us as your medical care facility. Our goal is to provide you with highest quality medical care at affordable cost. To make our services available to as many patients as possible on an affordable basis, we have adopted the financial collection policy outlined below. We ask you to read the policy carefully and sign prior to any treatment.

- WE MAY ACCEPT ANY ASSIGNABLE INSURANCE WITH APPLICABLE COVERAGE.
- WE OFFER FINANCIAL ASSISTANCE (DISCOUNT, WAIVER OR REDUCTION OF DEDUCTIBLES, CO-PAYS AND CO-INSURANCE) UNDER OUR INDIGENCY POLICY TO ALL ELIGIBLE PATIENTS ON CASE TO CASE BASIS
- FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS ARRANGED OTHERWISE
- WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD, AND AMERICAN EXPRESS CARD.
- WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

Dishonored checks will be charged back to the patient's account with a service fee of $25.00. Dishonored checks not redeemed within 20 working days of written notice to the maker will be referred to the prosecutor for collection.

Regarding Insurance

We may accept assignment of insurance benefits at our discretion if acceptable insurance identification is provided. Acceptable insurance identification is defined as a valid insurance card, policy/plan with applicable coverage, or telephone verification. As a courtesy to our patients, verifiable and assignable insurance will be billed by this surgeon's office. However, you will be personally responsible for your account balance regardless whether or not if your insurance will pay for your total balance of your claims, unless you're eligible for discounts under our indigency policy pre-determined before the services are rendered. Your insurance policy/employee benefits plan is a contract between you and your insurance company/employee benefits plan. We are not a party to that contract. In the event we do not accept assignment of benefits we require that you be pre-approved on our extended payment plan by providing a credit card or personal checking account with authorization to charge that amount for the balance due, if your insurance company/employee benefits plan has not paid your account in full within 45 days or has determined your claims to be your responsibility for the reasons of annual deductible, co-payment, non-covered services and not medically necessary.

If a patient chooses or is required to bill his/her own insurance, this office will provide an itemized statement and a HCFA-1500 Form to the patient, but will treat the account as a self-pay.

Regarding Discount

We may offer discounts, reduction or waiver of deductibles, coinsurance and co-pay to any eligible patients based on medical needs and ability to pay on a case-by-case basis under our Corporate Indigency Policy in accordance with applicable federal and state laws. You may apply for financial indigency discount assistance by asking our staff to determine if you're eligible.

Regarding Surgeon and Facility Charges

We will disclose to every patient our surgeon charges as clearly as practically possible before your medical or surgical procedures if it is known to us. Please feel free to ask our staff if you have any questions about charges and your payment responsibilities.

As you may be aware, your insurance company requires your doctors and surgeons to charge and bill the services separately from surgical facilities or hospitals. You shall not be surprised that you will receive separate surgeon, anesthesiologist, diagnostic labs, radiologists, pathologists, and others in addition to the surgical facility bills for your surgery. If you have any questions about your surgical facility bills, please direct your questions to that surgical center.

While we don't anticipate any unforeseeable circumstances, we have no control over any such event(s) that may arise. Should you require additional medical or surgical care in any event of the post surgical complications and reactions, you may incur additional expenses at this facility or outside this facility, such as a hospital.

The charges only include the stated date of services at this facility and do not include any other date of services from us or other providers and facilities.

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Regarding PPO and HMO Network Participation

As you may know, you may have choice to choose a surgeon or surgical facilities with or without PPO or HMO participation under different insurance coverage and benefits levels. We are dedicated to providing highest quality care to every patient; however we have no power to change your insurance coverage or network limitations. Most health care plan or insurance policies may provide surgical coverage to non-PPO providers and facilities, but at lower percentage of insurance reimbursement. Although it is your responsibility to verify your insurance coverage for non-PPO/HMO providers, we will always disclose to you as to our participation status to your insurance plan. We also provide every patient with financial assistance or discount with high deductibles and coinsurance for our Corporate Indigency Policy in accordance with applicable federal and state laws.

At this time, we don't participate in any managed care networks other than Medicare Fee-for-Service Plans (Medicare Part B). Most health plans or Insurance Polices may have coverage for out-of-network providers or facilities, but at different or lower percentage or level of reimbursement rates.

We will verify your insurance coverage and obtain pre-certification if applicable for all services as a courtesy to you before your surgery.

Please understand that all insurance verification is not a guarantee of insurance payment.

Compliance & Disclosure under California Business and Professions 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 or out-of-network coverage and cost sharing, my attending doctor(s) and/or clinic (facility) have disclosed to me at the time of initial contact 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 ordered or requested by my attending physician, in connection with my choice of a doctor or 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 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 of 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 significant beneficial interest: **Dr.Sutha Sachar, M.D.**

Your Responsibility for Cooperation

If we accept your insurance assignment as a payment from 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 insurance company from you.

In an event that you do receive insurance payment checks for your surgeries rendered by this doctor, you agree to submit such insurance reimburse 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, as there is no justification for you to keep the insurance payment for our services as you promised to pay for our services. You further agree to compensate us for any legal fees if we have to retain any legal services to collect past dues.

We are committed to serving you with highest quality care possible at affordable cost. Every staff at our office is ready to help you at all time.

If you have any questions regarding our financial policies, please do not hesitate to ask us at any time. We thank you for your co-operation.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X ____ ______________
Signature of Patient or Responsible Party — Patient Name (print) — Date

X ____ ______________
Signature of Co-Responsible Party — Your Name (print) — Date

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Coastal View Gastroenterology of South Bay Inc. Compliance Alert, 2013(A)(a)
PPACA Patient Advocacy for Freedom of Choice Disclosure and Compliance with California Business and Professions Code and California Health & Safety. Code § 1323(c)

Dear Provider of Patient Advocacy:

In compliance with new health care reform laws, PPACA, and all applicable federal and California laws, and as a long-standing patient advocacy practice for patient freedom of choice of healthcare providers solely based on the healthcare quality, safety, provider's reputation and patient satisfaction, we are excited to share with you on our 2013 compliance and advocacy updates.

According to the latest DOL Report in Dec 2012, about **74%** of all insured private industry workers participated in PPO plans that "Allow non-emergency services outside Network". In order to advocate for patient PPACA rights for freedom of choice of providers, Coastal View Gastroenterology of South Bay Inc. adopted the following new policies: (http://stats.bls.gov/ncs/ebs/detailedprovisions/2011/ownership/private/table02a.pdf)

Effective July 1, 2013, every healthcare provider must submit documents demonstrating your full and proper disclosures in compliance with federal and state laws, especially California Business and Professions Code and Cal. Health & Safety Code § 1323(c), as well as your managed-care network requirements, when scheduling for an appointment with Coastal View Gastroenterology of South Bay Inc..

You may fax or email the documents to Coastal View Gastroenterology of South Bay Inc. in advance of scheduling patient appointment, or any time for urgent care cases.

It is important that every provider must comply with both *public policies* in applicable federal and state laws and in *private agreement* with managed-care networks in advocating patient rights for freedom of choice. The documents submitted shall include **specific Network Disclosure Forms**, if any, under your PPO participating agreement, and **any forms of your choice demonstrating full and proper compliance with all applicable federal and state laws**.

It is also important to understand that California State law mandates for full and proper disclosures for any and all permissible self-referrals, regardless of in-network or out-of-network referrals, for both Medicare or non-Medicare patients, in addition to Medicare Stark Prohibitions and Anti-kickback Statutes.

California Business and Professions Code and Cal. Health & Safety Code § 1323(c) laws prohibit referrals to other health facilities in which the health facility has a significant beneficial interest unless written disclosure that patient may choose another facility.

As you are well aware that Coastal View Gastroenterology of South Bay has been fully dedicated to the patient advocacy for the quality care and patient choice through compliance, we have always shared with you on our compliance initiatives in protecting your practice and your own financial safety in the course of advocating patient rights.

We'll keep you updated on our forthcoming compliance and patient advocacy meetings and training programs.

Respectively,

Coastal View Gastroenterology of South Bay Inc.

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Patient Protection & Advocacy Policy

Affordable Care Act (ACA) Discount Disclosure
You Are Protected From Any Unexpected Costs And Bills

Dear Patient:

1. As your Patient Advocate (PA), we offer the highest care quality and safety possible at the **most affordable cost to you**, no matter if you are covered by an in-network or out-of-network health plan.
2. We offer an **Affordable Care Act Discount (ACA Discount)** under our Corporate Compliance Policy to anyone who qualifies, on a case by case basis. **You only pay what you can afford or are willing to pay** for your deductible and co-insurance, as outlined in your plan cost-sharing obligations, based on your medical need. Most people may qualify and **your satisfaction is guaranteed**.
3. Our Affordable Care Act (ACA) Discount is **similar to or even much better than all PPO discounts**, as our **ACA Discount is available from both in-network and out-of-network providers and facilities**.
4. Once you qualify, **you will NOT receive ANY unexpected invoices, bills or collection letters FROM US**, even if your insurance denies your claims.
5. As your Patient Advocate and Authorized Representative, and under the new federal health reform law PPACA (Patient Protection and Affordable Care Act, or ACA), we may appeal all of the claim denials or delays on your behalf, which is strictly in compliance with the new federal health reform law, PPACA.
6. As your Patient Advocate, **your best interest is our best interest**. To ensure that you also get this kind of ACA Discount from other providers known to us or affiliated with us, we will inform you of these facilities and/or providers, **so you may also receive the best care possible along with the ACA Discounts and Savings**.
7. With your informed choice, we will refer you to a provider who may also offer a compliant ACA Discount and ensure that **you are always protected from any unexpected costs and bills** under the new federal health reform law (PPACA).
8. As your Patient Advocate, we want **you to be fully protected from any unexpected costs and bills from any providers, unless otherwise authorized by you.**
9. You always have freedom of choice to receive healthcare from any provider you choose. However, we can not speak for or guarantee anything on behalf of other providers we don't know or are not affiliated with regarding their discount or collection policies. You are advised to contact them directly before scheduling your next appointment(s) or medical procedure(s).
10. **If you are willing to be protected from any unexpected costs and bills,** feel free to apply for our Affordable Care Act Discount under our Corporate PPACA Indigency Policy. "*Once indigency is determined, collection is no longer undertaken with regard to the patient for the forgiven amount*". Your satisfaction is guaranteed.

I have read and fully understand this Patient Protection & Advocacy Policy. My questions are fully answered.

______________________________ ______________________________ Dare ____________

Patient Name (print) Signature of Patient Date

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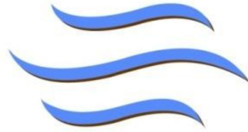


COASTAL VIEW GASTROENTEROLOGY, INC

Sutha Sachar, M.D.

Board Certified Gastroenterologist

3440 Lomita Blvd, Suite 420, Torrance, CA 90505

P 310.953.3269 F 323.300.2021

Dear Patient:

Due to new health care changes, physician's offices are requiring increased administrative time, increasing medical care costs and lower reimbursements from all the insurance companies. We have had to implement some changes to our medical practice:

1. Any forms that need to be filled out will have a $25 fee.(ie Jury Duty, Disability)

2. Any Colonoscopy or EGD that is cancelled without 48 hours notice will be charged $250 (we have a waiting list of patients that we can put in that spot)

Thank you for your understanding. It is truly my pleasure to be your physician.

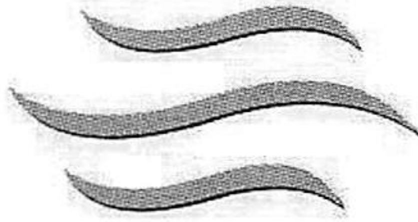
Sutha Sachar MD

I have read and understand the above fees that are implemented at this Gastroenterology office.

Patient Name (printed): ________________________________ Date:______________

Patient Signature:_____________________________________

Coastal View Gastroenterology Inc of South Bay



Pharmacy Information

Name of the Pharmacy_______________________________

Address or Cross Streets_______________________________

City & State_______________________________

Patient's Name_______________________________

I give authorization to Coastal View Gastroenterology to withdraw information from the pharmacy regarding any medication I have taken in the past present or future

Patients Signature_______________________ Date_______________________

Coastal View Gastroenterology Inc of South Bay 3440 Lomita Blvd Suite 420 Torrance, CA 90731;

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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 of 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 relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born 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 both 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 of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated 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, not 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 Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators 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 one 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 of 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 patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services ____________________

Patient's or Patient Representative's Initials

If any provision of 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: ____________________ ____________

Physician's or Authorized Representative's Signature (Date)

Coastal View Gastroenterology

Print or Stamp Name of Physician, Medical Group, or Association Name

By: ____________________ ____________

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

By: ____________________

Print Patient's Name

____

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

(2-08)