REGISTRATION
(PLEASE PRINT)

RIO VISTA SURGICAL ASSOCIATES, P.C.
90 RIVIERA BLVD
LAKE HAVASU CITY, AZ 86403
OFFICE (928)453-2900 FAX: 877-864-6566

Date ______ Home Phone (____) ______ Cell Phone (____) ______

PATIENT INFORMATION

Name ______ Last Name ______ First Name ______ Middle Initial

SS/HIC/Patient ID # ______

Address ______

E-mail ______

City ______

State ______ Zip ______

Sex ☐ M ☐ F Age ______ Birthdate ______

☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered for ______ years ☐ Minor

Patient Employer/School ______

Occupation ______

Employer/School Address ______

Employer/School Phone (____) ______

Whom may we thank for referring you? ______

In case of emergency who should be notified? ______ Phone (____) ______

PRIMARY INSURANCE

Person Responsible for Account ______ Last Name ______ First Name ______ Middle Initial

Relation to Patient ______ Birthdate ______ Soc. Sec. # ______

Address (If different from patient's) ______ Phone (____) ______

City ______ State ______ Zip ______

Person Responsible Employed by ______ Occupation ______

Business Address ______ Business Phone (____) ______

Insurance Company ______

Contract # ______ Group # ______ Subscriber # ______

Names of other dependents covered under this plan ______

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ______ Birthdate ______ Relation to Patient ______

Address (If different from patient's) ______ Phone (____) ______

City ______ State ______ Zip ______

Subscriber Employed by ______ Business Phone (____) ______

Insurance Company ______ Soc. Sec. # ______

Contract # ______ Group # ______ Subscriber # ______

Names of other dependents covered under this plan ______

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______ Name of Insurance Company(ies) and assign directly to Dr. ______ all insurance 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 authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______ Signature of Patient, Parent, Guardian or Personal Representative ______ Date

______ Please print name of Patient, Parent, Guardian or Personal Representative ______ Relationship to Patient

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RIO VISTA SURGICAL ASSOCIATES, P.C.
90 RIVIERA BLVD
LAKE HAVASU CITY, AZ 86403
OFFICE (928)453-2900 FAX (928-453-3388

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Rio Vista Surgical Associates, P.C. may use and disclose information (PHI) information to carry out treatment, payment and healthcare operations (TPO). Please refer to Rio Vista Surgical Associates, Notice of Privacy Practices for more complete description of such uses and disclosure.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Rio Vista Surgical Associates. P.C. reserves the rights to its Notice of Privacy Practices at anytime. A revised Notice of Privacy; Practices may be obtained by forwarding a written request to Rio Vista Surgical Associates, Privacy Officer at 90 Riviera Dr, Lake Havasu City, AZ 86403.

With my consent, Rio Vista Surgical Associates may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice to carry out TPO, such as appointment reminders , insurance items, and any call pertaining to my clinical care.

With my consent, Rio Vista Surgical Associates may mail to my home or other designated location any items that assist in carrying out TPO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to Rio Vista Surgical Associates use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except the extent that the practices Has already made disclosure in reliance upon my prior consent

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received a copy of Rio Vista Surgical Associates, P.C. Notice of Privacy Practices.

______________________	______________________	__________
Patients Name (Print)	Patient Signature	Date

RIO VISTA SURGICAL ASSOCIATES, P.C.
DR. ABE SAIZ, M.D.

FINANCIAL POLICY

Our practice is committed to providing the best medical care for our patients. If you have insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your understanding of our payment policy. We thank you for taking the time to read and understand the policy below.

NON-INSURED PATIENTS

Payment is due at the time services are rendered. For your convenience, payment can be made by cash, personal check, MasterCard, Visa or Discover.

If you are having treatment extending over a period of time, we expect payment to be made during the course of treatment. If necessary, payment arrangements can be made.

INSURED PATIENTS

As health care providers, our relationship is with you, not your insurance company.

Estimated co-insurance or co-pay is due at the time services are rendered. We do accept cash, personal check, MasterCard, Visa or Discover. We will gladly discuss your proposed treatment and answer any questions relating to your insurance to the best of our ability, however:

1) Your insurance is a contract between you and the insurance company. We are not a party to that contract. The filing of insurance claims is a courtesy that we extend.
2) Our fees are considered to fall within the acceptable range by most insurance companies.
3) Not all services are a covered benefit in all contracts.
4) Our estimate of insurance coverage is only an estimate based on the information available to us.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, please contact us promptly for assistance in the management of your account.

ALL CHECKS RETURNED FROM THE BANK ARE SUBJECT TO A $25.00 SERVICE CHARGE.

In the event that this agreement becomes a collection matter, the patient/guarantor shall be responsible for all charges and costs related to collection activities.

Each insurance plan is different and constantly changing. We request patients to inform us if there is any change in coverage. It is the patient's responsibility to know their individual insurance plan, benefits, and coverage and to know if Dr. Saiz is a provider on your plan.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES.

PRINTED NAME ______________________ SIGNATURE ____________________

Rio Vista Surgical Associates, PC

90 Riviera Drive - Lake Havasu City, AZ 86403-5716 - Phone: 928-453-2900 Fax: 928-453-3388

Our goal at Rio Vista Surgical Associates, PC is to provide quality medical care in a timely manner to all of our patients. In order to do so, we have had to implement policies for missed appointments, cancellations and no shows for scheduled procedures. These policies enable us to better utilize available appointments for our patients and to ensure that we serve your medical needs in an efficient and timely manner.

Please read and initial each policy notation and sign and date at the bottom.

<u>CANCELLATION OF AN APPOINTMENT:</u>
In order to be respectful of the medical needs of all of our patients, please be courteous and call Rio Vista Surgical Associates, PC promptly if you are unable to keep your scheduled appointment. We respectfully ask that you notify this office at least 24 hours in advance. Your early cancellation will give us the opportunity to serve the needs of another patient as we will then be able to reallocate this time to another patient in need. ***If there is no timely cancellation of your appointment we will charge a $25.00 Late Cancellation Fee.***

[___] Initials

<u>NO-SHOW POLICY FOR OFFICE VISITS:</u>
A "no-show" is a missed appointment for an office visit without a 24 hours notice. "No-Shows" inconvenience other patients who may need access to medical care. A failure to present at the time of a scheduled appointment without adequate notice will be recorded in the patient's chart as a "no-show". Repeated no-shows for your scheduled appointment may result in termination of the patient from the practice. ***There will be a $25.00 No-Show Fee applied to all missed appointments or late cancellations when there is no 24 hours advance notice.***

[___] Initials

<u>NO SHOW POLICY FOR SCHEDULE PROCEDURES AT A FACILITY:</u>
A "no-show" is a missed appointment for a scheduled procedure at a facility without a 24 hours notice. "No-Shows" inconvenience other patients who may need access to medical care. A failure to present at the time of a scheduled procedure without adequate notice will be recorded in the patient's chart as a "no-show". Repeated no-shows for your scheduled procedure may result in termination of the patient from the practice. ***There will be a $200.00 No-Show Fee applied to all missed procedures or late cancellations when there is no 24 hours advance notice.***

[___] Initials

I have read and understand the above policies and charges that will be applied. I understand that is my responsibility to notify Rio Vista Surgical Associates, PC in a timely manner if I have difficulty in keeping the scheduled appointments.

______________________	______________	______________
Printed Patient Name	**Date of Birth**	**Current Date**

______________________	______________________
Patient Signature	**Staff /Witness Signature**

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PERMISSION TO RELEASE YOUR MEDICAL INFORMATION

I, the undersigned, give my permission for the persons listed below (family members, significant others, friends) to be given any information in regards to my medical care. This includes all medical reports (laboratory, pathology, x-ray, consultations, and other diagnostic test results) and records of physical examinations. This permission is granted for in office and phone reports to any of the below listed. It also allows Rio Vista Surgical Associates, P.C. to release your medial information in case of emergency to any of the listed below.

1. Print Name ________________________ Relationship To Patient ____________;

2. Print Name ________________________ Relationship To Patient ____________;

3. Print Name ________________________ Relationship To Patient ____________;

Patient Name: ____:

Patient Signature:________________________ Date: ______________

Witness Signature:________________________ Date: ______________

Provider Signature: ________________________ Date: ______________

RIO VISTA SURGICAL ASSOCIATES

HEALTH MAINTENANCE

NAME:________________________________ DOB:__________________________

HAVE YOU HAD YOUR COVID VACCINE? YES NO

IF YES, WHAT ARE THE DATES OF VACCINE? 1ST__________________ 2ND____________________

WHAT IS YOUR PHARMACY?____

WHO IS YOUR PRIMARY DOCTOR:____

WHEN WAS YOUR LAST COLONOSCOPY?_____________________________________

WHEN WAS YOUR LAST MAMMOGRAM?______________________________________

WHEN WAS YOUR LAST INFLUENZA SHOT?___________________________________

WHEN WAS YOUR LAST PNEUMONIA SHOT?__________________________________

DO YOU SMOKE?____

DO YOU DRINK CAFFEINE?____

ARE YOU TAKING ANY NEW MEDICATIONS SINCE YOUR LAST VISIT?_______________

____

RIOVISTA SURGICAL ASSOCIATES

90 RIVIERA DR
LAKE HAVASU CITY, AZ 86403
928-453-2900 FAX: 928453-3388

Patient Name: ______________________ Date of Birth: ___/___/____ Age: ________

Emergency Contact: ______________________ Relationship: __________ Phone # ________

Reason for your visit today ____

MEDICAL HISTORY (Circle all that apply):

Diabetes	High Blood Pressure	High Cholesterol	Thyroid Disease
COPD (Emphysema)	Asthma	Heart Disease	Atrial Fibrillation
Strokes	Peripheral Arterial Disease	Headaches	Rheumatoid Arthritis
Enlarged Prostate (BPH)	Kidney Cancer	Kidney Stones	Bladder Cancer
Breast Cancer	Colon Cancer	Diverticulitis	Pancreatitis
Intestinal Obstruction	Acid reflux	Glaucoma	Hepatitis
HIV (AIDS)	Melanoma		

Other ____

PRIOR SURGERIES ☐ Please check box if you've had no other surgical history

Previous Surgical Procedures:	When:

Have you had a COLONOSCOPY in the past? YES or NO If yes – When? __________

LIST ALL CURRENT MEDICATIONS (Including aspirin and over the counter medication's)

MEDICATION	DOSAGE (How much, how often?)

ALLERGIES: Are you allergic to any MEDICATIONS? (CIRCLE) YES or NO

NAME OF MEDICATION:	TYPE OF REACTION:

ARE YOU ALLERGIC TO ANYTHING ELSE? (Circle) YES or NO

EXPLAIN: ______________________________

IS THERE ANYTHING ELSE YOU FEEL THAT YOUR PHYSICIAN/SURGEON SHOULD KNOW?

____

____

PRINT YOUR NAME______________________________

YOUR SIGNATURE ______________________________ Date ____/____/______

IF NOT PATIENT, RELATIONSHIP TO PATIENT (PARENT, GUARDIAN, ETC.)______________

Constitutional

Have you had recent weight loss (> 10 lbs.)?	[] Yes	[] No
Have you had recent fevers?	[] Yes	[] No
Are you fatigue/extremely tired?	[] Yes	[] No
Do you have night sweats?	[] Yes	[] No
Have you had recent weight gain (> 10 lbs.)?	[] Yes	[] No

Head and Neck

Do you have sleep apnea?	[] Yes	[] No
Do you have hay fever/seasonal allergy?	[] Yes	[] No
Has there been any changes in your voice?	[] Yes	[] No

Cardiovascular

Do you have a history of heart murmur?	[] Yes	[] No
Any unusual chest pain w/ exertion?	[] Yes	[] No
Do you have any leg or foot swelling?	[] Yes	[] No
Do you have a history of heart disease/heart attack?	[] Yes	[] No
Do you suffer from pain in legs when you walk?	[] Yes	[] No
Do you have palpitations or abnormal heart rhythm?	[] Yes	[] No
Do you have a pacemaker?	[] Yes	[] No
Do you have artificial heart valves?	[] Yes	[] No

Respiratory/Pulmonary

Do you have a persistent cough?	[] Yes	[] No
Do you have any shortness of breath?	[] Yes	[] No
Do you have asthma?	[] Yes	[] No
Do you have a history of tuberculosis?	[] Yes	[] No
Have you recently coughed up blood?	[] Yes	[] No
Do you have a history of valley fever?	[] Yes	[] No

Hematology

Do you have any blood disease or bleeding disorders?	[] Yes	[] No
Do you have unusual bleeding (bruise easily)?	[] Yes	[] No
Do you have blood clots (legs or lungs)?	[] Yes	[] No
Could you have HIV or AIDS?	[] Yes	[] No
Do you take a blood thinner (Coumadin/Aspirin/Plavix)?	[] Yes	[] No

Gastro Intestinal

Do you have blood in stool?	[] Yes	[] No
Any recent Diarrhea?	[] Yes	[] No
Any recent constipation?	[] Yes	[] No
Any nausea or vomiting?	[] Yes	[] No
Do you have difficulty swallowing?	[] Yes	[] No
Do you have severe frequent heartburn?	[] Yes	[] No
Have you had recent loss of appetite?	[] Yes	[] No

Gastro Intestinal

History of liver disease (cirrhosis or hepatitis)	[] Yes	[] No
History of diverticulitis?	[] Yes	[] No
History of jaundice?	[] Yes	[] No
Do you have a history of stomach ulcers?	[] Yes	[] No
Any stool incontinence (stool leaking)?	[] Yes	[] No
Have you ever had an upper endoscopy (stomach)?	[] Yes	[] No
Have you ever had a colonoscopy?	[] Yes	[] No

Neurologic

Do you have unusual headaches?	[] Yes	[] No
Do you have seizures?	[] Yes	[] No
History of stroke or stroke symptoms (TIA)?	[] Yes	[] No
Do you suffer from fainting spells?	[] Yes	[] No

Muscular Skeletal

Do you have joint problems?	[] Yes	[] No
Do you have a history of gout?	[] Yes	[] No
Do you have a history a back problems/sciatica?	[] Yes	[] No

Psychiatric

Do you suffer from depression?	[] Yes	[] No
Any history of eating disorders?	[] Yes	[] No
Do you suffer from anxiety?	[] Yes	[] No
Psychiatric problems?	[] Yes	[] No

Genito-Urinary

Any history of kidney stones?	[] Yes	[] No
Any history of kidney disease?	[] Yes	[] No
Do you suffer from frequent kidney infections?	[] Yes	[] No
Have you had any recent blood in urine?	[] Yes	[] No
Do you have any urine incontinence (leaking)?	[] Yes	[] No
Do you have painful urination (peeing)?	[] Yes	[] No

For Females Only

Do you have any nipple discharge	[] Yes	[] No
Have you gone through menopause?	[] Yes	[] No
Are you pregnant?	[] Yes	[] No
Have you had a mammogram in the last two years?	[] Yes	[] No

For Males Only

Do you have difficulty urinating (peeing)?	[] Yes	[] No
Do you suffer from impotence?	[] Yes	[] No
Do you awake at night to urinate (pee) more than twice?	[] Yes	[] No
Do you have problems with your prostate?	[] Yes	[] No

Family History (Check all that apply)

Mother: O Diabetes O Heart Disease O High Blood Pressure O Blood Disease
O Kidney Disease O Thyroid Disease O Cancer (Type of Cancer): ______________

Father: O Diabetes O Heart Disease O High Blood Pressure O Blood Disease
O Kidney Disease O Thyroid Disease O Cancer (Type of Cancer): ______________

Brother: O Diabetes O Heart Disease O High Blood Pressure O Blood Disease
O Kidney Disease O Thyroid Disease O Cancer (Type of Cancer): ______________

Sister: O Diabetes O Heart Disease O High Blood Pressure O Blood Disease
O Kidney Disease O Thyroid Disease O Cancer (Type of Cancer): ______________

Maternal Grandfather:
O Diabetes O Heart Disease O High Blood Pressure O Blood Disease
O Kidney Disease O Thyroid Disease O Cancer (Type of Cancer): ______________

Maternal Grandmother:
O Diabetes O Heart Disease O High Blood Pressure O Blood Disease
O Kidney Disease O Thyroid Disease O Cancer (Type of Cancer): ______________

Social History

Occupation: O Employed O Retired O Unemployed O Disabled

Marital Status: O Single O Married O Divorced O Widow O Life Partner

Do you smoke: O Yes O No O Quit O Never

How often do you drink alcohol: O Occasionally O Daily O Never

Do you use recreational drugs: O Yes-occasionally O Yes-frequently O No-Never