Eric M. Kagel, MD
2505 Samaritan Drive Ste 208
San Jose, CA 95124
A division of Bay Area Surgical Specialist, Inc.

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 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 arrive 15min before your appointment and have your current insurance cards and a picture ID with you at the time of check in.

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Today's Date: _____

PATIENT DEMOGRAPHICS

Patient's Legal Name: (Last, First, Initial)		**Preferred Name**:	**SSN:**
Home Address:		**City & State**:	**Zip**:
Date of Birth	**Gender** ❑ M ❑ F	**Marital Status**: ❑Single ❑Mar ❑Div ❑Sep ❑Wid	**Email**:
Best Contact Number: ❑ Cell ❑Home ❑ Work	Other Contact Number: ❑ Cell ❑Home ❑ Work		Other Contact Number: ❑ Cell ❑Home ❑ Work
Employer:	**Occupation**:		**Work Phone#:**
Primary Care Physician:	**Employment Status**: ❑ Full-Time ❑ Part-Time ❑ Retired ❑ Not Working		
Who referred you to our office? (Physician, family member, friend, etc. - Please list their name) :			

IF PATIENT IS A MINOR PLEASE COMPLETE:	PARENT: (Name/Relation)	Work#:	Cell#:
	PARENT: (Name/Relation)	Work#:	Cell#:

RESPONSIBLE PARTY/GUARANTOR (IF DIFFERENT FROM ABOVE OR THE PATIENT IS A MINOR)

Name:	Relationship:	Date of Birth:
Address:	City & State:	Zip:

INSURANCE INFORMATION

Name of **Primary** Insurance Carrier:		
Subscriber Name:	Subscriber SSN:	Subscriber DOB:
ID#:	Group#:	
Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other		
Name of **Secondary** Insurance Carrier:		
Subscriber Name:	Subscriber SSN:	Subscriber DOB:
ID#:	Group#:	
Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other		

IN CASE OF EMERGENCY CONTACT

Name of local friend or relative:	Relationship to patient:	Home phone:	Cell/Work phone :

GENERAL INFORMATION

	Preferred Language:
Ethnicity: ❑Hispanic/Latino ❑Not Hispanic/Latino ❑Decline	Race: ❑American Indian/Alaska Native ❑Black/African American ❑Hawaiian/Pacific Islander ❑ White/Causasian ❑ Other_____ ❑Decline

Revised: 02/17/2017

Patient Name: _____ **Date**: _____

Current/Retired Occupation: _____

Height: _____ **Weight:** _____ **Gender: M /F Age:** _____ **Dominant hand (Right/Left)**

History & Medical Information

1. **Nature of visit**: _____

2. **Date symptoms began**: _____Were x-rays/test done? Y/N Where? _____

3. **Has problem been treated: ☐ Yes ☐ No Where?** _____

4. **Medical History**:

☐ Anemia	☐ Epilepsy	☐ High blood pressure	☐ Osteoporosis
☐ Bleeding Disorders	☐ Gout	☐ Kidney Disease	☐ Arthritis
☐ Cancer _____	☐ Heart Failure	☐ Lung/Respiratory Disorders	☐ Rheumatic Fever
☐ Depression	☐ Hepatitis	☐ Mitral Valve Prolapse	☐ Stroke
☐ Diabetes	☐ High Cholesterol	☐ Nerve Disorder	☐ Thyroid Disorder
	☐ HIV/AIDS	☐ Osteoarthritis	☐ Other

5. **List all medications/herbs/vitamins:** _____
_____

Local Pharmacy Name, Phone Number and Address:

_____

6. **Allergies** (Describe reaction) **None**
☐ Penicillin _____ ☐ Aspirin _____ ☐ Narcotic Agent/Codeine _____
☐ Anesthesia _____ ☐ Shellfish _____ ☐ Sulfa drugs _____
☐ Nickel/Metal _____ ☐ Radiographic Contrast Dye _____
☐ Other _____

7. **Are you currently pregnant? ☐ Yes ☐ No**

8. **Surgical History**: (Have you had surgery?) ☐ Yes (if yes- date and type) ☐ **None**
_____
_____

9. **Social History**: (Only check what is pertinent to you)
Tobacco Use: **Y/N** Packs per day? _____ How many years? _____
Alcohol Use: **Y/N** How much per week? _____ How many years? _____
Recreational Drug Use: **Y/N** Type? _____ How much? _____
Exercise/Sports? **Y/N** Describe: _____

10. **Family History**: (List relationship of family member(s) who have had these problems)
☐ Diabetes _____ ☐ Heart Disease _____ ☐ Kidney Disease _____
☐ Hypertension _____ ☐ Stroke _____ ☐ Mental Illness _____
☐ Rheumatology _____ ☐ Bleeding Disorder _____ ☐ Cancer _____
☐ Other Family History: _____

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Welcome to the office of Eric M. Kagel, M.D. and thank you for choosing us as your healthcare provider. The following is a guideline to help you understand our financial policy.

PATIENT INFORMATION

Your Personal Information sheet is an important part of your medical record. We may ask that you update this information at each visit to keep this data current. While this may seem inconvenient, it is necessary to know your insurance and contact information, as these are subject to frequent changes. Please bring your insurance card as proof of coverage to each of your visits.

PAYMENT FOR SERVICES

You are responsible for paying your co-payment, if applicable, at your visit before seeing the doctor. If we participate as providers for your health plan, we will bill your insurance company. If we are not contracted with your insurance company, you are responsible to pay your visit after the services are rendered, and you may then submit your claim to your insurance company for reimbursement. Your copy of the superbill may be used for this purpose.

YOUR INSURANCE POLICY

It is necessary for you to know the specific details of your own health plan coverage and to determine if we participate as a contracted provider. Our office contracts with many insurance companies and coverage varies greatly. It is especially important for you to notify us if there are restrictions regarding referrals for services to be performed by other specialist or outside facilities such as laboratories, pathologist, or radiologists. You will be responsible for all charges for services rendered including injections and medical supplies if your insurance company denies payment.

BILLING

Our billing department (BASS MEDICAL GROUP) follows all federal and state guidelines regarding laws of privacy and fraud. In the event of collection proceedings, I agree to pay any and all collection and legal fees in addition to any outstanding balance I owe. I further understand that balances not paid within 90 days from the date they are deemed your responsibility and will be referred to an outside collection agency, and I will be responsible for any attorney's fees, collection expenses and interest. I also understand that this account will be listed with local and national credit bureaus.

OTHER FEES FOR SERVICE

ADMINISTRATIVE FEES WILL CHARGED IN THE FOLLOWING SITUATIONS:

Returned checks and collection fees:	$25.00
Disability Forms:	$25.00

RELEASE OF MEDICAL RECORDS

Copies of medical records must be requested in person, due to confidentiality laws and HIPPA guidelines. A 48-hour advance notice is needed for medical records requests.

Medical records copying:	$15-$25
X-rays loan only, this is fully refundable upon return of all films	$100

BECAUSE CONSIDERABLE TIME AND EFFORT IS INVOLVED, THE FOLLOWING FEES MAY APPLY FOR LATE CANCELLATIONS OR FAILURE TO KEEP AN APPOINTMENT:

$100.00 if cancellation is made less than 72 hours prior to surgical procedures.
$ 75.00 if cancellation is made less than 24 hours for in-office procedures.
$ 50.00 for no show appointment

CLINICAL FEES MAY BE CHARGED IN THE FOLLOWING SITUATIONS:

After hours or on call M.D. advise or treatment: as determined individually by the M.D.

Your signature below indicates that you have read, understand, and agree to comply with this Financial Policy.

Signature _____ Date _____

Printed Name _____

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Consent to Treat

I hereby acknowledge that I or the child entrusted to me need medical care and treatment, and I authorize and consent Eric Kagel, MD, Division of Bay area Surgical Specialists, Inc. and its physicians and providers to perform medical services. I consent to the use of diagnostic and therapeutics means to treat the medical condition, including but not limited to examination, radiographs, local anesthetics, injections, bracing, casting, laboratory tests, physical therapy and diagnostic imaging.

Patient Name:	Signature:
Relationship (If signing for minor):	
Date:	

Assignment of Benefits

I hereby assign and transfer to Eric Kagel, MD Division of the Bay Area Surgical Specialist, Inc. the benefits, monies and sums or other credits payable to myself or child for treatment of their medical condition, or other insurance policy, or any other state, federal or private insurance policy which might be applied towards payment of or reimbursement for any and all services rendered or goods supplied as a result of treatment contemplated by this agreement. If for any reason I am unable to assign or transfer such rights, I hereby authorize and appoint Bay Area Surgical Specialists, Inc. as my agent with respect to the pursuance, receipt and application of such funds as it sees fit.

I understand that I am financially responsible to pay in full in the event that my health insurance does not reimburse in full for services rendered.

Medicare Authorization: I certify this information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request the payment of authorized benefits be made on my behalf Eric Kagel, MD and its physicians and providers rendering service during my treatment(s).

I understand that Bay Area Surgical Specialist, Inc. does not participate in the Medi-Cal Program, and that patients will be financially responsible for services rendered.

I understand that I may be referred for professional services to other facilities and Physicians and providers that are not employees or agents of Bay Area Surgical Specialist, Inc. Examples would include outpatient surgery centers, hospitals, anesthesiologists, physical therapists, medical supply company's cryotherapy unit companies, MRI facilities and laboratories. Bay Area Surgical Specialists, Inc. is not responsible for the acts or omissions of these facilities or practitioners. The financial relationship will be between the patient and the facility or provider and not Eric Kagel, MD Division of Bay Area Surgical Specialists, Inc.

Patient Name:	Signature:
Relationship (If signing for minor):	
Date:	

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Authorization to use or disclose my health information

Note: This is a legal requirement for patient privacy. Your medical information will not be used for marketing purposes

Eric M Kagel, MD Division of Bay Area Surgical Specialists, Inc. may disclose medical health information only to:

Name	Relationship (family, friend)
Address:	Phone
Signature of Patient or authorized representative	Date

Acknowledgement of receipt of privacy notice

I acknowledge that I have received a copy of the privacy notice of Eric M. Kagel Division of Bay Area Surgical Specialists, Inc.

Signature of Patient or Representative	Print Name of Signer	Date

This section is mandated by the State of California

Notice to Consumers:

Medical Doctors are licensed and regulated by the Medical Board of California.

(800) 633-2322 www.mbc.ca.gov

I acknowledge that I understand that physicians are licensed and regulated by the Medical Board of California.

Signature of Patient or Representative	Date

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HIPAA/NOTICE OF PRIVACY PRACTICES

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 of 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 test, 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 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 patients 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 nay 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 our 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.