

CAREY B. STROM, M.D.
8631 West 3rd Street, Ste. 1017E, Los Angeles, CA 90048

Account No.	<h2 style="margin: 0;">Patient Registration</h2>			Date
Personal Information				
Patient Name (Last, First, MI)			Address	
Social Security#			City, State	Zip Code
Date of Birth	Sex	Home Phone	Cell Phone	
Martial Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other			E-Mail Address	
Primary Language			Your Regular Physician	Phone No.
Ethnicity Race Religion			Referring Physician	Phone No.
Employment Information				
Employment Status (Circle One)				
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employment <input type="checkbox"/> Not Employed <input type="checkbox"/> Retired (Date) <input type="checkbox"/> Student				
Name of Employer/Union/Guild			Occupation	Work #
Employer Address			Employer City, State, ZIP	
Additional Information				
Driver's License State	Mother's Maiden Name		Place of Birth City & State	Pharmacy Name
Driver License ID	Patient's Maiden Name		Pharmacy Phone	
Emergency Contact				
Name	Relationship	Home Phone	Work Phone	
Address, City	State, Zip Code	Legal Guardian <input type="checkbox"/> Yes <input type="checkbox"/> No	Cell Phone	

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Insurance Information				
Primary Insurance		Code	Subscriber ID#	Phone Number
Effective Date	Subscriber Name & Date of Birth		Group#	Group Name
Primary Insurance Claim Address				
Secondary Insurance		Code	Subscriber ID#	Phone Number
Effective Date	Subscriber Name & Date of Birth		Group#	Group Name
Secondary Insurance Claim Address				
Third Party Billing (Or Remarks)				
Street Address		City, State		Zip Code

- AUTHORIZATION TO PAY -

I hereby authorize my insurance provider to pay the physician responsible for my care directly. **I understand that Carey B. Strom, M.D. is not a contracted provider of any insurance policies other than Medicare, but as a courtesy will bill my insurance for the out of network benefits where applicable** and authorize the release of my medical records to my third party payer in order to obtain payment. I fully understand that my insurance may not cover all of the charges and that I am responsible for payment of my account. In the event that my insurance policy issues payment to me, I agree to forward full payment to the rendering physician immediately. I further understand that in the event that my account remains unpaid after 120 days it will be subject to a 6% interest charge.

SIGNATURE: _____ **DATE:** _____

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NOTICE OF PRIVACY PRACTICES

To Our Patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent serious threat to your health and safety or the health and safety of another individual or the public. We shall only make disclosures to a person or organization able to help prevent a threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request, however, if we do agree, we are bound by our agreement except when otherwise required by law, emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Office Manager.

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4. You may ask us to amend your health information if you believe it is incorrect or incomplete and as long as the information is kept for or by our practice. To request an amendment, your request must be in writing and submitted to the Office Manager. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice, or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. If you have any questions regarding this notice or our health information privacy policies, please contact the Office Manager.

I, hereby acknowledge that I have been presented with a copy of Carey B. Strom, M.D., Notice of Privacy Practices.

Signature _____

Print Name _____

Date _____

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Patient Record of Disclosures

In general, the HIPAA privacy rule gives the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

HOME TELEPHONE # _____

_____ Ok to leave message with detailed information

_____ Leave message with call back number only

WORK TELEPHONE # _____

_____ Ok to leave message with detailed information

_____ Leave message with call back number only

CELLULAR TELEPHONE # _____

_____ Ok to leave message with detailed information

_____ Leave message with call back number only

WRITTEN COMMUNICATION

_____ Ok to mail to my home address

_____ Ok to mail to my work/office address

_____ Ok to fax to this number _____

If you would like to give our office permission to discuss your protected health information and your account/billing information with your spouse or any other individual, PLEASE LIST THE NAMES OF THOSE INDIVIDUALS HERE:

OTHER INSTRUCTIONS _____

Patient Signature _____ Date _____

Print Name _____ Date of Birth _____

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HEALTH HISTORY QUESTIONNAIRE – GASTROENTEROLOGY

Patient Name: _____

MRN: _____

Date of Appointment: ____/____/____ (mm/dd/yy)

Please fill this form out as completely as possible.

PAST MEDICAL HISTORY – *place a checkmark in the box next to any medical problems you have had in the past*

Anemia	Diabetes	Lactose Intolerance	
Anxiety/Depression	Diverticulitis	Liver Disease	
Barrett’s Esophagus	Heart Disease	Lung Disease	
Bleeding Disorder	Heartburn	Pancreatitis	
Bowel Obstruction	Hemorrhoids	Sleep Apnea	
Cancer	Hepatitis A	Stroke	
Type:	Hepatitis B	Thyroid Disease	
Celiac	Hepatitis C	Ulcer	
Cirrhosis	High Blood Pressure	Ulcerative Colitis	
Colon Polyps	Irritable Bowel Syndrome	Other (please specify below)	
Crohn’s Disease	Kidney Disease		

PAST SURGICAL HISTORY – *place a checkmark in the box next to any surgeries you have had and the date of surgery if you know it*

Appendectomy	Coronary Artery Surgery	Stomach Surgery	
Bowel Resection	Gallbladder Surgery	Thyroid Surgery	
Breast Surgery	Heart Surgery	Other (please specify below)	
Colon Surgery	Obesity Surgery		

IMMUNIZATIONS: If yes, give the approximate year given

- Pneumococcal Date _____
- Hepatitis A Date _____
- Hepatitis B Date _____
- Tetanus Date _____

Have you ever had a colonoscopy?

- Yes No Date _____

Findings _____

Have you ever had an upper endoscopy?

- Yes No Date _____

Findings _____

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MEDICATIONS – Please list any medication(s) you currently take, including over-the-counter medications

Name	Dose (mg, number of tablets, etc)	How often (once a day, twice a day, only as needed, etc)

ALLERGIES

Do you have any allergies to medications, Latex, or foods?
Please list them along with reaction. If none, please write none.

SOCIAL HISTORY

Tobacco Use

- Never smoked
- Former smoker
- Every day smoker
- Heavy smoker
- Light smoker
- Passive smoke exposure – secondhand smoke

Alcohol Use

Do you ever drink alcohol? Yes / No
If yes, please indicate the type and quantity per week:

Drug Use

Do you use recreational drugs? Yes / No
If yes, please indicate what type:

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FAMILY HISTORY – *place a checkmark to report problems your family members have had. Please state the age when they had the problem, if you know it.*

I was adopted, so I do not know my family history.

	Mother	Father	Sister	Brother	Son	Daughter	Other
	Alive?	Alive?	Alive?	Alive?	Alive?	Alive?	
Barrett's Esophagus							
Bleeding Problem							
Celiac Disease							
Colon Cancer							
Colon Polyps							
Crohn's Disease							
Diabetes							
Esophageal Problems							
Esophageal Cancer							
HIV/AIDS							
Hemorrhoids							
H-Pylori							
Irritable Bowel Syndrome							
Lactose Intolerance							
Liver Disease							
Pancreas Disease							
Psychiatric Disease							
Stomach Cancer							
Reflux							
Ulcerative Colitis							

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310-550-0400
310-285-0482 Fax
www.doctorstrom.com

MEDICAL RECORD RELEASE AUTHORIZATION

TO: _____
(DOCTOR/OFFICE/HOSPITAL)

(ADDRESS/FAX NUMBER)

I, * _____ give my authorization to release all my medical records
to the following person:

Carey B. Strom, M.D., FASGE
8631 West 3rd Street, Ste. 1017E,
Los Angeles, CA 90048
Or
Fax to office at 310-285-0482

*Name of patient _____

*Address _____

*Birthdate _____

*Signature _____

*Date _____

***Fill these sections only**

CAREY B STROM MD
8631 West 3rd St, Suite 1017 E
Los Angeles CA 90048

Please Only Fill If You Are A Non-Medicare Patient

PHYSICIAN NETWORK STATUS

I understand that Dr. Carey Strom is an OUT OF NETWORK provider and all procedures will be billed at an OUT OF NETWORK rate. I understand that Dr. Strom will submit an insurance claim on my behalf for the OUT OF NETWORK benefits as a courtesy.

INITIALS _____

ANESTHESIA SERVICES

I understand that my insurance may not cover anesthesia services and that I am responsible for the payment of all anesthesia related charges. I understand that the anesthesia fee is separate from all other fees and that I will be responsible for payment at the time of service or will be billed at a later date.

INITIALS _____

LABORATORY SERVICES

I understand that if Dr. Carey Strom determines that specimens from my procedure need laboratory testing, I will receive a separate bill from the laboratory and I am responsible for any charges incurred.

INITIALS _____

PATHOLOGY SERVICES

I understand that if Dr. Carey Strom determines that biopsies are to be taken during my procedure, I will receive a separate bill from the UCLA Department of Pathology for the processing of the slides. I understand I will also receive a separate bill from Tower Pathology Associates for the reading of the slides.

INITIALS _____

FACILITY SERVICES

I understand that Doheny Endosurgical Center is NOT contracted with my insurance and that all facility use fees will be billed at an OUT OF NETWORK rate. I understand that this bill is separate from all others and it is my financial responsibility.

INITIALS _____

There is a 3% credit card fee.

INITIALS _____

Patient's Signature

Date

Patient's Printed Name

Carey B. Strom, M.D. has financial interest in
The Surgery Center of Beverly Hills

Please Only Fill If You Are A Medicare Patient

Patient Name:

Date:

Advanced Beneficiary Notice of Noncoverage (ABN)

NOTE: Medicare may not cover the services listed below and you may receive a separate bill from your doctor.

1. **Email access** to our office to assist you in scheduling, pre-certifying, and other non-medical administrative questions or concerns.
2. Enhanced access to the physician such as same-day appointments, before or after hours appointments, phone call consultations, and prescription refills **in lieu of making an appointment.**
3. **Assistance in completing forms** such as claims appeals, non-formulary drug approval, or writing medical excuses to airlines and hotels to help avoid cancellation fees.
4. Notification of non-urgent labs or x-rays by phone fax or email **without an appointment** when appropriate.
5. **Pre-authorization** of medical testing and treatment.
6. **Photocopying and providing medical records** to physicians and insurance companies at no extra charge.
7. **Waiver of the \$100 fee** for missed appointments and lack of 24 hour cancellation notice.
8. **Endoscopies and colonoscopies may not be covered either unless medically indicated.**

WHAT YOU NEED TO KNOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading this ABN.

Signature:	Date:
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