Dat Tien Nguyen, M.D., Inc.

Colon and Rectal Surgery
General and Weight Loss Surgery

2324 Santa Rita Road Suite 6, Pleasanton, CA 94566
1262 E. North Street, Manteca, CA 95336

Phone: (925) 460-3205 Fax: (925) 460-3795
Phone: (209) 824-4444 Fax: (209) 815-9813

Information Registration Form

Your name:_____ Gender: □ M □ F Date of Birth: _____
Social security #:_____ Driver license #:_____
Address:_____ City:_____ State/zip: _____
Home phone #:_____ Work phone #:_____
Cellular phone #: _____ E-mail:_____

Employer:_____ Employer's phone #:_____
Employer address:_____ City:_____ State/zip:_____

Reffering physician:_____ Reffering physician's phone #:_____
Reffering physician's address:_____ City:_____ State/zip:_____

Emergency contact name/relationship:_____Phone#:_____
Address:_____ City:_____State/zip:_____

Spouse/parent's name:_____ Phone #:_____
Address:_____ City:_____ State/zip:_____

Spouse/parent's employer:_____ Phone #:_____
Address:_____ City:_____ State/zip:_____

PRIMARY INSURANCE CO:_____ ID#:_____
Subscriber name:_____ SSN:_____ Group#:_____
Address/phone#:_____

SECONDARY INSURANCE CO:_____ ID#:_____
Subscriber name:_____ SSN:_____ Group#:_____
Address/phone#:_____

ASSIGNMENT OF BENEFITS:

I, the undersigned, have insurance coverage with _____ and assign directly to DAT T. NGUYEN, M.D., INC. all surgical and/or 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. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Signature: _____ Date: _____

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Medical Questionnaire

Patient's Name: _____ Age: _____ Main Complaint: _____
Primary Physician/Referring Physician: _____ Phone:_____

Medical History:
Please list past and current medical illnesses: _____
_____
_____
Please list all surgeries you have had:_____
_____
_____
Hospitalization (reasons & dates): _____
_____
_____

Medications:
Current medications and dosages:_____
_____
_____
_____
_____

Medication Allergies:
Please list the names of medication and the reaction:_____
_____
_____

Family Medical History:
Please list affected member and medical illness/cancer: _____
_____
_____

Habits:
Do you currently smoke cigarettes?_____ If no, have you ever smoked cigarettes? _____
When did you quit? _____ How many do or did you smoke daily? _____
Do you drink alcoholic beverages? _____ How many drinks weekly and what type? _____
Have you used illicit drugs? _____ What type? _____ When did you use last? _____

Social History:
Marital status (circle one): Single/Married/Divorced/Widowed
How many children do you have (please include ages): _____

Do you have any of the following conditions:

Skin:
Rash? □No □Yes
Lump? □No □Yes
Unusual change of a mole? □No □Yes

Head & Neck:
Visual problems (besides needing glasses)? □No □Yes
Noes infection? □No □Yes
Noes bleeding? □No □Yes
Sore throat? □No □Yes
Swelling/lump?
-in mouth or oral cavity? □No □Yes
-in neck area? □No □Yes

Cardiovascular/heart-related:
Short of breath:
-at rest? □No □Yes
-with activity? □No □Yes
-lying flat? □No □Yes
Recent chest pain? □No □Yes
Past heart attack? □No □Yes
Congestive heart failure? □No □Yes
Heart valve disease? □No □Yes
Any leg or calf pain w/ walking? □No □Yes

Lung:
Breathing problem? □No □Yes
History of asthma? □No □Yes
Any lung disease caused by smoking? □No □Yes
Recurrent pneumonia? □No □Yes
Recurrent bronchitis? □No □Yes
Recent cough? □No □Yes
Coughing blood? □No □Yes
Sleep apnea? □No □Yes

Gastro-intestinal:
History of liver disease? □No □Yes
History of pancreatic disease? □No □Yes
Swallowing problem? □No □Yes
Heart burn? □No □Yes
Nausea/Vomiting? □No □Yes
Blood in vomit? □No □Yes
Recent change in appetite? □No □Yes
Abdominal bloating? □No □Yes
Abdominal pain? □No □Yes
Diarrhea? □No □Yes
Constipation? □No □Yes
Recent change in bowel habits? □No □Yes
Blood in stool? □No □Yes

Genitalia/Urinary:
History of kidney disease? □No □Yes
History of kidney stone? □No □Yes
Pain with urination? □No □Yes
Blood in urine? □No □Yes
Incomplete emptying of bladder? □No □Yes
Frequent urination? □No □Yes

Genitalia/Urinary (cont.):
Female:
Abnormal vaginal discharge? □No □Yes
Taking birth control pills? □No □Yes
Male:
Testicle lump? □No □Yes

Hematological:
Deep venous thrombosis (clot in veins)? □No □Yes
Pulmonary embolus (clot in lungs) □No □Yes
Bleeding disorders? □No □Yes
History of blood transfusion? □No □Yes

Endocrine:
Diabetes? □No □Yes
Thyroid diseases? □No □Yes
High cholesterol or triglycerides? □No □Yes
Pituitary tumor? □No □Yes
Taking steroid? □No □Yes

Neurological:
History of stroke? □No □Yes
Nerve problems? □No □Yes

Musculo-skeletal:
Degenerative or osteoarthritis? □No □Yes
History of neck pain or problems? □No □Yes
History of back pain or problems □No □Yes
Joint pain?
-Shoulder? □No □Yes
-Hip? □No □Yes
-Knee? □No □Yes
-Ankle? □No □Yes
Muscle lump or swelling? □No □Yes

Infections:
History of bacterial resistance infection? □No □Yes
History of sexually transmitted disease? □No □Yes
History of HIC/AIDS? □No □Yes
History of Hepatitis B or C infection? □No □Yes

General:
Fever? □No □Yes
Night Sweats? □No □Yes
Unexpected weight loss? □No □Yes
Unusual fatigue? □No □Yes

Psychological:
Depression? □No □Yes
Alcohol abuse? □No □Yes
Drug addiction? □No □Yes
Schizophrenia? □No □Yes

Please list any other symptoms not previously listed that you have significant concern with:

_____
_____
_____
_____
_____
_____
_____
_____

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Financial Policy

Thank you for choosing Dat T. Nguyen, M.D., Inc as your provider of surgical care. Our commitment is to provide high quality service. Payment for your treatment is your obligation in helping to support this commitment. To help us obtain payment for our service, all patients are required to complete the Information Registration Form before consultation with our physician.

- **Without your current insurance information at the time of service, you will be treated as a self-pay patient.**
- **All self-pay accounts are payable at the time of service**
- **Co-pays are due prior to consultation with the physician**
- **All HMO and EPO patients must have a valid referral prior to consultation with the physician**
- **Our office accept cash, check, Visa, MasterCard**

Regarding Insurance Coverage:

Our office accepts assignment of insurance benefits for insurance companies that we are contracted with. The details of your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract or exactly what benefits are included or excluded in your plan. Please be aware that some, and may be all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances. In the event you do not have benefits for what you were seen for, the balance of payment is you responsibility. You are also responsible to provide our office valid and up-to-date insurance information. If you provide incorrect insurance information to our office and payment is denied for any reason, you will be financially responsible for all charges.

Thank you for understading our financial policy. Please let us know if you have any questions or concerns.

Please check appropriate box:
□ I have a PPO plan.
□ I have an HMO/ EPO plan with an authorization or a referral letter.
□ I am electing to use the PPO option of my POS plan.
□ The services have not been otherwise referred or authorized as required by my health plan.

I have carefully read the financial policy. I understand and agree to this financial policy.

Name of patient or responsible party: _____

Signature: _____ Date: _____

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Health Insurance Portability and Accountability Act (HIPPA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected health Information
Your protected health information may be used and disclosed by your physician, our office staff and other outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your heath care bills, to support the operation of the physician's practice, and other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information maybe provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: You protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when our physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of an appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate to determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time in writing except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information, under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply. You physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit the use and disclosure of your protected health information will not be restricted. You then have he right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper cope of the notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We have the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.
We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before **August 15, 2004**. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received the Notice of our Privacy Practices:

Your Name:_____

Your Signature:_____ Date:_____

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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 incompletely rendered, will be determined by submission to arbitration as provide by California law, and not by lawsuit or resort to court process except as California law provided for judicial review of arbitration proceeding. Both parties to this contract, by entering into it, are 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 arbitration.

Article 2: **All Claims Must Be Arbitrated:** It is the intention of the parties that this agreement shall cover all claims or controversies whether or not 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 associations, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (herein after collective referred as "Physician") to a patient, including any spouse or heirs of the parent and any children , whether born or unborn, at the time of the occurrence giving the any claim. In the case of any pregnant mother, the term "patient" herein shall mean both 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, and 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 demand for arbitration must be communicated in writing by U.S. Mail, postage prepaid, to all parties, describing the claim against the Physician, the amount of damage sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both partied shall have the absolute right to arbitrate separately of liability and damages upon the written request of the arbitrator. Patient shall pursue his/her claims with reasonable diligences, and the arbitration shall be governed to the pursuant to Code of Civil Procedures §§1280-1259 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expense, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Retroactive Effect:** The patient intends to this agreement to cover all service render by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: **Revocation:** This agreement may be revoved by written notice delivered to the Physician with in 30days of the signatuere and if not revoked will govern all medical serviced received by the patient.

Article 6: **Severability Provision:** In the event any provison(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with California law.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP THE RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT

By:_____
Physician's or Duly Authorized Representative Signature

By: DAT TIEN NGUYEN,M.D.,INC.

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

_____
Print Name of Translator

By:_____
Patient's Signature (Date)

By:_____
Print Patient's Name

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

_____
Print Name and Relation to Patient

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