IMPORTANT PRE-VISIT INFORMATION

Welcome, you have an appointment to see Dr. Howard Kaufman

During your visit, Dr. Kaufman will discuss the nature of your problem with you, and if necessary he may need to perform additional diagnostic tests which may include a rectal and/or pelvic exam.

CANCELATION POLICY: A $15.00 fee will be charged to you for appointments canceled with less than 24 hours' notice.

IMPORTANT
PLEASE BRING THE FOLLOWING ITEMS WITH YOU

- Any prescription medication that you are taking. Please bring either the container or an itemized list.
- A translator if you are non-English speaking.
- The enclosed Patient Questionnaire forms – please be sure to complete them before arriving for your appointment.
- All insurance cards
- Pertinent operative, pathology and lab reports from your current physician.
- Pertinent x-ray reports and films of diagnostic tests performed by your current physician.
- Pathology slides from previous biopsy if applicable.

There is a FEE-based parking lot available
- We do not validate for parking
- Entrance is located on Fair Oaks Ave. south of our building

Your copayment is due at the time of service
Method of Payment:
- Cash (we appreciate exact change)
- Check
- Credit Card

We look forward to serving you with clinical excellence and compassion.

Thank you.

Huntington Colorectal & Pelvic Floor Center
10 Congress Street, Suite 300
Pasadena, CA 91105
626-397-5896 ph * 626-397-5899 fax

Rev 6_2012
HUNTINGTON COLORECTAL AND PELVIC FLOOR CENTER
PATIENT REGISTRATION INFORMATION

Last Name: ___________________________ First: ___________________________ M.I.: _______

Date of Birth: ___________ Age: ___________ Religion: _______________________

Race: ___ Asian ___ Black or African American ___ American Indian or Alaskan Native
___ Native Hawaiian or Other Pacific Islander ___ White ___ Refuse to Report

Ethnicity: ___ Hispanic/Latino ___ Non Hispanic/Latino ___ Refuse to Report

Preferred Language: ________________

SS#: ____________________ Driver’s License: ____________________ Sex: ___________ Marital Status: ___________

Address: ____________________________ City & Zip Code: ________________________

Home Tel: (____) ________ Cell phone: (____) ________ Home email: ________________

Employer: __________________________ Occupation: __________________________ Employer Tel: (____)

Referring Physician: __________________________ Referring Telephone: (____)

PHARMACY: __________________________ PHARMACY#: ___________________  

Responsible Party (If different from above)

Name: ________________________________ Date of Birth: ___________ Age: ___________

Address: ____________________________

City & Zip Code: _____________________ Home Telephone: (____)

SS#: ____________________ Driver’s License: ____________________ Cellphone: (____)

Sex: ___________ Marital Status: ___________ Home email: _____________________

Occupation: __________________________ Employer: __________________________

Employer Address: ____________________

City & Zip Code: _____________________ Work Telephone: (____)

Emergency Contact (relative or friend at an address different from above)

Name: ____________________ Relationship: __________________

Home Telephone: (____) ________ Cell phone: (____) ________

Work Telephone: (____) __________________

Insurance Information

Primary Insurance: __________________________ Ins. Co. Phone: ____________________

IPA/Medical Group (HMO only): __________________________ ID#: ____________________

Subscriber Name: __________________________ Subscriber Date of Birth: ___________

Subscriber SS#: __________________________

Secondary Insurance: __________________________ Ins. Co. Phone: ____________________

IPA (HMO only): __________________________ ID#: ____________________

Subscriber Name: __________________________

Subscriber SS#: __________________________
CONSENT FORM

1. CONSENT FOR TREATMENT
   I hereby authorize my consent to be treated now and in the future by physicians providing services for Howard S. Kaufman, MD, Inc.

2. ASSIGNMENT OF BENEFITS
   I hereby authorize Howard S. Kaufman, MD, Inc. to furnish information to insurance carrier concerning this illness. I hereby irrevocably assign to Howard S. Kaufman, MD, Inc. all payments for medical services rendered and all major medical benefits.

3. MEDICARE AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST
   I certify that the information given by me in applying for payment under Title XVIII 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 or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for physician’s services to the physician or organization furnishing the services.

4. RELEASE OF INFORMATION FOR BENEFITS
   I authorize release of any information acquired in the course of my examination or treatment which may be needed for the payment of professional charges and related services.

5. FINANCIAL AGREEMENT
   I understand that charges for any diagnostic tests will be in addition to the consultation fee, and that I am directly financially responsible for all charges incurred for medical services and/or surgical procedures rendered for myself and/or my dependents, which are not covered by valid insurance benefits. I agree to pay any legal interest, collection expense and attorney’s fees or other costs incurred, should it become necessary to assign any amount I may owe for collection.

7. PERSONAL AFFIRMATION
   I certify that all statements given to the physicians and personnel are complete and accurate to the best of my knowledge. A copy of this agreement shall be considered as effective and valid as the original. This agreement will continue until revoked by me in writing.

   Patient Name: ____________________________  Medical Record #: ____________________________  Date: ____________________________

   Patient/Guarantor Signature: ____________________________  (Guarantor Relationship): ____________________________  Date: ____________________________

   Witness Signature: ____________________________  Remarks: ____________________________

8. PRE-AUTHORIZE
   I hereby authorize Howard S. Kaufman, MD, Inc. to automatically bill my credit card account for Howard S. Kaufman, MD, Inc. fees that are not covered by my insurance. Howard S. Kaufman, MD, Inc. is only authorized to bill my account for insurance balances not paid by my insurance company, or personal balances that are over 60 days.
   Card Issuer Name: (Circle One)  Visa  MasterCard  Amex and Discover

   Account #: ____________________________  Cardholder’s Name: ____________________________
   Expiration Date: ____________________________  Signature: ____________________________
HUNTINGTON COLORECTAL AND PELVIC FLOOR CENTER
PATIENT EMAIL CONSENT FORM
To Address the risks of using email

Patient name_________________________

Email________________________________

1. RISK OF USING EMAIL
Transmitting patient information by email has a number of risks that patients should consider before using email. These include, but are not limited to, the following risks:
   a) Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
   b) Email senders can easily misaddress an email.
   c) Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.
   d) Employers and on-line services have a right to inspect email transmitted through their systems.
   e) Email can be intercepted, altered, forwarded, or used without authorization or detection.
   f) Email can be used to introduce viruses into computer systems.
   g) Email can be used as evidence in court.
   h) Emails may not be secure, including at Huntington Colorectal and Pelvic Floor Center and its affiliates, and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. CONDITIONS FOR THE USE OF EMAIL
Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Patients must acknowledge and consent to the following conditions:
   a) Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email will be read and responded to within any particular period of time.
   b) Email must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via email.
   c) Email may be printed and filed in the patient's medical record or stored in the patient's electronic medical record.
   d) Office staff may receive and read your messages.
   e) Provider will not forward patient identifiable emails outside of Huntington healthcare providers or other providers submitted as treating or referring physicians without the patient's prior written consent, except as authorized or required by law.
   f) The patient should not use email for communication regarding sensitive medical information.
   g) Provider is not liable for breaches of confidentiality caused by the patient or any third party.
   h) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. INSTRUCTIONS
To communicate by email, the patient shall:
   a) Avoid use of his/her employer's computer.
   b) Put the patient's name in the body of the email.
   c) Key in the topic (e.g., medical question, billing question) in the subject line.
   d) Inform Provider of changes in his/her email address.
   e) Acknowledge any email received from the Provider.
   f) Take precautions to preserve the confidentiality of email.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT
I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the Providers and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with patient by email. If I have any questions I may inquire with my treating physician's office.

Patient signature_____________________

Date_______________________________

Witness signature___________________

Date_______________________________

Howard S. Kaufman, MD
10 Congress Street, Suite 300
Pasadena, CA 91105
Tel: 626-397-5896
Patient Record of Disclosure

The HIPPA privacy rule gives individuals the right to request restrictions on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communication of PHI if 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 phone number
____ Ok to leave message with detailed information
____ Leave a message with call back number only

____ Work phone number
____ Ok to leave message with detailed information

Written Communication:

____ Ok to mail to home address
____ Ok to mail to work address
____ Ok to fax to this number

You may discuss my medical condition with:

________________________________________________________________________

Thank you for your assistance in this matter. If you have any questions, please do not hesitate to contact our office.

Patient Signature or Legal Representative

Print Name

Date ____________________ DOB ____________________
Huntington Colorectal & Pelvic Floor Center
10 Congress Street, Suite 300
Pasadena, CA 91105
Ph: 626-397-5896 Fax: 626-397-5899

Request for Medical Records

Date: ________________________________

Name: ______________________________

Date of Birth: _______________________

I hereby authorize:

(Name of physician/hospital/agency) __________________________ Telephone No./Fax No. __________________

Address ____________________________ City __________________ State __________________ Zip code __________________

To furnish: __________________________

Howard S. Kaufman, M.D.

The following medical records: copies of the above named patient's medical records including:
operative reports, X-rays, laboratory and pathology reports, biopsy slides and blocks, etc.

Specifically: ____________________________

________________________________________________________________________

Thank you for your assistance in this matter. If you have any questions, please do not hesitate to contact our office.

________________________________________
Patient Signature or Legal Representative

________________________________________
Date
Conditions of Admission to Huntington Memorial Hospital

1. CONSENT TO MEDICAL AND SURGICAL PROCEDURES: The undersigned consents to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, which may include, but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia or hospital services rendered to the patient under the general and special instructions of the patient's physician or surgeon. You understand that the hospital and staff have the right to photograph or videotape you for purposes of diagnoses, treatment or internal hospital education and training programs. Photos and videotapes taken for purposes of diagnosis or treatment will become part of your medical record. If you or your legal representative do not want the hospital to photograph or videotape you, you must make a written request to the hospital.

2. NURSING CARE: This hospital provides only general duty nursing care unless, upon orders of the patient's physician, the patient is provided more intensive nursing care. If the patient's condition is such as to need the service of a special duty nurse, it is agreed that the patient or his/her legal representative must arrange such. The hospital shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.

3. FINANCIAL ARRANGEMENT: The undersigned agrees, whether he/she signs as agent or a patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the hospital in accordance with the regular rates and terms of the hospital. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorneys' fees and collection expenses. All accounts shall bear interest at the legal rate.

4. ASSIGNMENT OF INSURANCE BENEFITS AND/OR PAYMENTS: The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the hospital of any insurance benefits and/or payments, otherwise payable to or on behalf of the patient for this hospitalization or for these outpatient services, including emergency services if rendered, at a rate not to exceed the hospital's actual charges. A lien is granted to the hospital on any and all proceeds payable to me or on my behalf, received by reason of any judgement, settlement, or compromise of any claim or legal action related to the injuries which caused my hospitalization.

5. HEALTH CARE SERVICE PLAN OBLIGATION: This hospital maintains a list of healthcare service plans with which it contracts. A list of such plans is available upon request from the financial office. The hospital has no contract, express or implied, with any plan that does not appear on the list. The undersigned agrees that he/she is individually obligated to pay the full charges of all services rendered to him/her by the hospital if he/she belongs to a plan which does not appear on the above mentioned list.

6. PARTICIPATION IN TEACHING PROGRAMS: It is understood that the hospital is a teaching institution. Unless the hospital is notified to the contrary in writing, as part of the health education program of this institution, house officers under the direction of patient's attending physician or other students in contracted allied health training programs may participate in patient's care.

7. PROPOSITION 65: Certain products used for patient care in the hospital contain or are sterilized using chemicals known to the state of California to cause cancer or reproductive toxicity. It is understood that you may be exposed to the chemicals in question that are known to the state to cause cancer, or birth defects or other reproductive harm (Safe Drinking Water and Toxic Enforcement Act of 1986).

8. PERSONAL VALUABLES: It is understood and agreed that the hospital maintains a safe for the safekeeping of money and valuables, and the hospital shall not be liable for the loss or damage to any money, jewelry, documents, furs, fur coats and fur garments or other articles of unusual value and small size, unless placed therein, and shall not be liable for loss or damage to any other personal property, unless deposited with the hospital for the safekeeping. The liability of the hospital for loss of any personal property, which is deposited with the hospital for
physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, anesthesiologist and the like, are independent contractors with the patient and are not employees or agents of the hospital. **Some independent contractors may bill separately.**

**Patient's initials:** __________________________

The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to medical surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered the patient under the general and special instructions of the physician.

**10. RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES:**

The circumstances under which the hospital may use or disclose health information related to you concerning the care and including treatment information you receive here are described in the Notice of Privacy Practices, which is provided to you the first time you receive services from the hospital and is otherwise available to you upon request. The Notice of Privacy Practices is incorporated into this Conditions of Admission by this reference. The patient hereby acknowledges the receipt of the Notice of Privacy Practices.

The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, the hospital may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable, for all or any portion of the hospital's charges, including, but not limited to insurance companies, health care service plans, or Worker's Compensation carriers. Special permission is needed to release this information if the patient is treated for alcohol or drug abuse.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above, and accept its term, and agree that they are irrevocable.

**Date:** ________________ **Time:** ________________ a.m./p.m. **Signature:** __________________________

(Patient/Parent/Conservator/Guardian)

If signed by other than patient, indicate relationship: __________________________

**Witness:** __________________________ **Interpreter:** __________________________

**Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative**

agree to accept financial responsibility for services rendered to the patient and to accept the terms of Financial Agreement, Assignment of Insurance Benefits, and Health Care Service Plan Obligation provisions above and agree that they are irrevocable.

**Date:** ________________ **Time:** ________________ a.m./p.m.

Financial responsible party's signature: __________________________

**Witness:** __________________________ **Interpreter:** __________________________

**Patient's name:** __________________________

**Admission date:** __________________________
PATIENT'S MEDICAL HISTORY

Date: ___ / ___ / ___ Name: ___________________ Age: ___ Sex: ___ Race: ___

Marital Status: (circle one) S. M. Div. Wid. Sep. Occupation: ________________________________
Referring Diagnosis: _________________________________________________________________

REFERRED BY:

Referring Physician: __________________________ Telephone __________________________
Address: __________________________________________ City: ______ State: ______ Zip: ______
Primary Physician: __________________________ Telephone __________________________
Address: __________________________________________ City: ______ State: ______ Zip: ______

How were you referred to us?

_____Physician _____ Web site _____ Friend _____ Speaking Engagement

_____ Health Fair _____ Insurance Group _____ Conference

CHIEF COMPLAINT (and duration) _______________________________________________________

_________________________________________________________________________________

DESCRIBE WHY YOU ARE BEING SEEN TODAY (section must be completed):

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

FAMILY HISTORY OF CANCER OR COLON PROBLEMS:

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

Name:__________________________ M.R. # __________________________
List Pertinent Family, Social and/or
Personal History:

Anesthetic Complications: ____________________________
Alcohol: ____________________________
Tobacco: ____________________________
List All Previous Surgical
Procedures: ____________________________

List All Previous
Hospitalizations: ____________________________

Check Appropriate Boxes. No mark
means not asked.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Has Pt. Ever Had

- Major Trauma
- Mental Illness
- Alcoholism
- Diabetes
- Heart Disease
- Communicable disease such as TB, Typhoid fever, Amebiasis, etc.
- Hepatitis

List ALL Drugs Pt. Takes Routinely (Give Dosage)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>How Long?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Tetanus toxoid
Blood or plasma transfusion.
Reaction?
Horse serum (TAT, GAT) Reaction?
Penicillin or sulfa. Reaction?

Yes No 2

Within the past Six Months Has Pt. Taken:

- Digitalis
- Anti-convulsants
- Anti-hypertensive agents
- Corticosteroids
- Narcotics
- Blood thinners

LIST ALL KNOWN DRUG (or other) ALLERGIES. If none, write “NONE”

Immunization History:
Tetanus (date)
Pneumonia (date)
Influenza (date)
Polio (date)
Measles, Mumps, Rubella (date)
Others

Patient Name: ____________________________
Date: / /
<table>
<thead>
<tr>
<th>SYSTEM REVIEW — Check appropriate spaces</th>
<th>Use this Space for Continuation of Present Illness and/or to Describe Positive Points in the System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>GENERAL:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>EYES:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>CARDIORESPIRATORY:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>GASTROINTESTINAL:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>GENITOURINARY:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>NEUROPSYCHIATRIC:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>MUSCULOSKELETAL:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>OB-GYN:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I have reviewed all of the above information with the patient.

Physician Signature: ____________________________  M.D.  Date: __________/________/________

Patient Name: ____________________________