Keith P. Donald, M.D.
REGISTRATION FORM
(Please Print)

PATIENT INFORMATION

Today's Date:			Primary Care Physician:		
Patient's Last Name:	First:	Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status: ❑ Single ❑ Mar ❑ Div ❑ Sep ❑ Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former / Maiden Name):	Sex: ❑ F ❑ M	Age:	Birth Date: / /
Street address:		Social Security #:	Home Phone:		
P.O. Box:	City:		State:	ZIP Code:	
Occupation:	Employer:		Employer phone no.: ( )		
Race: ❑ Caucasian/White ❑ African American ❑ Chinese ❑ Filipino ❑ Japanese ❑ Korean ❑ Vietnamese ❑ Other Pacific Islander ❑ Mexican ❑ Other Spanish ❑ Other: _____		Language: ❑ English ❑ Spanish ❑ Other: _____	Interpreter Needed: ❑ Yes ❑ No		
Preferred Pharmacy (Name and Location):		Do you have any drug allergies? If so, please list:			

Email Address:

INSURANCE INFORMATION

(Please give your insurance card and ID to the receptionist.)

Responsible Party if Minor Patient:	Birth Date: / /	Address (if different):	Home Phone:	
Guarantor Employer Name:	Guarantor Employer Address:		Guarantor Employer Phone:	
Name of primary insurance:	Subscriber Name:		ID / Policy #:	Group #:
Patient's Relationship to Subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other
Name of Secondary Insurance:	Subscriber's Name:		ID / Policy #:	Group #:
Patient's Relationship to Subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to Patient:	Home Phone:	Work Phone:
Alternate Contact Person:	Relationship to Patient:	Home Phone:	Work Phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Keith P. Donald, M.D.** or insurance company to release any information required to process my claim(s).

Patient/Guardian signature _____ *Date* _____

Keith P. Donald, M.D., F.A.C.S.
General and Thoracic Surgery
Advanced Laparoscopic Surgery
Diagnostic Endoscopy

PATIENT: _____ DATE OF BIRTH: _____ AGE: _____ SEX: _____

CURRENT MEDICAL PROBLEM: _____

CURRENT MEDICATIONS: NAME STRENGTH DOSE

** SEE LIST ATTACHED ☐

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10) _____
11) _____
12) _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?			CIRCLE ONE FOR EACH ITEM:	WHEN?
1) DIABETES	YES	NO		
2) SEIZURES	YES	NO		
3) STROKE	YES	NO		
4) HIGH BLOOD PRESSURE	YES	NO		
5) HEART ATTACK	YES	NO		
6) HEART FAILURE	YES	NO		
7) ASTHMA	YES	NO		
8) PRODUCTIVE COUGH	YES	NO		
9) ULCER	YES	NO		
10) BLOOD CLOTS	YES	NO		
11) KIDNEY STONES	YES	NO		
12) LIVER DISEASE	YES	NO		
13) MRSA	YES	NO		
14) OTHER	YES	NO		

_____

LIST ALL PAST OPERATIONS & DATES (INCLUDING UPPER ENDOSCOPY AND COLONOSCOPY):

_____
_____
_____

RECENT HOSPITALIZATIONS / WHY?

_____
_____

DO YOU CURRENTLY SMOKE? YES / NO IF YES, HOW MUCH PER DAY? _____

HAVE YOU EVER SMOKED? YES / NO IF YES, HOW MUCH DID YOU SMOKE? _____

WHEN DID YOU QUIT? _____

DO YOU CONSUME ALCOHOL? YES / NO IF YES, HOW MUCH PER WEEK? _____

OCCUPATION: _____ NO OF CHILDREN: _____

SIGNATURE: _____ DATE: _____

5196 Hill Road East, Suite 201
Lakeport, California 95453
(707)263-4108 Fax (707) 263-4101

Keith P. Donald, M.D., F.A.C.S.
General and Thoracic Surgery
Advanced Laparoscopic Surgery
Diagnostic Endoscopy

PROCEDURE LATE CANCELLATION / NO-SHOW POLICY

Operating room time is a very limited and costly resource at our hospital. Once your procedure is scheduled, anesthesia staff, registered nurses and the operating room are reserved for your procedure. In addition, your surgeon has reserved this time for your procedure. Late cancellations or "no-shows" for a procedure wastes this valuable time and resource, since there is not enough time left for your surgeon or the hospital to schedule another patient into these unused valuable slots. Many patients wait months for their scheduled procedure to occur.

We have instituted a $100 prepaid fee before we will reschedule any patient who is a "no-show" or cancels their scheduled procedure within 96 hours of the scheduled procedure. At least 4 days are required to allow surgeons and the hospital a chance to adequately fill an unused OR slot. Exceptions to this policy will only be verifiable medical emergencies.

Please remember to call the office to reschedule or cancel any procedure at least 4 days before the scheduled date. We also thank you kindly for calling at least 72 hours ahead of time for rescheduling or canceling office visits.

X_____ _____
Patient's Signature acknowledging understanding and acceptance of this policy. Date

5196 Hill Road East, Suite 201
Lakeport, California 95453
(707)263-4108 Fax (707) 263-4101

Keith P. Donald, M.D., F.A.C.S.
General and Thoracic Surgery
Advanced Laparoscopic Surgery
Diagnostic Endoscopy

Dear Patient:

We want to take a moment to explain to you the process this office uses in scheduling your procedure.

Your procedure will be scheduled in coordination with the hospital scheduler. Detailed instructions will then be mailed directly to you. The instructions you receive will be specific to the procedure you are having and will include any preparation you are responsible for completing, pre-operative visit and outpatient post-operative appointment. It can take several weeks, depending on the date of your procedure, to receive these instructions.

If there are dates you will be unavailable for scheduling, please give us these dates now.

If your procedure requires a bowel preparation, the prescription **will be waiting for you** at the pharmacy you listed on your registration page by the time you receive the instructions. Please pick up your prescription promptly. **Do not** wait until you are about to use the medication. Sometimes the pharmacy needs to order these items. Please call to be sure they are ready for you before trying to pick them up.

IF YOU WILL BE HAVING A COLONOSCOPY: Please take a moment before you leave today, to tell us which bowel preparation you prefer, especially if you ***DO NOT*** want us to order our standard bowel preparation (Suprep) for your procedure. The **Suprep** is **not** a covered benefit of every insurance and can be as much as $130, depending on the pharmacy you use. Most insurance companies do not cover ***ANY*** bowel preparations, so you should prepare yourself for a minimum expense of approximately $35, even if you select our alternative bowel preparation of **Nulytely (solution)**.

All procedures will require that you have someone to take you to and from the hospital, ensuring your safe return home. Please start talking to your family and friends about this now.

Once scheduled for your procedure, you may receive a phone call from the pre-registration department of the Sutter Lakeside Hospital. You may be asked for a pre-payment of your estimated coinsurance amount. You should be aware of your financial responsibility, however, your procedure will still be performed as scheduled and you also have the right to make those payments **after** your insurance has processed the claim.

Please see the Late Cancellation/No Show policy provided to you separately.

If you have any questions regarding our scheduling process, please speak with Cyndi or Kathy before you leave today. If you have any questions after you receive your instructions in the mail, our contact information will be included for your convenience. Please keep all of your instructions until after the first visit back to our office following your procedure.

We sincerely hope this explanation makes the process a little easier for you.

Dr. Donald's Staff

_____ _____

Patient's Signature acknowledging understanding and acceptance of this policy. Date

5196 Hill Road East, Suite 201
Lakeport, California 95453
(707)263-4108 Fax (707) 263-4101

Acknowledgment of Receipt of Notice of Privacy Practices

Keith P. Donald, M.D. reserves the right to modify the privacy practices outlined in the notice.

Signature
I have received a copy of the Notice of Privacy Practices for **Keith P. Donald, M.D.**

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form.)

_____
Relationship of Patient Representative to Patient

Notice of Privacy Practices

Keith P. Donald, M.D.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Keith P. Donald, M.D. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information
Appointment reminders: Your health information will be used by our staff to send you Appointment reminders:

Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. . We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights
You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health Information
- The right to receive confidential communications concerning your medical condition And treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health Information has been disclosed
- The right to receive a printed copy of this notice

Keith P. Donald, M.D. Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Kathy Campa or Cyndi Hill. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Cyndi Hill
Keith P. Donald, M.D.
5196 Hill Road East, Suite 201
Lakeport, CA 95453

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is:

Cyndi Hill
Keith P. Donald, M.D.
5196 Hill Road East, Suite 201
Lakeport, CA 95453
(707) 263-4108

Effective Date
This notice is effective on or after June 27, 2008.