DANIEL R. MARCUS, M.D.
GENERAL SURGEON • MINIMALLY INVASIVE & ROBOTIC SURGERY

4640 Admiralty Way, Suite 1020
Marina Del Rey, CA 90292
P: 310-305-1813

Date: _____

Name: _____ Age: _____ DOB: _____/_____/_____

Address: _____ Home Tel: (_____) _____

City _____Zip_____ Wk Tel: (_____) _____

Email: _____ Cell: (_____) _____

Referring Physician: _____ SS# _____

Primary Care Physician: _____ Telephone: _____

Pharmacy _____ Telephone: _____

How did you hear about Dr. Marcus? _____

Have you been to our website? _____ was our website helpful? ☐No ☐Yes If No, pls. list reason:

_____

What is the reason for your visit today? _____

Please describe why you are interested in having the procedure(s) listed above:_____

_____

_____

Have you consulted with other physicians about procedure(s) indicated above: ☐No ☐Yes

If yes, please describe your understanding of the procedure(s) _____

Is this procedure a revision from a previous surgery ☐No ☐Yes If yes, how many previous surgeries? _____

What is your "ideal time frame" for procedure(s) completion _____

Employer _____ _____ Occupation_____

Emergency Contact Name: _____ Phone Number_____

Marital Status: _____

Primary Insurance Co. _____ Policy # _____

Group # _____ Name of person insured _____ SS# _____

Providers Phone # _____ Copay _____

Secondary Insurance Co. _____ Policy # _____

Group # _____ Name of person insured _____ SS# _____

Providers Phone # _____ Copay _____

HEALTH INFORMATON

Personal Past History:
Do you have any chronic medical problems? (Circle all that apply)

High Blood Pressure	Diabetes	Cancer
Heart Disease	Kidney Disease	HIV or AIDS
Heart Failure	Psychiatric Diagnosis	Stroke
Seizures	Bleeding Problems	Hepatitis
Heart Attack	Liver Disease	Emphysema
Chest Pain	Gastric Reflux	Stomach Problems
	Asthma	Other _____

Is there a personal or family history of anesthetic complications? ☐No ☐Yes

If yes, please explain_____

Family History:
Do you have a family history of any medical problems? (Circle all that apply) Please indicate family member.

High Blood Pressure	Diabetes	Cancer
Heart Disease	Kidney Disease	HIV or AIDS
Heart Failure	Psychiatric Diagnosis	Stroke
Seizures	Bleeding Problems	Hepatitis
Heart Attack	Liver Disease	Emphysema
Chest Pain	Gastric Reflux	Stomach Problems
	Asthma	Other _____

Please list all prior operations:	Date	List any complications
1._____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Please list all prior Hospitalizations:	Date	List any complications
1._____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Please list **ALL** medications and/or dietary supplements including:
(Prescriptions, Over the Counter Medicines, Aspirin, Vitamins and Herbal Supplements such as Fish Oil, Saw Palmetto, Flax Seed Oil and St. John's Wort)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Please list **ALL** allergies and describe reactions: (i.e. Shellfish, Latex, Penicillin, etc).

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Social History:

Have you ever used tobacco products? ☐No ☐Yes If yes, how long? _____ How much? _____
Which tobacco product(s) have you used?_____
If you are a former smoker, state the year you stopped: _____
Past or current use of Nicotine Gum, Patch, or any other type of stop-smoking aid: ☐No ☐Yes
If yes, please list: _____

Alcohol Consumption: _____Never (Do not consume alcohol) _____ Rare (1-2 drinks a week)

_____ Moderate (7-10 drinks a week) _____ Heavy (daily or more than 10 drinks a wk)

Did you ever drink heavily in the past? ☐No ☐Yes
Are you feeling hopeless about the present/future? ☐No ☐Yes
Do you currently have thoughts of harming yourself? ☐No ☐Yes

Review of Systems:

Please answer the following Yes or No questions to the best of your ability. Do you have any of the following conditions, illnesses or symptoms?

CARDIOVASCULAR

High Blood Pressure	Y ___ N ____	Heart Failure	Y ___ N ____
Heart Attack	Y ___ N ____	Irregular Heartbeat	Y ___ N ____
Angina/chest pain	Y ___ N ____	Heart Murmur	Y ___ N ____
Heart bypass surgery	Y ___ N ____	Do you exercise?	Y ___ N ____
Pacemaker	Y ___ N ____	Comments: _____	

NEUROLOGICAL

Stroke	Y ___ N ____
Seizures	Y ___ N ____
Fainting	Y ___ N ____
Dizziness	Y ___ N ____
Headache	Y ___ N ____
Double Vision	Y ___ N ____

PSYCHIATIC

Depression	Y ___ N ____
Anxiety	Y ___ N ____
Psychiatric Care	Y ___ N ____
Obsessive Compulsive Disorder	Y ___ N ____

ENDOCRINE

Diabetes	Y ___ N ____
Thyroid Disease	Y ___ N ____
Taken Steroids	Y ___ N ____

HEMATOLOGIC/ONCOLOGIC/

Bleeding Tendency	Y ___ N ____
Easy Bruising	Y ___ N ____
Anemia	Y ___ N ____
Sickle Cell Disease	Y ___ N ____
Blood clots in legs	Y ___ N ____
Blood clots in lungs	Y ___ N ____
Radiation Therapy	Y ___ N ____

URINARY/REPRODUCTIVE

Kidney Disease	Y ___ N ____
Urinary Disease	Y ___ N ____
Dialysis	Y ___ N ____
If female, could you be preg?	Y ___ N ____

Number of live births_____

Number of pregnancies _____

Date of last mammogram _____

Date of date of menses (period)_____

RESPIRATORY

Abnormal Chest X-ray	Y ___ N ____
Asthma	Y ___ N ____
Bronchitis	Y ___ N ____
Emphysema	Y ___ N ____
Recent Chest Infection	Y ___ N ____
Shortness of Breath	Y ___ N ____
Shortness of Breath at night	Y ___ N ____
Shortness of Breath on exertion	Y ___ N ____
Cough	Y ___ N ____
Cough with Sputum	Y ___ N ____
Sleep Apnea	Y ___ N ____
-Use a C-PAP Machine	Y ___ N ____

MUSCULOSKELETAL

Sciatica	Y ___ N ____
Herniated disc	Y ___ N ____
Arthritis	Y ___ N ____
Rheumatoid	Y ___ N ____
Neck, Back, Arm,Leg Prob	Y ___ N ____

INFECTIOUS

GASTROINTESTINAL

Jaundice	Y ___ N ____
Hepatitis	Y ___ N ____
Ulcers	Y ___ N ____
Hiatal Hernia	Y ___ N ____
Heartburn	Y ___ N ____

SKIN

Basal cell skin cancer	Y ___ N ____
Melanoma	Y ___ N ____
Staph Infection	Y ___ N ____

EYES

Cataracts	Y ___ N ____
Glaucoma	Y ___ N ____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to Daniel Marcus, M.D., Professional Corporation, all Medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. If the nature of the disability be such that it is not covered by insurance, I will be responsible to the doctor for payment of the entire bill. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured/Guardian Date

_____ _____

Patient's Signature Date

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PATIENT FINANCIAL POLICY AGREEMENT

We would like to take this opportunity to welcome you to our practice and thank you for choosing Dr. Daniel R. Marcus to provide your surgical care. We appreciate your trust and look forward to keeping you happy and healthy.
As part of our services, we try to contain the rising cost of healthcare. In an effort to do this, we have implemented this Financial Policy which we ask you to read carefully and sign. An original copy of this agreement will be in your medical chart. You may receive a copy of your records if you so desire.

INSURANCE BENEFITS AND COVERAGE

As a courtesy to you our billing service AssetMD, Inc will submit your insurance claim(s) for treatment/procedure(s) rendered at this office or by Dr. Marcus. Please be advised that your insurance policy is a contract **between you and your insurance company**. We are not a party to that contract. If you ever have any questions regarding your coverage and or benefits, please contact your insurance company directly. Ultimately, you are responsible for all costs incurred during treatment with the exception of insurance contracted adjustments. These adjustments are determined by the contract the doctor has with the individual insurance company.

COPAYMENTS, DEDUCTIBLES AND COINSURANCE

We require payment of any co-payments due at the time of service. **We accept cash, check and credit and/or debit cards**. If you have any deductible or coinsurance amounts that need to be met, you will be billed once your insurance has processed and paid their portion of the claim.

UNINSURED PATIENTS AND NON-COVERED BENEFITS

Full payment is due at the time of service. **We accept cash, check and credit and or/debit cards**. In some instances may be made for some patients on a case by case basis with our billing service AssetMD. While we try to accommodate all of our patients our billing service does maintain strict guidelines regarding payment plans.

BALANCE AND STATEMENT

You will receive a statement once a month, if you have a balance owing monies. Failure to pay a balance by the third billing statement will result in your account being turned over to the collection process. If you have made a payment agreement and fail to make two consecutive monthly payments, your account will be turned over to the collection process. **Please note there is a fee of $25.00 plus balance owed for all returned checks.**

AGREEMENT TO ENDORSE CHECK PAYMENT RECEIVED FROM YOUR INSURANCE COMPANY

I understand that Daniel R. Marcus, MD is a non-participating provider with my insurance company and that reimbursement for claims that he submits to my insurance company on my behalf might be paid directly to the patient or the subscriber of my policy.

I agree to endorse to Daniel R. Marcus, MD any check payment I receive from my insurance company for services he rendered by affixing my signature on the back of the check and immediately forwarding it to his office. I also agree to enclose a copy of the explanation of benefits (EOB) to allow for the proper processing of the payment and crediting to my account. If I fail to do so, the collection process will start immediately and possible legal action.

In order to refrain from raising our fees, we must control our costs and maintain efficiency in the business aspect of our practice. We are dedicated to providing you and your family with the best possible care available. We will also attempt to accommodate you whenever possible. If you have any questions, please contact our office and we will be happy to discuss them with you. Thank you for your understanding. We look forward to providing your care.
I have read the Patient Financial Policy; I understand it and agree to its terms.

Patient: _____

Signature: _____ Date: _____

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Financial Policy/Assignment of Benefits

Thank you for choosing Dr. Daniel Marcus for your medical provider. Dr. Marcus is not a participating provider with any insurance plan; by choosing him for your treatment, you are willfully going out of your insurance network.

We require pre-payment in advance of the surgery. Please note that the deposit paid at the time of scheduling is not considered payment in full. The deposit and payment from the insurance carrier will be considered payment in full. In the instance that your claim is processed through the Multiplan Shared Savings Plan, you will be responsible for the amount applied to the out of network deductible and out-of- pocket cost.

Dr. Marcus will file a claim with your insurance company for your procedure. Your signature below indicates that you are assigning benefits to Dr. Marcus so that he may be paid directly by your insurance carrier. In the event that your insurance submits the payment directly to you, your signature indicates that you will forward the full payment received promptly to Dr. Daniel Marcus.

While in some instance pre-certification is required for services, satisfying this requirement is not a guarantee of payment from your insurance carrier. In cases where payment is denied, we may request that you become engaged in assisting our billing department to appeal the payer's decision of non-payment.

Patient: _____

Signature: _____ Date: _____

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NOTICE OF PATIENT INFORMATION PRIVACY PRACTICES

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review it carefully.

LEGAL DUTY

We are required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURE OF HEALTH INFORMATION

We use your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care what we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health benefits that could be of interest of you.

We may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with written authorization to release information, for any reason, you may later revoke that authorization, in writing, to stop future disclosures at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of our personal health information at any time upon signing a release. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

CONCERNS AND COMPLAINTS

If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager. You may also send a written complaint to the US department of Health and Human Services. For further information on our health information practices or if you have a complaint, please contact our office manager or Dr. Marcus.

I have acknowledged that I have reviewed/ received Daniel R. Marcus, M.D.'s Medical Practice Notice of Privacy Practices.

_____ _____

Print Name Date

_____

Patient Signature