Desert Cities Allergy/Otolaryngology

Dr. Majid Torabi **Dr. Ryan Salvador** **Mitch Claire, P.A.**

PATIENT INFORMATION

LAST NAME: __________________________ FIRST NAME: ________________________ MIDDLE INITIAL:_________

ADDRESS: _________________________________ CITY: ___________________STATE: ______ ZIP: ______________

MAILING ADDRESS (IF DIFFERENT INCLUDE CITY STATE AND ZIP CODE)

____

SS#: __________________________ DATE OF BIRTH: ___________ MALE ___ FEMALE ___ M S W D

OCCUPATION: _____________________________________ EMPLOYER: _________________________________

HOME NUMBER: ________________ (PARENT# IF MINOR) CELL NUMBER: ________________________

(PARENTS # IF MINOR) WORK NUMBER:_______________________

EMAIL: ____ @ _______________________________________

RACE: ________________________ ETHNICITY: ________________________ LANGUAGE:_____________________

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RESPONSIBLE PARTY INFORMATION (FOR MINORS OR PATIENTS INSURED UNDER FAMILY MEMBER INSURANCE)

RESPONSIBLE PARTY/PARENT NAME: ________________________ RELATIONSHIP TO PATIENT: _____________

SS#: ____________DATE OF BIRTH: ___________ PHONE NUMBER: ______________ OCCUPATION__________

SECOND PARENT NAME: ________________________RELATIONSHIP TO PATIENT: ________________________

SS#: ____________DATE OF BIRTH: ___________ OCCUPATION: ________________PHONE NUMBER___________

****

SPOUSE (IF DIFFERENT FROM RESPONSIBLE PARTY): _____________________ DATE OFBIRTH: ______________

SS#: ____ PHONE NUMBER _____________________________

****

EMERGENCY CONTACT (IF WE CAN NOT REACH YOU IMMEDIATELY)

NAME: ____ PHONE: ______________________________

PREFERRED PHARMACY NAME AND CROSS STREET: ____

PRIMARY CARE DOCTOR: ____

YOUR SIGNATURE IS NECESSARY TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED: **I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and or surgical benefits, including major medical benefits to which I am entitled to Desert Cities Allergy/Otolaryngology. A photocopy of this is to be considered as valid as the original.**

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTANT IT.

PATIENT OR GUARDIAN SIGNATURE: _____________________________________ DATE: _______________________

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OFFICE POLICY

Dear Patients,

****Note: read through ALL policies, it contains important information****

In response to the complex healthcare industry, we have taken steps to optimize our operations in order to spend more time on patient care and less time on administration. This will require your help. Please carefully read the items below as they will be strictly enforced. Our goal is to provide high quality, compassionate and timely health care.

1. **There will be a $25.00 charge for all appointments not kept or rescheduled at least 24 hours prior to your visit. ($60 for Saturday apt.) There will be a $50.00 charge for all allergy test appointments not kept or rescheduled 48 hours prior to your visit. If you are scheduled for surgery there will be a $100.00 charge for all surgery appointments not kept or rescheduled at least 1 week in advance.**
2. **Know your insurance plan. Many visits may not be covered. It is incumbent upon you to know what your benefits are. Our office cannot keep up with the changes in your health plans. If your insurance changes you are responsible for notifying our office of this change.**
3. **Copayments, Deductibles, and Coinsurance payments are due at the time of service. We do not bill for copayments. We accept cash and credit card payments no checks under $100.00.**
4. **There is an additional charge to fill out all forms and for any administrative requests to include copying medical records.**
5. **There is a charge for all returned checks.**
6. **All pharmacy refill requests should be done by calling your pharmacy and asking them to fax our office a refill request. This should be done before you are out of your medication.**
7. **You must update us with new address and telephone information immediately. You also need to inform us of any name changes and new paperwork will need to be completed.**
8. **In an effort to help our allergy patients, we ask everyone not to wear perfume/cologne etc. when coming into our office, we appreciate your cooperation.**
9. **Reminder calls are not always done, even when we do not call, patients are responsible for remembering their appointment.**

I have read and agree to follow the above mentioned guidelines.

_____ _____ _____

Patient Name (Please Print) **Patient/Guardian's Signature** **Date**

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Eligibility Form

Patient Name **Date of Birth**

_____ _____

Insurance Information

Your insurance is a method for you to receive reimbursement for fees you have paid to the physician for services rendering. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not with our office, it is your responsibility to pay deductible, co-insurance and any other balances not paid by your insurance as per your contact. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill.

I am enrolled with _____ my coverage began _____

(Name of Insurance) **(Date of Eligibility)**

_____ _____

Subscriber's Name Printed **Subscriber or Responsible Party**

_____ _____

Subscriber ID # **Group #**

I understand that if my eligibility has not been established within the next 60 days, I or the person finically responsible for me will assume full responsibility for all charges incurred by myself. I agree that the above information is true and accurate. If I have submitted false information, I or the person financially responsible for me will pay in full all such charges, within 30 days.

_____ _____

Signature (Patient or Parent) **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 incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. 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 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 association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the 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, any 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 US mail postage prepaid to all parties, describing the claim against Physician, the amount of damages 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 parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees, and expenses, along with a pro rata share of the neutral arbitrator's fee and expenses.

Article 4: Retroactive Effect: The patient intends this agreement to cover all services rendered 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 revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

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

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

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

_____	_____
Patient's name (printed)	**Patient's Signature (Date)**
_____	_____
Patient's Representative/Guardian name (Printed)	**Patient's Representative/Guardian signature (Date)**
_____	_____
Physician or Representative name/stamp	**Physician or Representative signature (Date)**

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NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Background The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

How the Rule Works General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices. The Privacy Rule does not require the following covered entities to develop a notice:

- Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity.
- A correctional institution that is a covered entity (e.g., that has a covered health care provider component).
- A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information.

Content of the Notice. Covered entities are required to provide a notice in plain language that describes:

- How the covered entity may use and disclose protected health information about an individual.
- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.
- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.
- Whom individuals can contact for further information about the covered entity's privacy policies. The notice must include an effective date for the specific requirements for developing the content of the notice. A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices for covered health care providers with direct treatment relationships with individuals.

Providing the Notice.

- A covered entity must make its notice available to any person who asks for it.
- Health Plans must also: Provide the notice to individuals then covered by the plan no later than April 14, 2003 (April 14, 2004, for small health plans) and to new enrollees at the time of enrollment. Provide a revised notice to individuals then covered by the plan within 60 days of a material revision. Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years.
- Covered Direct Treatment Providers must also: Provide the notice to the individual no later than the date of first service delivery (after the April 14, 2003 compliance date of the Privacy Rule) and, except in an emergency treatment situation, make a good faith effort to obtain the individual's written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain

the acknowledgment and the reason why it was not obtained. When first service delivery to an individual is provided over the Internet, through e-mail, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual's first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice. In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgment from individuals. Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the provider's office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.

- A covered entity may e-mail the notice to an individual if the individual agrees to receive an electronic notice for the specific requirements for providing the notice. Organizational Options.
- Any covered entity, including a hybrid entity or an affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.
- Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities. Frequently Asked Questions to see Privacy Rule FAQs, visit the desired link below: FAQs on Notice of Privacy Practices FAQs on ALL Privacy Rule Topics (You can also go to http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std_alp.php, then select "Privacy of Health Information/HIPAA" from the Category drop down list and click the Search button.)

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HIPPA Compliance Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with the restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) las allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	Yes	No
May we leave a message on your answering machine at home or on your cell phone?	Yes	No
May we discuss your medical condition with any member of your family?	Yes	No

If YES, please name the members allowed: _____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

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Medical Information Authorization

(California Civil Code s56)

(Leave "Provider of health information" Blank)

Provider of health information: _____

Address: _____

Phone: _____ Fax: _____

Requestor of health information: Desert Cities Allergy Otolaryngology Inc.

Address: 39000 Bob Hope Dr., Probst 202 Rancho Mirage, CA 92270

Phone: 760-346-1788 Fax: 760-346-1422

Requestor and any of its authorized agents is hereby authorized under part 2.6 Division 1, of the California code, to receive any and all medical information including, but not limited to, all information in possession of the above named provider of health care regarding the medical history, mental or physical condition, or treatment of the patient:

Patient name: _____ D.O.B. _____

This information may be used for any activity reasonably related to the determination and protection of the legal rights of the patient, as agreed between the patient and the requestor. This authorization shall remain in effect for an indefinite period, or until withdrawn by the patient. Any photo copy of this authorization shall be as valid as the original.

I consent to this authorization, and acknowledge receipt of a copy of this authorization at the time of signing.

Signature: _____ Relationship: _____ Date: _____

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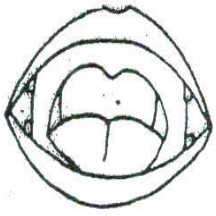
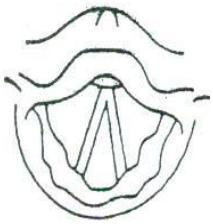
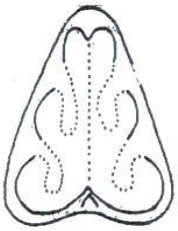
OFFICE USE ONLY:

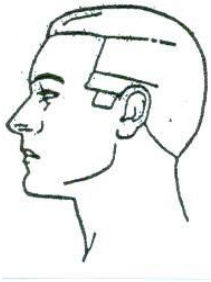
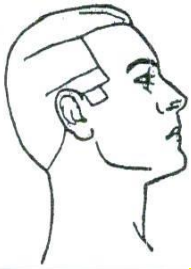
Patient Name: _____ DOB: _____ PCP: _____

Insurance: _____ ID # _____

Weight: _____ Height: _____ Temp: _____ B/P: _____ Pulse: _____

Impression/Treatment:

_____

_____

_____

_____

PATIENT USE ONLY:

Reason for visit today: _____

Do you feel your overall general health is (Please circle one) [Good] [Fair] [Poor]

Do you have any bleeding tendencies [Yes] [No]

Do you have any of the following Illnesses (circle all that apply) [High Blood Pressure] [High cholesterol] [Diabetes] [Heart Condition] [Hypothyroidism] Please list any additional illnesses: _____

Smoking Habits: [Never smoke] [Current smoker ____ packs/day] [Quit smoking ____ days/months/years]

The following questions pertain to your ears, do you have any of the following (circle all that apply) if none apply: (None)

Trouble hearing [Right] [Left] Pain in [Right] [Left] Drainage from [Right] [Left] Pressure/Fullness [Right] [Left] Ringing [Right] [Left] Dizziness Have you been exposed to loud noises [Yes] [No]

System Review (Please circle any of the following you've been experiencing) or (NONE)

[Difficulty Breathing] [Bloody Noses] [Difficulty swallowing] [Foreign body sensation in throat] [Acid reflux] [Cough/Blood] [Chest pain] [Heart Palpitations] [Tingling Sensations] [Headache] [Double Vision] [Blurry Vision] [Diarrhea] [Constipation] [Upper extremity weakness] [Lower extremity weakness]

Please list any Surgeries from the Neck and up: _____

Allergic Reactions to medications: _____

Please list any medications you are currently taking _____

_____