



CHIPSA

CHIPSA Hospital

Nubes 670 Esq. Creston
Secc. Jardines del Sol
Playas de Tijuana
Baja California
Mexico, CP 22505

Medical Records

PO Box 1850
Chula Vista, CA
91912-1850

Hospital Fax

011-52 (664) 680-2908

Patient Admissions

(877) 424-4772
(619) 565-1105
011-52 (664) 680-2902

admissions@chipsa.com

Admission Information

Centro Hospitalario Internacional Pacifico, SA de CV



ADMISSION INSTRUCTIONS

IF YOU WISH TO BE ADMITTED IMMEDIATELY: Call toll-free CHIPSA PATIENT SERVICES with the following itinerary and flight information:

- 1) Airline Name
- 2) Flight Number
- 3) Arrival Date
- 4) Arrival time

TIMELY ARRANGEMENTS: When traveling to San Diego, California contact CHIPSA for Lindberg International Airport shuttle pickup. Note: US taxi costs are well over \$100 to the CHIPSA hospital from the San Diego airport area; CHIPSA shuttle service is \$60 and will be included on your CHIPSA bill.

- Please arrange to arrive on a weekday if possible.
- Book your flight to the San Diego International Airport
- Upon arrival, proceed to the Traveler Aid Desk near the baggage claim area.
- A hospital driver will meet you at the Traveler Aid Desk.

ITEMS TO BRING WITH YOU:

Medical Records: (If not available, do not delay arrival. CHIPSA will send for records)

- Pathology reports
- Current lab test results
- Surgical summaries
- Discharge summaries
- Any radiology reports and the films or CDs (*X-ray, CT, MR, PET/CT*)
- CHIPSA admission forms (*If you arrive with these forms filled out, it will expedite your ingress process after you arrive at CHIPSA*).
- Adequate amounts of your current medications, and personal medical supplies.
- Stationery, envelopes, and US postage stamps.
- Personal items and swim clothing. Mexico has very warm days and cool nights.
- Camera and recorder, tapes and batteries.
- Personal computer, DVD players – CHIPSA has wi-fi for internet access as well as computer and DVD players available.
- Proof of citizenship (passport and/or birth certificate and driving license for US citizens)
- \$22 USD for Tourist Visa*

***Note:** Upon arrival in Mexico, you will need to get a 6-month Tourist's VISA from Secretaria Relaciones Exteriores (SRE). Your diver will help you through this process, which includes filling out forms at the SRE office at the border, and a visit to a Mexican bank to process payment. The process takes about half an hour. You will need your passport and/or driver's license and birth certificate. Cost: \$22 USD (please have cash available for payment to bank).



FINANCIAL INFORMATION

COSTS: The average cost of treatment will be around \$4,800 per week deposit plus 11% tax (\$5,328 per week) which covers Private room with bath, food (based on Gerson's diet), basic immunotherapy (Coley Fluid, supportive IVs), daily physicians' fees, 24-hour nursing, room service, weekly hydrotherapy, every and standard labs. Additional supportive therapies may be suggested by your physician (i.e., photopheresis, dendritic cell vaccines, tumor-antigen vaccine, autologous vaccines, etc) which may incur additional charges (see Admission Deposit and Payment, below).

COMPANION ROOM AND BOARD: You are encouraged to bring a companion. No individual aspect of the treatment is difficult to understand, but the initial learning curve is quite steep due to the many details involved. Experience has shown that a "buddy system," rather than a "solo effort," is more likely to result in accurate replication of the treatment when you return home. Companions will be billed \$55.50 per day (which includes 11% Mexican tax -- \$388.50 per week) for meals, bedding, linens, towels, and toiletries.

ADMISSION DEPOSIT: During admission, you will be asked to make an initial \$5,500 USD deposit (see costs below). Your individualized treatment plan will be designed by your treating physician and ongoing financial arrangements should be discussed with the hospital finance department. You should anticipate minimum weekly retainer of \$5,500 US dollars (*due each week*). Additional treatment costs and special protocols will be posted frequently and made available upon request. All services require Mexico 11% federal tax.

PAYMENT: Bank to bank wires, traveler's checks or cash are preferred. Please note: CHIPSA does not normally accept personal checks, cashier's checks, bank drafts, insurance assignments cards, as forms of payment. Money orders drawn on major international banks are accepted.

INSURANCE ASSISTANCE: Insurance Claim Filing Services, Houston, Tx, (713) 937-1921, provides expert coding, and will interface with third-party payers on behalf of patients. A modest contingency fee is assessed only if claims are paid.



CONTINUITY OF CARE / PATIENT INFORMATION DISCLOSURE AND RELEASE

INFORMATION DISCLOSURE AUTHORIZATION

- I consent and agree that information, medical care data, testimonial disclosure, photograph(s), or medical image(s) provided by me or by my primary medical care representative(s) ("Guardian") on my behalf may be distributed to and used by the Centro Hospitalario Internacional Pacifico S.A (known as: C.H.I.P.S.A. or "CHIPSA") or its licensees or assigns for the purposes of medical care, doctor care, medical staff training, and for any other purposes CHIPSA deems appropriate to provide medical care or to inform the medical professionals or the general reference in the field of medical care represented by CHIPSA and employing nutritional protocols for addressing general and degenerative disease.
- I have been advised that I may be identified by name in a medical payment and /or insurance claim filing. I understand that in some circumstances the information disclosure and opinions, photograph(s) may portray features that may make my identity recognizable.
- I grant this consent as a voluntary contribution in the interest of my medical treatment and for possible medical studies. I understand that I release and discharge CHIPSA and CHIPSA Medical Services, Patient Services and all parties acting under their license and authority from all rights that I may have in the photograph(s), or medical image(s), including any claim for payment in connection with their distribution or publication.
- I understand to the extent permitted by law, I have the right to inspect medical disclosure and copy the photographs, or medical images (X-ray, MRI, CT scans) that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization only in writing at any time, except to the extent that action has been taken in reliance on this authorization. If I do not revoke this authorization, it will expire _____ years from the date of its execution.

PATIENT MEDICAL CARE AUTHORIZATION

- I understand that CHIPSA hereby will provide the appropriate medical care that is agreed upon by me (the "Patient") for treating my personal health condition and that I have been told and made aware that there is no promise of a positive medical outcome, expectation or guarantee of a cure. I also understand that no hospital or medical staff in any health care environment can promise a cure and I realize that CHIPSA can only assist my attempt to be healthy and provide comfort during my stay at their facility.

HIPAA AUTHORIZATION

- I understand that my personal medical information and its disclosure for medical care, patient services and financial service, photograph(s), or medical image(s) disclosed, or some portion thereof, may be protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because CHIPSA may be exchanging and receiving the information, photograph(s), or medical image(s) in the capacity of a health care provider or health plan covered by HIPAA, the photograph(s) or medical image(s) may be disclosed as an example of promoting CHIPSA patient care services and may no longer be protected by HIPAA.

Patient Signature _____ Date _____

Patient Name (print) _____

City _____ State _____ Zip _____ Country _____

- YES, by signing this form, I certify that I have read the above authorization and release and fully understand its terms.

Guardian Signature (optional) _____ Date _____

Guardian Name (print) _____

City _____ State _____ Zip _____ Country _____

- YES, by signing this form, I certify that I have read the above authorization and release and fully understand its terms.

Internal Use Only:

Date of submission _____ CHIPSA Admission # _____

Please return to: CHIPSA Hospital, Nubes #670, Colonia Jardines del Sol, Tijuana Playas, Baja California, Mexico, CP 22700

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HIPAA AUTHORIZATION TO USE & DISCLOSE PATIENT HEALTH INFORMATION

Name: _____ Hospital: _____

Patient Name: _____ Phone #: _____

Date of Birth: _____ SS #: _____ Medical Record Number: _____

1. I authorize the use or disclosure of the above named individual's health information as described below _____

2. The following individual(s) or organization(s) are authorized to make the disclosure: _____

3. The type of information to be used or disclosed is as follows: (check the appropriate boxes and include other information where indicated)

Date(s) of Service: _____

- | | |
|---|--|
| <input type="checkbox"/> Face Sheet / Registration Sheet / Referral Sheet | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Implant Information |
| <input type="checkbox"/> ER Record | <input type="checkbox"/> Pathology Report |
| <input type="checkbox"/> H&P | <input type="checkbox"/> Medication List |
| <input type="checkbox"/> Consults | <input type="checkbox"/> Discharge Instructions |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Entire Record |
| <input type="checkbox"/> Lab Results | <input type="checkbox"/> Radiology Results |
| <input type="checkbox"/> Home Care Records | <input type="checkbox"/> OTHER: please specify _____ |
| <input type="checkbox"/> EKG / Cardiology Testing Results | |

4. I understand that if my record contains sensitive information such as mental health information, drug and alcohol abuse information or HIV related information, separate authorizations will be required.

5. The information identified above may be used by or disclosed to the following individual or organization(s):

Name: _____

Address: _____

6. This information for which I'm authorizing disclosure will be used for the following purpose:

- Sharing with other health care providers as needed
- Other (please describe): _____

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. Unless I specify differently, this authorization will expire six months from the date signed or identified as: _____

9. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign, to ensure healthcare treatment.

Signature of patient or legal representative **Date**

If signed by legal representative, relationship to patient _____

Signature of witness **Date**

I have been offered a copy of this Authorization Form Accept Refuse

The patient has given verbal authorization to release the above identified information. I have witnessed the verbal authorization. The patient has been informed of the nature of the authorization and freely gives his or her consent.

Signature of witness **Date**

Signature of witness **Date**

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CHIPSA USmail
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USA, 91912-1850

Hospital Fax
011-52 (664) 680-2908

Patient Services
(877) 424-4772

Patient Checklist

Medical Records: (If not available, do not delay arrival. CHIPSA will send for records)

- Pathology reports
- Current lab test results
- Surgical summary
- Discharge summaries
- Any radiology reports and the films (X-ray, CT, MRI) when possible.

Acceptable Mail Addresses for correspondence, official documents or medical records:

CHIPSA / Gerson Hospital
Nubes 670 Jardines Del Sol
Playas Tijuana, BC
Mexico C.P. 22700

CHIPSA Patient Services
627 H Street, Suite A90
Chula Vista, California
USA 91910

CHIPSA USPO Box
PO Box 1850
Chula Vista, California
USA 91912

Supplies of your current prescription medications and medical supplies.

Some medications (pain killers, especially morphine and Demerol) and supplies (e.g. colostomy fittings) are not internationally standard. Colostomy patients, please bring colostomy sleeves. Please, also bring any of the following for you stay:

- Cassette or CD recorder, fresh tapes, CD & batteries.
- Blank notebooks, pens and pencils.
- Envelopes and US postage stamps (if you wish)
- Clock radio or travel alarm.
- Personal articles (toilet/grooming).
- Pajamas, robe, slippers, and informal clothing for the cool evenings

Identity Verification for medical care such as a driver-license, birth certificate or medical VISA document MAY BE required for USA and Canadian citizens upon entry into Mexico and re-entry into the USA. However, identity papers are usually NOT required to enter Mexico, CHIPSA recommends that ID preparations should be considered however, to avoid confusion.

Medical file folder provided by CHIPSA (forms that shall be apart of your arrival)

- Admission: medical consent forms (HIPAA)
- Patient health history
- Medical liability release form
- Quality of life questionnaire
- Agreement to follow-up



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CENTRO HOSPITALARIO INTERNACIONAL PACIFICO, SA

Gerson Medical Center

Center of Integrative Medicine
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