BSI
Broadway Surgical Institute
1451 Broadway St.
Santa Monica, Ca.90404

Date_____

PATIENT INFORMATION

Name_____ Social Security No._____

Home Address _____ City_____ State/Zip_____

Home Phone_____ Cell_____ D/L # _____

Employer _____ Occupation_____

Work Address_____ City_____State/Zip _____

Work Phone_____ Email _____

Gender _____Age_____ DOB_____ Marital Status _____

Emergency Contact _____ Relationship_____

Phone # Home _____ ☐ Cell _____ ☐ Work _____

Do you have an Advance Directive for Healthcare? ☐ Yes ☐ No

Do you have a copy with you? ☐ Yes ☐ No

Referred to this Office by _____

Please Circle (*optional Survey Data*)

Race: ◯ American Indian ◯ Asian ◯ Black or African American ◯ Caucasian ◯ Other

Ethnicity: ◯ White ◯ Hispanic/Latino ◯ Other

BSI
Broadway Surgical Institute

PRIMARY INSURANCE

Insurance Company Name _____ Subscriber #_____ Group #_____

Address _____City_____State/Zip _____

Name of Subscriber (*if other than Patient*) _____ Relationship_____

Subscribers Date of Birth_____

PLEASE SUBMIT YOUR INSURANCE CARD AND PICTURE ID WITH THIS FORM, SO WE MAY MAKE A COPY.

SECONDARY INSURANCE

Insurance Company Name _____ Subscriber #_____ Group #_____

Address _____City_____State/Zip _____

ASSIGNMENT OF INSURANCE BENEFITS

I CERTIFY THAT I HAVE INSURANCE COVERAGE WITH THE ABOVE INSURANCE CARRIER(S) AND HEREBY AUTHORIZE BROADWAY SURGICAL INSTITUTE TO RE-LEASE TO THE CARRIER(S) ANY INFORMATION THAT IS NECESSARY TO OBTAIN INSURANCE BENEFITS. I ASSIGN TO BROADWAY SURGICAL INSTITUTE ALL MY RIGHT, TITLE, AND INTEREST IN AND TO ANY AND ALL HEALTHCARE AND/OR SURGICAL BENEFITS OTHERWISE PAYABLE TO ME FOR ANY MEDICAL TREATMENT, RENDERED BY BROADWAY SURGICAL INSTITUTE AS DESCRIBED IN THE ATTACHED MEDICAL CLAIM FORM. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE** FOR ALL CHARGES INCURRED, WHETHER OR NOT PAID BY INSURANCE AND AGREE TO PAY ANY APPLICABLE DEDUCTIBLE AND CO-PAYMENT AMOUNT NOT COVERED BY MY INSURER, PLAN OR PAYER.

I UNDERSTAND THAT MY INSURANCE COMPANY MAY ISSUE A CHECK FOR SERVICES PROVIDED BY BROADWAY SURGICAL INSTITUTE TO MY SELF OR POLICY HOLDER. AS PART OF THIS ASSIGNMENT I AUTHORIZE THE PROVIDER TO ENDORSE ANY CHECK MADE PAYABLE TO THE PROVIDER AND TO MYSELF FOR SERVICES RENDERED. IN ADDITION, I AGREE TO ENDORSE ANY INSURANCE CHECK SENT TO ME BY MY INSURANCE CARRIER FOR SERVICES RECEIVED AND FORWARD TO BROADWAY SURGICAL INSTITUTE (***WITHIN 10DAYS UPON RECEIPT OF SUCH CHECK***)

IF I DEPOSIT SUCH A CHECK INTO MY PERSONAL ACCOUNT, I AGREE TO SEND BROADWAY SURGICAL INSTITUTE A PERSONAL CHECK FOR THE EQUIVALENT AMOUNT. FAILURE TO REMIT PAYMENT WITHIN THE GIVEN TIME FRAME CAN RESULT IN COLLECTIONS EFFORTS BY THE PROVIDER, OUTSIDE COLLECTIONAGENCY, AND/OR LEGAL ACTION.

Signed_____ Date_____

Print Name_____

If not signed by Patient please circle: Parent (for a minor) Guardian Minor/Other Spouse Beneficiary/ Personal Representative

Reviewed by Physician _____ DATE _____

DISCLOSURE NOTICES

Patients Rights:

In recognition of the responsibility of this Center in the rendering of patient care and our commitment to high standards of quality professional care, these rights and responsibilities are affirmed as the policies and practices of Broadway Surgical Institute.

1. Patients may exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation, marital status, or the source of payment for care. These rights also apply to adolescent patient and their parent/guardian.
2. Patients have the right to considerate and respectful care, with consideration given to the psychosocial, spiritual and cultural variables that influence the perception of illness.
3. Patients have the right to receive as much information about any proposed treatment or procedure as the patient may need in order to make an informed consent or to refuse treatment. This information shall include a description of the procedure or treatment and the medically significant risks involved in the treatment, expected benefits, alternate courses of treatment or non treatment, and the risk involved in each and to know the name of the person who will carry out the procedure or treatment.
4. Patients or his/her representative have the right to actively participate in the development and implementation of his/her plan of treatment allowing his/her to make informed decisions as to the treatment. To the extent permitted by law, this includes the right to refuse treatment and to be informed of medical consequences of such refusal. This right must not be construed as a mechanism to demand the provision of treatment or services to be deemed medically unnecessary or inappropriate.
5. Patients have the right to choose their own physicians.
6. Patients have the right to privacy concerning the medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discretely. The patient has the right to be advised as to the reason for the presence of any individual.
7. Patients have the right to confidential treatment of all communications and records pertaining to the care and stay at *Broadway Surgical Institute.* Written permission shall be obtained before the medical records can be made available to anyone not directly concerned with the care.
8. Patients have the right to a response to any reasonable request made for service within *Broadway Surgical Institute's* capacity and mission.
9. Patients have the right to refuse treatment to the extent permitted by law and are informed of the medical consequences of such refusal. The patient accepts responsibility for his/her actions should he/she refuses treatment or not follows the instructions of the physician or facility.
10. Patients have the right to reasonable continuity of care and to know, in advance, the time and location of their procedure as well as the identity of persons providing the care.
11. Patients have the right to be informed of continuing healthcare requirements following discharge.
12. Patients have the right to examine and receive an explanation of bill, regardless of source of payments.
13. All patients' rights apply to the person who may have legal responsibility to make decision regarding medical care on behalf of the patient.
14. Patients have the right to designate visitors of his/her choosing in accordance with our Centers policy.
15. Patients, or designated representative, have the right to participate in the consideration of the ethical issues that a rise in the care of the patient.
16. Patients have the right to be informed of the mechanism for the review and resolution of concerns regarding the quality of care.
17. Patients and/or their legal representative have access to the information contained in the medical record. Written permission will be obtained before medical records can be made available to anyone not directly concerned with their care. Picture ID will be required upon arrival.
18. Patients have the right to reasonable access to care.
19. Patients have the right to access protective services.
20. Each Patient or, when appropriate, the patients representative will be given a written copy of the patients rights in advance of furnishing or discontinuing patient care whenever possible.
21. Patients have the right to participate in the development and implementation of his plan of care.
22. Patients have the right to appropriate assessment and management of pain.

23. Patient has his/her right to personal privacy.
24. Patient or his/her representative has the right to make informed decisions regarding his /her care. The patients rights include being informed of his/her health status, being involved in care planning, treatment, evaluation and prognosis, and being able to request or refuse treatment.
25. The patient will be free from any act of discrimination or reprisal.
26. If a patient is adjudged incompetent under applicable state laws by a court of a proper jurisdiction, the rights of the patient are exercised by the person appointed under state law to act on the patients behalf.
27. If a state court has not adjudged a patient incompetent, any legal representative or surrogate designated by the patient in accordance with state law may exercise the patient's rights to the extent allowed by state law.
28. The patient will be free from all forms of abuse or harassment.
29. Patients have the right to the confidentiality of his/her clinical record(s).
30. Patients have the right to access information contained in his/her clinical records within a reasonable time frame.
31. Patient has the right to receive care in a safe setting.

PATIENT RESPONSIBILITIES:

1. To work with your healthcare team and to follow all safety rules.
2. To show respect and consideration to our staff, and to other patients and visitors.
3. To respect the privacy of other patients.
4. To give your healthcare team complete and correct information to the best of his/her ability about health, any medications, including over the counter products and dietary supplements, and any allergies or sensitivities.
5. To tell your Doctor about any changes in your health after you leave our facility.
6. To keep, or cancel your appointments for your healthcare.
7. To tell your healthcare team if you wish to change any of your decisions.
8. To ask for clarification if information or instructions are not understood.
9. Inform his/her provider about any Advance Directive and provide a copy at admission.
10. To accept personal financial responsibility for any charges not covered by his/her insurance.
11. Provide transportation by a responsible adult to take him/her home from the facility and remain with him/her for 24 hours, if required by his/her Physician.
12. Follow treatment plan prescribed by his /her provider and participate in his/her care.

COMMENTS ABOUT THE CARE YOU RECEIVED:

If you have a comment, complaint or grievance about the quality of care or services received, we would like to hear from you. Please contact our patient advocate, Renee Galvan at 1451 Broadway, Santa Monica, CA 90404, (310-260-2827)

Complaints and grievances can be filed with any of the following:

County of Los Angeles Public Health Health Facilities Inspection Division 3400 Aerojet Avenue Suite 323 El Monte, CA 91731 626-312-1104 800-228-1019 Publichealth.lacounty.gov/hfd/howto.htm	Medical Board of California Central Complaint Unit 2005 Evergreen Street Suite 1200 Sacramento, CA 95815 800-633-2322 916-263-2424 http: //www.mbc.ca.gov	Accreditation Association for Ambulatory Healthcare 5250 Old Orchard Rd, ste 200, Skokie, Ill 60077 847-853-6060 www.AAAHC.org	Office of the Medicare Beneficiary Ombudsman 877-486-2048 www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

NOTICE OF PRIVACY PRACTICES:

The Health Insurance Portability & Accountability Act of 1966 (HIPPA) requires all health records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally to be kept confidential. This Federal Law gives you, the patient, significant new rights to understand and control how your health information is used. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information, and how we may use and disclose your health information. You have the right to file a formal written complaint with us or with the Department of Health and Human Services, Office of Civil Rights, 200, Independence Ave., South Washington, DC. 20201 Phone: 877-696-6775, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

ADVANCE DIRECTIVES:

An Advance Directive refers to your written instructions about your future medical care, in the event you become unable to speak for yourself. There are two (2) types of Advance Directives: A living will and a medical power of attorney. If you would like a copy of the official state Advanced Directive forms you may download them from wwwcalhealth.org. Or a copy is available to you upon request.

Please be advised, based on reasons of organization conscience, Broadway Surgical Institute, will initiate all reasonable efforts to revive a patient should a medical emergency occur, including resuscitative or other stabilizing measures, regardless of the contents of any advance directive/living will/health care proxy or instructions from a healthcare agent. The center will ensure that patients are fully informed of this policy prior to receiving any care. We will provide patients with information on applicable State health and safety laws relative to advance directives/living wills.

OWNERSHIP/ FINANCIAL INTEREST:

Please be advised that these physicians have a financial interest in Broadway Surgical Institute LLC.
Alexander P. Hersel MD
Timothy Davis MD
Akash Bajaj, MD
Scott Rosenzweig, MD
Douglas Freedman, MD
Rostam Khoshsar, MD

_____ DATE_____ TIME_____
Print Name (Patient)

_____ _____
Signature Patient Staff Signature
Signature □ Patient □ Parent/Guardian □ Representative **Staff Signature**

Patient Name: _____ Date of Surgery: _____

Advance Directive

_____I have an Advance Directive. YES☐ NO ____ I would like information on Advance Directive. YES_____ NO ____

_____I brought a copy of my Advance Directive and gave a copy to Broadway Surgical Institute.

PATIENT FINANCIAL AGREEMENT

PROPOSED PROCEDURE(S):

We would like to share the following policies with you so that you understand your responsibilities regarding charges for the service rendered to you by this facility.

Patients who cancel less than 48 hours prior to their procedure (or are a NO show) will be charge **$100.**

A Tuesday surgery must be cancelled before 5pm on the Friday prior to the procedure.

There will be no exceptions for the late cancellation, i.e. illness, work- related, etc. Your Surgery costs include physician and anesthesiologist's time, nursing staff, supplies ordered for your visit, and the time reserved for you, during which no other patients can be booked for appointment and/or surgical procedures.

You the Patient are also responsible for other associated fees that may include anesthesia, professional, lab and prescriptions. Surgery fees are payable to the surgery center and billed separately through a billing agency.

Broadway Surgical Institute, LLC will bill your Insurance for the facility fees. Patient is responsible for his/her deductible, if not met prior to billing for facility fees. If your Insurance carrier fails to pay for services within 90 days, you will be notified about the unpaid charges and asked to contact your Insurance carrier to help collect payment for your procedure. *In the event any charges are uncollectible from your Insurance carrier we will balance bill you for the remaining balance (after we have received a denial from your Insurance carrier).* Broadway Surgical Institute, LLC will work with you on amounts that are owed in the event this should happen.

There will be two (2) or three (3) separate charges for your procedure. If you are having anesthesia there will be a charge from the anesthesiologist. There will be a charge for the facility. There will also be a professional charge from the doctor and possible pathology fees.

We would be glad to try and help answer any questions you may have regarding co-insurance; however, since there are multiple insurance plans it is advisable that you contact your Member Services Department with you Insurance carrier to obtain this information.

I, _____, understand that the fees are for performance of the procedure(s) outlined, and are being done in OUT OF NETWORK FACILITY with all insurance companies (except Medicare and Some HMO's). I am choosing to use my out of network benefits and NOT for a guaranteed result. If additional procedures are added on the day of the surgery, or if re-operation is necessary, there may be additional charges.

I have read, understand and agree to the terms of this agreement.

_____ Date: _____

Signature ☐ *Patient* ☐ *Parent/Guardian* ☐ *Representative*

Member Authorization Form for a Designated Representative to Appeal a Determination

To: **Insurance Carrier**

Date: _____

Member Name: _____

Member Insurance ID Number: _____

I hereby authorize: _Broadway Surgical Institute____ to appeal Insurance Carriers determination concerning

_____

on my behalf, as my Designated Representative, and as a part of the appeal. I hereby authorize Insurance Carrier in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative in all aspects of the appeal. I understand that these communications may contain the following:

> All medical and financial information contained in my insurance file, including but not limited to treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder and HIV status relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed.

I understand this information is privileged and confidential and will only be released as specified in this Authorization, or as required or permitted by law. This authorization is valid for a period of one year.

_____
Signature of Member or Legal Guardian/Representative

_____
Signature of Witness_____ **OR** Designated Representative_____

_____
Print Name of Witness/Designated Representative

_____
Title (if on Providers staff) OR Relationship to Member

BSI
Broadway Surgical Institute

The undersigned certifies:

_____I have received a copy of the Patients Rights.
My Responsibilities as a Patient.
Grievance procedures: In addition, I have been informed that any grievance will be appropriately investigated and I will receive a written response within 30 days.

_____I have received notice on The Policy of Broadway Surgical Institute regarding Advance Directives.

_____I have an Advance Directive. YES☐ NO☐ I would like information on Advance Directive. YES_____ NO☐

_____I brought a copy of my Advance Directive and gave a copy to Broadway Surgical Institute.

YES _____ NO _____ Comment _____

_____I received notification of Ownership and Financial Interest.

_____I have received Notification that Broadway Surgical Institute is an Out of Network provider and that my Insurance May send the reimbursement check to me the patient. I understand that this payment is to be endorsed and the Attached EOB (explanation of Benefits) will be mailed or brought to Broadway Surgical Institute upon receipt.
I understand that My Insurance Company notifies Broadway Surgical Institute when the check has been mailed to me.

_____ I also understand that if I receive the payment from my Insurance Company and I deposit these check(s) I will be Fully Responsible for the check(s) and amount as well as any associated legal fees incurred to collect this money.

_____I understand that my Insurance contract is between my insurance company and myself.

_____I understand I am responsible for all Payments due to Broadway Surgical Institute for my procedure that my Insurance does Not cover.

_____ **DATE** _____

Print: Patient/Representative Name

_____ **Relationship**_____

Signature: ☐ Patient, ☐ *Parent/ Guardian* ☐ *Representative*

Assignment of Benefits

Name of Insured (print): _____

Insurance Co. Name: _____

Policy Number: _____

I, hereby assign to **Broadway Surgical Institute** all my right, title, and interest in and to any and all health care and/or surgical benefits otherwise payable to me for medical treatment, including major medical, rendered by the assignee as described in the attached medical claim form.

I acknowledge that my insurance company may issue a **check** and **explanation of benefits** for services provided by **Broadway Surgical Institute** directly to myself or my policy holder. As part of this assignment I authorize the provider to endorse any **check** made payable to the provider and to myself for services rendered. In addition, I agree to endorse any insurance **check** sent to me by my insurance carrier for services received from the above provider and forward both the **check** and **explanation of benefits** to **Broadway Surgical Institute** within *5 days* upon receipt of such **check**. If I deposit such a **check** into my personal account I agree to send to **Broadway Surgical Institute** a **check** for the equivalent amount along with the **explanation of benefits**. Failure to remit payment within the given time frame can result in collections efforts by the provider, outside collection agency, and/or legal action.

I acknowledge that it is my responsibility and agree to pay any applicable deductible and co-payment amount not covered by my insurer, plan, or payer.

Signed: _____ Date: _____

If not signed by the patient, please indicate relationship:

( ) Parent or guardian of minor patient (to the extent minor could not have consented to care)
( ) Guardian or conservator of patient
( ) Beneficiary or personal representative of deceased patient
( ) Spouse or person financially responsible (where information solely for purpose of processing application for dependent health care coverage)

BSI
Broadway Surgical Institute

Authorizations for Release of Health Information

Please answer the following three questions regarding the release and disclosure of your medical and billing information. Please return the completed form (signed and dated) to the front desk.

1. Do we, Broadway Surgical Institute, have your permission to release your medical information to ALL <u>your</u> healthcare providers and insurance companies? ☐ Yes ☐ No

2. Do we, Broadway Surgical Institute, have your permission to obtain your medical information from ALL of your healthcare providers and insurance companies? ☐ Yes ☐ No

3. Please list all family member(s)/guardian(s) that may access your <u>medical records and/or financial and billing information.</u> Please List ALL:

Name of Person	Relationship to Patient	Medical Only	Billing Only	Both
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

I have the right to revoke this authorization at any time. My revocation must be in writing, signed by me or my legal representative, and delivered to Broadway Surgical Institute Attn: HIPAA Compliance Officer, via mail or in person. It will be effective only when Broadway Surgical Institute actually receives it. The information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Printed Patient Name _____ Patient's Date of Birth _____

Signature of Patient _____ Date _____

Signature of Client/Personal Representative _____ Relationship to Patient _____

Please note, this form expires one year after signed. You will be asked to complete this form annually.

CREDIT CARD TRANSACTION FORM

FOR OVERAGE

Your procedure has been estimated by your physician.

In the Event your Procedure takes longer than the estimate quoted by your Physician, you authorize Broadway Surgical Institute to charge your Credit Card below for additional cost.

Patient Name:_____ **Date of Surgery:** _____

CARDHOLDER INFORMATION

☐ **VISA** ☐ **MASTERCARD** ☐ **AMERICAN EXPRESS** ☐ **DISCOVER**

CARD NUMBER: _____

EXPIRATION DATE: _____

CARD HOLDER NAME: _____

CARD CODE: _____

AMOUNT TO CHARGE: _____

VOUCHER #: _____

DATE OF SERVICE: _____

Signature of Card Holder: _____

Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Other_____

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing Broadway Surgical Institute (the "Facility") as your health care provider. This statement explains how we bill our patients and their insurance plans for the services we provide.

In-Network Services

If you are a member of an insurance plan with which the Facility has a comprehensive services agreement (or is "in-network") we will bill your insurance plan for your care. We will also bill you for your in-network payment obligations, which could be in the form of a co-payment, co-insurance, and/or a deductible.

Out-of-Network Services

If you are a member of an insurance plan with which the Facility does not have a comprehensive services agreement (or is "out-of-network"), we will ask you to sign a Communication and Election form like the one attached as Exhibit A to this statement. The form makes clear that you understand your treatment options and financial obligations, and have chosen to seek treatment at the Facility.

It is possible that your insurance does not provide coverage for out-of-network care, including the services the Facility will provide to you. In that event, the Facility will bill you, and you will be responsible for, the full cost of the services we provide you.

It is also quite possible that your insurance does provide coverage for out-of-network care, including the services the Facility will provide to you. In that event, we will bill you for your patient share responsibilities, but will absorb the cost of any out-of-network penalties your insurer may impose and bill you based on your in-network level benefits only. That means we will seek payment from you for your in-network level co-payment, co-insurance, and/or deductible, if any. We will seek primary payment from your insurer. Like the discounted fee we charge you, we will charge your insurance company a discounted fee as well. If for some reason your insurer does not pay the discounted fee it owes to the Facility, you will be responsible for that fee, in addition to your own financial responsibility portion.

We customarily expect payment at the time we render services. If you have any questions regarding our billing procedures, please do not hesitate to contact a member of the Facility's billing staff.

Signature: _____ Date: _____

OUT OF NETWORK

Communication & Election

I _____ understand that Broadway Surgical Institute is an OUT OF NETWORK Facility. I understand that I am responsible for any deductibles and or copay's associated with my Insurance Plan. I was informed prior to my procedure that I could consult with the billing department to answer any and all questions or concerns that I may have about my financial obligation with my procedure.

I wish to exercise my option to use my OUT OF NETWORK benefits and fully understand my financial obligation. I have chosen to use Broadway Surgical Institute to have my procedure/treatment performed. I have been provided with a copy of the Broadway Surgical Institute Patient Financial Policy, and I understand that I will be financially responsible for my co-insurance and deductibles.

"Your insurance carrier may send payment directly to you. Once you receive the check, you must turn over the check and the explanation of benefits to the surgery center within 5 business days."

_____
Print Name

_____ _____
Patient Signature Date

PATIENT INFORMATION SHEET

Patient Name _____

DOB:_____ Insurance:_____

Date of Service	Procedure	Physician	Case Cancelled Yes or No	Cancellation Comments Date and Time MD Office Notified