LAS VEGAS SURGICAL ASSOCIATES

Peter A. Caravella, MD FACS
Eddy H. Luh, MD FACS
Anne O'Neill, MD FACS FRCS
Yogesh K. Patel, MD FACS

8930 W. Sunset Rd. #250, Las Vegas, NV 89148
Tel (702) 202-2000 Fax (702) 202-3448

PATIENT INFORMATION

Patient Name (Last, First MI): _____ DOB: _____ Age: ____

Address (Street-City-State-Zip): _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security No.: _____ Marital Status: _____ Race/Ethnicity: _____

Employer Name: _____ Employer Phone: _____ Occupation: _____

Employer Address: _____

Spouse's Name (Last, First MI): _____ DOB: _____

Social Security No.: _____ Spouse's Cell/Work Phone: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Who is financially responsible for this bill? _____

Referring Doctor: _____ Doctor's Phone: _____

****If patient is a minor**** Legal Guardian Name: _____ DOB: _____

Relationship: _____ Phone: _____

Address (Street-City-State-Zip): _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Phone #: _____

Address (Street-City-State-Zip): _____

Name of Insured: _____ Relationship: _____

ID Number: _____ Group Number: _____

Secondary Insurance Name: _____ Phone #: _____

Name of Insured: _____ Relationship: _____

ID Number: _____ Group Number: _____

****If WORKMAN'S COMP**** DOI: _____ Adjustor Name & Phone: _____

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PATIENT HISTORY

Patient Name: _____ Age: _____ Date: _____

Referring Doctor: _____ Phone#: _____
Primary Care Doctor: _____ Phone#: _____
OB/GYN: _____ Phone#: _____
Oncologist: _____ Phone#: _____
Radiation Oncologist: _____ Phone#: _____
Cardiologist: _____ Phone#: _____
Lung Doctor: _____ Phone#: _____

Height: _____ Weight: _____ Fever? Y / N

Month/Yr of last mammogram: _____ Location: _____ Do you have films: _____
Month/Yr of last menstrual period: _____ Menopause Yr: _____ Hysterectomy Yr: _____

Allergic to any medications? Y / N If so, please list: _____

Allergic to iodine or shellfish? Y / N

Are you taking an oral contraceptive? Y / N If yes, for how long? _____

Do you have any metals or pacemakers? Y / N

Are you on dialysis? Y / N

Have you ever smoked? Y / N How many per day?____ For how many years?____

Do you consume alcohol? Y / N How often? _____

List all prior surgeries and procedures (i.e. back surgery, tonsils, gallbladder, etc):
_____
_____

List all prior illnesses (i.e. high blood pressure, diabetes, anxiety, migraines, etc):
_____
_____

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BREAST HISTORY

Patient Name: _____ Age: _____ Date: _____

CHIEF COMPLAINT Please circle all that apply:

BREAST LUMP	BREAST PAIN	ABNORMAL MAMMOGRAM
BREAST SWELLING	NIPPLE DISCHARGE	DIAGNOSIS OF CANCER
BREAST REDNESS	BREAST ABSCESS	BREAST SKIN CHANGES

Breast / Family History:

History of breast biopsies:	Y	N	Date of biopsy: _____
History of breast surgeries:	Y	N	Date of surgery: _____
Do you have a history of breast problems?	Y	N	
Do you examine your breasts every month?	Y	N	
Do you have breast implants?	Y	N	
Any nipple discharge?	Y	N	
Any changes in your nipple?	Y	N	
Have you had a hysterectomy?	Y	N	
If yes, are your ovaries still present?	Y	N	
Are you on hormone replacement therapy?	Y	N	If yes, for how long? _____

Have you ever been diagnosed with any of the following:

Breast mass	Y	N
Fibrocystic (lumpy) breasts	Y	N
Breast Cancer	Y	N
Cancer other than breast	Y	N
Benign growths	Y	N
Cysts on the breast	Y	N
Chest/Breast trauma	Y	N
Breast abscess	Y	N

Recent Work-Up:

Ultrasound	Y	N	Date: _____
Mammogram	Y	N	Date: _____
Liver Scan	Y	N	Date: _____
Blood Work (CBC)	Y	N	Date: _____
Blood Work (CHEM)	Y	N	Date: _____
Breast Gene Testing (BRCA1)	Y	N	Date: _____
Breast Gene Testing (BRCA2)	Y	N	Date: _____

HEREDITARY CANCER QUESTIONNAIRE

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Gender (M/F): _____ **Today's Date(MM/DD/YY):** _____ **Healthcare Provider:** _____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☑Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	-------	---	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER *(Female or Male)*							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	UTERINE (ENDOMETRIAL) CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME COLON POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid, Prostate*						

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Hereditary Breast and Ovarian Cancer Syndrome - Red Flags*

Personal and/or family history† of:

- ☐ Breast cancer diagnosed before age 50
- ☐ Ovarian cancer
- ☐ Two primary breast cancers
- ☐ Male breast cancer
- ☐ Triple Negative Breast Cancer
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer‡§
- ☐ Three or more HBOC-associated cancers at any age‡§
- ☐ A previously identified HBOC syndrome mutation in the family

†Close blood relatives include first-, second-, or third-degree in the maternal or paternal lineage

‡In the same individual or on the same side of the family

§HBOC-associated cancers include breast (including DCIS), ovarian, pancreatic, and aggressive prostate cancer

Hereditary Colon Cancer - Red Flags*

An individual with any of the following:

- ☐ Colorectal or endometrial cancer before age 50
- ☐ MSI High histology before age 60¶
- ☐ Abnormal MSI\IHC tumor test result (colorectal/endometrial)
- ☐ Two or more Lynch syndrome cancers** at any age
- ☐ Lynch syndrome cancer** with one or more relatives with a Lynch syndrome cancer^
- ☐ 10 or more cumulative colorectal adenomas at any age

An individual with any of the following family histories:

- ☐ A first- or second-degree relative with colorectal or endometrial cancer before age 50
- ☐ Two or more relatives with a Lynch syndrome cancer**, one before the age of 50^
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age^
- ☐ A previously identified Lynch syndrome, MAP, AFAP, or FAP syndrome mutation in the family
- ☐ One or more relatives with 10 or more cumulative colorectal polyps (adenomas) at any age

¶MSI High histology includes: Mucinous, signet ring, tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, or medullary growth pattern

***Lynch syndrome-associated cancers include colorectal, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas*

^Cancer history should be on the same side of the family

**Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com*

Hereditary Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: _____ Date: _____

Healthcare Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment: _____

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MEDICATION LOG

Patient Name: _____ Date: _____

Pharmacy: _____ Phone#: _____

Allergies: _____

MEDICATION	DOSAGE (MG)	HOW OFTEN? (# OF TIMES/DAY)	FOR WHAT DISEASE?

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MEDICATION POLICY

If you are prescribed medication during your care and treatment, there are several guidelines which you must follow.

1. The medication given to you should be taken as prescribed by your doctor. The medications may not be used for any other purposes than that for which they were given to you. These medications may not be given or sold to any other individual.

2. You will be given a specific amount of medication to last a specific length of time. You must keep track of your medications to make sure you do not run out before the specified time. It is your responsibility to have follow-up appointments scheduled far enough in advance so you do not run out of medication.

3. Requests for medication refills will only be considered during regular office hours (8:00 a.m. to 5:00 p.m.). No refills will be given after regular office hours, on weekends, or on holidays. In addition, please be advised: **No request for any refills are processed on Friday afternoons.**

4. Requests for medication refills should be called into your pharmacy who will in turn call our office. **Please allow 48 hours for this process**. If you have not had a follow-up appointment for some time, your refill will need to be reviewed by your physician and may not be refilled until you have been seen again.

5. No new refills or medications will be given if you have not been seen for three (3) months. It is your responsibility to make a follow-up appointment with our office.

6. If you call for medication or refills outside of regular office hours, you will be instructed to go to the emergency room. There you will be evaluated by an emergency room physician who will decide whether or not to refill your medication. Emergency department policy regarding medication refills is typically very strict, and there is no guarantee that you will get your refill. If the emergency department is busy, you may have to wait a long period of time to be seen.

7. While under the doctor's care, all pain medications will be given at the doctor's discretion. If you have received pain medications from another doctor, please notify us. **Breaking these rules may be grounds for termination of your treatment.**

Signing below indicates that you understand and accept the policies outlined above regarding your pain medications.

Signature: _____ Date: _____

Printed Name: _____

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IMPORTANT OFFICE PROTOCOLS

COPAYMENT / COINSURANCE / DEDUCTIBLE
Copayment or coinsurance is due at the time of visit. There are no exceptions. In addition to this payment, we will collect fees that will be applied towards your deductible. Please check with your insurance company for the correct amount. Initials _____

SURGERY COPAYMENT / COINSURANCE
To avoid cancellation, copayment or coinsurance is due in full one week prior to your scheduled surgery. There are no exceptions. Please check with your insurance company for the percentage that you are responsible for. Initials _____

LATE APPOINTMENTS
You are considered late if you arrive 15 minutes past your scheduled appointment. Your appointment will be cancelled and rescheduled to another day. Initials _____

RESULTS / FOLLOW-UPS
Results are not given over the phone. There are no exceptions. You must return to the office to discuss results with your doctor. You are responsible for scheduling your own follow-up appointments with our office after all biopsies, surgeries and radiology studies are performed. Initials _____

RADIOLOGY ORDERS
You are responsible for scheduling your own radiology appointment. Las Vegas Surgical Associates will give you a copy of the referral and contact information. Referrals will only be made if Dr. O'Neill has authorized the test at your last visit. Without a written order from your physician, Las Vegas Surgical Associates will not send out a referral. Initials _____

FORM COMPLETION (FMLA, INSURANCE, DISABILITY FORMS)
After surgery, most employers require the completion of several forms to excuse you from working. You are responsible for providing these forms to the physician. Patient section must be filled out by you. Please note these forms can only be completed after the scheduled surgery date. Las Vegas Surgical Associates does not fax to companies. There is a $15 fee for each form submitted to LVSA. Initials _____

TREATMENT OF STAFF
At the discretion of the physician, you will be discharged from our care if you act in an abusive manner to the staff. Initials _____

By signing this contract, you as our patient, agree to be an active participant in your care. In agreeing to do so, you acknowledge an understanding that you may be discharged from our care at the discretion of the physician if any of the above terms are not followed. Initials _____

I FULLY UNDERSTAND AND ACCEPT THE TERMS STATED ABOVE.

Signature: _____ Date: _____

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CONSENT & ACKNOWLEDGEMENT FOR TREATMENT

I, _____, understand that as part of my healthcare, Las Vegas Surgical Associates originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a 3rd party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I hereby authorize treatment of the person named above by the Las Vegas Surgical Associates. I give the Las Vegas Surgical Associates authorization to disclose to the following individuals information regarding my treatment.

Name: _____ Relationship: _____
Name: _____ Relationship: _____

I give my consent for a representative of the office of Las Vegas Surgical Associates to speak to an interpreter on my behalf. Initials _____

I fully understand and **accept** the terms of this consent.

Signature: _____ Date: _____

I **decline** the terms of this consent.

Signature: _____ Date: _____

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AGREEMENT OF FINANCIAL RESPONSIBILITY

I/We agree to pay all collection expenses Las Vegas Surgical Associates may incur in collection or delinquent balance, plus $25.00 returned check fee, attorney's fees, court costs, filing fees, including charges or commissions that may be assessed by any collection agency retained to pursue this matter. Collection fees will be 40% for regular collections and 50% for legal collections or forwards, which may be as much as twice the original principal balance owed. Patient further agrees to pay an interest rate of 2% per month, 24% per year from the first date the account becomes delinquent.

Credit information must be used for permissible purposes only. Unauthorized access is a crime and may result in criminal prosecution. Customers are required to retain supporting documentation for each transaction.

I/WE CERTIFY WE HAVE READ AND UNDERSTAND ALL THE INFORMATION PROVIDED. I/WE CERTIFY THE INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY/OUR KNOWLEDGE.

_____

Signature of Responsible Party Social Security No. Date

HIPPA COMPLIANCE: Our office, staff and associates are conversant with and abide by the rules, regulations and statutes relevant to the protocols of law regarding the Federal Law Governing the Protection of Individual Consumer Privacy.

PRIVACY POLICY: We do not share "Non Public Information" with any "Third Parties or Entities". All information provided shall be kept confidential.

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AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

This authorization authorizes the release of Protected Health information pursuant to 45 CFR Parts 160 & 164.

By signing below, I authorize Las Vegas Surgical Associates to use and disclose a copy of my protected health information.

_____

(Name and address of recipient)

For the purpose of: _____

- I understand I have the right to refuse to sign this authorization.
- I have the right to revoke this authorization in writing at anytime. Any uses or disclosures already made with my permission cannot be taken back.
- To revoke this authorization, please send a written statement to Las Vegas Surgical Associates.

Signature: _____ Date: _____

Print Patient's Name: _____

Date of Birth: _____ SSN: _____

RELEASE OF MEDICAL RECORDS, FINANCIAL AGREEMENT & AUTHORIZATION OF TREATMENT

- I HEREBY AUTHORIZE TREATMENT OF THE PERSON SIGNING BELOW BY LAS VEGAS SURGICAL ASSOCIATES.

- I authorize Las Vegas Surgical Associates to release to my insurance company(s) any information including the diagnosis and record of any treatment or examination rendered to me during my care. I request that payment of authorized Medicare or private insurance benefits be made on my behalf to Las Vegas Surgical Associates for any services furnished me.

- Should there be insurance benefits available, I accept full responsibility for all my bills incurred.

Signature: _____ Date: _____

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 Nevada law, and not by a lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are voluntarily giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Article 2: **All Claims Must Be Arbitrated**: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, 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.

Filing by Physician 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 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 notice or demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator to preside over the matter who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Nevada Revised Statutes (NRS) 38.206 – 38.248, 41A.035, .045, .097, .100, .110, .120, 42.005 and .021 and the Federal Arbitration Act (9 U.S.C. §§ 1-4), and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees and expenses, along with a pro rata share of the arbitrator's fees and expenses, and hereby waive the provisions of NRS 38.238.

Article 4: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 5: **Severability Provision**: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with Nevada and federal law.

Article 6: **Condition of Treatment:** I understand that signing this arbitration agreement is not a condition of my receiving medical treatment.

I understand that I have the right to receive a copy of this 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.

_____ ***INITIAL HERE TO INDICATE THAT YOU HAVE BEEN GIVEN THE DOCUMENT TITLED "A BRIEF LOOK AT ARBITRATION FOR THE PATIENT."***

By: _____
Physician or Duly Authorized Representative Signature (Date)

By: _____
Patient's Signature (Date)

By: _____
Print or Stamp Name of Physician, Medical Group or Association Name

_____
Print Patient's Name

By: _____
Signature of Translator (if applicable) (Date)

By: _____
Patient's Representative's Signature (if applicable) (Date)

_____
Print Name of Translator

_____
Print Name and Relationship to Patient

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

PREMIER PHYSICIANS
INSURANCE COMPANY
A Risk Retention Group

A BRIEF LOOK AT ARBITRATION FOR THE PATIENT

Introduction

Arbitration is an alternative dispute resolution procedure that has been endorsed by such groups as the California Medical Association, and noted to be a favored method of resolving disputes by the United States Supreme Court.

If you are unfamiliar with arbitration in general the information included here provides some of the basic principles of arbitration.

What is arbitration?

Arbitration is an alternative way of resolving disputes. Instead of taking your disagreement through the long and expensive process of court litigation, you and the doctor agree in advance to submit any disputes to an arbitrator for his or her determination. The arbitrator is selected from among the numerous retired judges who are available and qualified to serve on these matters, and is mutually agreed upon by both you and the doctor. After the arbitration hearing, which is usually less formal than a court proceeding, the arbitrator makes the decision ("award"). Although the procedures are different, generally the same laws and same measure of damages which apply in court proceedings also apply in arbitration.

Does arbitration prevent you from making a claim?

No. By selecting arbitration as the means to resolve a disagreement, all you are essentially doing is moving the claim to a different forum (i.e., from a jury to an arbitrator) to hear and ultimately decide your claim.

Does it prevent you from obtaining a financial award?

No. Arbitration does not restrict or prevent you from obtaining a financial award in any manner. If the arbitrator accepts and agrees with your claim he will determine a damage award.

The United States Supreme Court has, in fact, previously held that arbitration is strongly favored as an expeditious and economical alternative to the court system.

May I be represented by an attorney of my choice?

Yes. Any party to arbitration may be represented by an attorney of his or her choice, at his or her own expense. The arbitrator will hear the facts and decide the matter whether or not the parties are represented by lawyers.

Who is bound by this agreement?

If you choose to sign the arbitration agreement, you will be agreeing to bind yourself and anyone who could bring suit in connection with treatment or services provided to you by the doctor. If you sign on behalf of a family member or some other person for whom you have responsibility, you will bind that person as well as anyone who could sue in connection with treatment or services provided to that person by the doctor. Likewise, the doctor or anyone suing on behalf of the doctor is bound.

What does arbitration cost?

In general, arbitration is less expensive than court actions. The arbitrator's fees are ordinarily shared equally by the parties. The amount of those fees will depend upon the complexity and length of the case.

If either party does not like the arbitration result, could there still be a jury trial in court?

Generally, the answer is "no". The whole purpose of arbitration is to avoid the expense, delay and inconvenience of going to court. Arbitration awards may be reviewed, and potentially *reversed* ("vacated") by a court in limited circumstances.

A Message to Our Patients About Arbitration

The attached contract is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the courts.

By signing this agreement you are substituting an arbitrator for a jury to resolve your claims. You can still call and question witnesses, present evidence, and have an attorney of your choice, at your expense. This agreement generally helps to lower litigation time and costs for both patients and physicians. Further, both parties are spared the rigors of a trial and the publicity that may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.