COMPREHENSIVE INFECTIOUS DISEASE CONSULTANTS

Antimicrobial Stewardship * HIV Medicine * Infection Prevention * Telemedicine & Information Technology

PATIENT REGISTRATION

PATIENT INFORMATION

Gender ☐ Male ☐ Female

Name [Last, First Middle] | Birth Date | Age | Social Security Number

Address | Driver License/ID Number | Issuing State

City | State | Zip

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widow(er) ☐ Partnered ☐ Separated

Employment Status: ☐ Full Time ☐ Retired ☐ Part Time ☐ Student ☐ Self Employed ☐ Other _____

Home | Work Ext.

Cell Phone | FAX: ☐ Personal Fax ☐ Work Fax

Personal E-Mail

Race: ☐ Asian ☐ Chinese ☐ Korean ☐ Filipino ☐ Vietnamese ☐ Japanese ☐ African American ☐ Hispanic/Latino ☐ White ☐ _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic

Preferred Language: ☐ English ☐ Spanish ☐ _____ ☐ _____

Preferred Communication: ☐ Home ☐ Work ☐ Cell ☐ E-Mail #1 ☐ E-Mail #2 ☐ Personal Fax ☐ Work Fax

PRIMARY CARE PHYSICIAN NAME & PHONE NUMBER

EMERGENCY CONTACT INFORMATION

Name (Last, First Middle) Relationship to patient

EMPLOYMENT INFORMATION

Name of Company

Contact Phone

Address | Referring Physician: | City | State

City | State | Zip

Office Phone

Work Phone | Direct Phone

PRIMARY INSURANCE COMPANY INFORMATION

Type: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ EPO

HMO: ☐ Medicare HMO ☐ Medicaid HMO ☐ HMO

Name of Insurance Company

Subscriber Name

Relationship To Patient: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Subscriber Social Security Number | Subscriber Birth Date

Policy # | Group #

Provider Contact Number | Website

SECONDARY INSURANCE COMPANY INFORMATION

Type: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ EPO

HMO: ☐ Medicare HMO ☐ Medicaid HMO ☐ HMO

Name of Insurance Company

Subscriber Name

Relationship To Patient: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Subscriber Social Security Number | Subscriber Birth Date

Policy # | Group #

Provider Contact Number | Website

I, the undersigned, certify that I (or my dependent) have insurance coverage with the insurance company(ies) listed above and assign directly to **Comprehensive Infectious Disease Consultants**, 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 said insurance company(ies). Furthermore, my signature below shall serve as consent for treatment. I hereby authorize **Comprehensive Infectious Disease Consultants** and its physicians, healthcare providers, and employees to release all information necessary to secure payment of benefits. I authorize the use of my signature on all insurance submission. ***Note:*** All 30 days past due accounts are subject to charges of **1.50%** per month.

Date | Signature

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18370 Burbank Blvd Suite 412 Tarzana, CA 91356-2843
Telephone: (818) 506-3384 Fax: (818) 774-2298 (818) 699-1278

E-PRESCRIBING CONSENT FORM

ePrescribing is defined as a physician's ability to electronically send accurate, error free, and understandable prescription directly to pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribing program. These include:

- √ **Formulary and benefit transactions:** Gives the prescriber information about which drugs are covered by the drug benefit plan.
- √ **Medication history transactions:** Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- √ **Fill status notifications:** Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that **Comprehensive Infectious Disease Consultants** may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to **Comprehensive Infectious Disease Consultants** to enroll me in the ePrescribe program. I have had an opportunity to ask questions and all of my questions have been answered to my satisfaction.

_____ _____
Print Patient Name Patient Date of Birth

_____ _____
Signature of Patient or Representative Date

_____
(If Representative, Print Name and Relationship to Patient)

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MEDICATION LIST

Name (Last, First):		DOB:	

LIST YOUR PRESCRIBED DRUGS and OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS

No.	Name of Drug	Strength	Frequency Taken (Directions)	Prescribed By
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				
25.				

COMPREHENSIVE INFECTIOUS DISEASE CONSULTANTS

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.
Answer all questions to the best of your acknowledge and abilities.

Patient Name (Last, First, Middle) _____ **Date of Birth:** _____ **Age:** _____

Date of Last Physical: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widow(er) ☐ Separated **Gender:** ☐ M ☐ F

Childhood Illness: ☐ Chickenpox ☐ Measles ☐ Mumps ☐ Rubella ☐ Polio ☐ Rheumatic Fever

PERSONAL HEALTH HISTORY

Immunizations and Dates:

Immun.	Date	Immun.	Date	Immun.	Date	Immun.	Date
☐ Chickenpox		☐ Influenza		☐ Pneumonia		☐ Tetanus	
☐ Hepatitis		☐ MMR (Measles, Mumps, Rubella)					

List any medical problems that other doctors have diagnosed.

Hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No If YES, please provide date: _____

☐ See Medication List Form

OFFICE USE ONLY: Original Date: _____ Revised Date: _____ Updated By: _____

COMPREHENSIVE INFECTIOUS DISEASE CONSULTANTS

HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Allergies to Medication. ☐ No Known Drugs Allergies (NKDA)

Name of the Drug	Strength	Frequency Taken	Prescribed By

HEALTH HABITS AND PERSONAL SAFETY

Exercise
☐ Sedentary (No Exercise) ☐ Occasional (work or recreation, less than 4x/week 30 mins.)
☐ Mild (climb stairs, walk 3 blocks, golf) ☐ Regular (work or recreation, 4x/week 30 mins.)

Diet
Are you dieting? ☐ Yes ☐ No If YES, are you on a physician prescribed medical diet? ☐ Yes ☐ No
# of meals you eat in an average day? _____
Rank salt intake: ☐ Hi ☐ Med ☐ Low Rank fat intake: ☐ Hi ☐ Med ☐ Low

Caffeine ☐ None ☐ Coffee ☐ Tea # of cups/cans per day? _____

Alcohol
Do you drink alcohol? ☐ Yes ☐ No If YES, what kind? _____
How many drinks per week? _____
Are you concerned about the amount you drink? ☐ Yes ☐ No
Have you considered stopping? ☐ Yes ☐ No
Have you ever experienced black-outs? ☐ Yes ☐ No
Are you ever prone to "binge" drinking? ☐ Yes ☐ No
Do you drive after drinking? ☐ Yes ☐ No

Tobacco
Do you use tobacco? ☐ Yes ☐ No ☐ Cigarettes - pks/day _____ ☐ Chew - #/day _____
☐ # of years ☐ or year quit _____ ☐ Pipe #/day _____ ☐ Cigars - #/day _____

Drugs
Do you currently use recreational or street drugs? ☐ Yes ☐ No Drug Name: _____
Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No

Sex
Are you sexually active? ☐ Yes ☐ No If YES, are you trying for a pregnancy? ☐ Yes ☐ No
If not trying for pregnancy, list contraceptive or barrier method used: _____
Any discomfort with intercourse? ☐ Yes ☐ No
Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? ☐ Yes ☐ No

Personal Safety
Do you live alone? ☐ Yes ☐ No Do you have vision or hearing loss? ☐ Yes ☐ No
Do you have frequent falls? ☐ Yes ☐ No Do you have an Advanced Directive or Living Will? ☐ Yes ☐ No
Would you like information on the preparation of Advanced Directive or Living Will? ☐ Yes ☐ No
Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? ☐ Yes ☐ No

MENTAL HEALTH

Is stress a major problem for you? ☐ Yes ☐ No
Do you feel depressed? ☐ Yes ☐ No
Do you panic when stressed? ☐ Yes ☐ No
Do you cry frequently? ☐ Yes ☐ No
Have you ever attempted suicide? ☐ Yes ☐ No
Do you have problems with eating or your appetite? ☐ Yes ☐ No
Have you ever seriously thought about hurting yourself? ☐ Yes ☐ No
Do you have trouble sleeping? ☐ Yes ☐ No
Have you ever been to a counselor? ☐ Yes ☐ No

COMPREHENSIVE INFECTIOUS DISEASE CONSULTANTS

HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS
Father		
Mother		
Sibling ☐ M ☐ F		
Sibling ☐ M ☐ F		
Sibling ☐ M ☐ F		
Sibling ☐ M ☐ F		
Sibling ☐ M ☐ F		
Sibling ☐ M ☐ F		
Sibling ☐ M ☐ F		

	AGE	SIGNIFICANT HEALTH PROBLEMS
Children ☐ M ☐ F		
Children ☐ M ☐ F		
Children ☐ M ☐ F		
Children ☐ M ☐ F		
Children ☐ M ☐ F		
Grandmother: Maternal		
Grandfather: Maternal		
Grandmother: Paternal		
Grandfather: Paternal		

WOMEN ONLY

Age of onset of menstruation: _____ Date of last menstruation: _____ Period every _____ days

Heavy periods, irregularity, spotting, pain, or discharge? ☐ Yes ☐ No

Are you pregnant or breastfeeding? ☐ Yes ☐ No Number of pregnancies: _____

Have you had a D&C, hysterectomy or cesarean? ☐ Yes ☐ No

Any urinary tract, bladder, or kidney infections within the last year? ☐ Yes ☐ No Number of live births: _____

Any blood in urine? ☐ Yes ☐ No

Any problems with control of urination? ☐ Yes ☐ No

Any hot flashes or sweating at night? ☐ Yes ☐ No

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? ☐ Yes ☐ No

Experienced any recent breast tenderness, lumps, or nipple discharge? ☐ Yes ☐ No

Date of last pap and rectal exam? _____

MEN ONLY

Do you usually get up to urinate during the night? ☐ Yes ☐ No _____

Do you feel pain or burning with urination? ☐ Yes ☐ No _____

Any blood in your urine? ☐ Yes ☐ No _____

Do you feel burning discharge from penis? ☐ Yes ☐ No _____

Has the force of your urination decreased? ☐ Yes ☐ No _____

Have you had any kidney, bladder, or prostate infections within the last year? ☐ Yes ☐ No _____

Do you have any problems emptying your bladder completely? ☐ Yes ☐ No _____

Any difficulty with erection or ejaculation? ☐ Yes ☐ No _____

Any testicle pain or swelling? ☐ Yes ☐ No _____

Date of last prostate and rectal exam? _____

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain

☐ Skin _____
☐ Head/Neck _____
☐ Ears _____
☐ Nose _____
☐ Throat _____
☐ Lungs _____
☐ Chest/Heart _____
☐ Back _____
☐ Intestinal _____
☐ Bladder _____
☐ Bowel _____
☐ Circulation _____

Recent Changes in:

☐ Weight _____
☐ Energy Level _____
☐ Ability to sleep _____
☐ Other _____

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FINANCIAL RESPONSIBILITY INFORMATION

We hope that you understand that our credit and collection policies are a necessary part of assuring the financial resources required to maintain health care service for our patients and community.

As a courtesy to our patients with private health care insurance we do complete and file claims with the appropriate insurance companies; however, all patients are kindly reminded that the financial responsibility for our services still remains theirs – **the patients** – and not their insurance companies. Even though an insurance claim is filed on the patient's behalf, our office cannot accept responsibility for collecting the claim nor can we get involved in negotiating settlement on a disputed claim. Payment for our services is at all times the sole responsibility of the patient.

Charges for medical services are due and payable at the time services are rendered. This includes co-payments and/or deductibles. In the event other arrangements are made with an office and/or our billing representatives, a statement will be sent to you with the payment due as indicated on the statement.

Any and all unpaid balances over thirty (30) days are subject to charges of 1.50% per month.

If you have health insurance coverage, it should be understood that this is an agreement between you and your insurance company to pay certain amounts for medical care. Your doctor's bill is an agreement between you and your physician. You are responsible for the payment of your bill regardless of the status of your insurance claim. This also applies to Personal Injury claims.

If unusual circumstances should make it impossible for you to meet our credit terms, we invite you to call or personally discuss the matter with our billing office. This will avoid misunderstandings and enable you to keep your account in good standing. Any and all costs incurred with enforced collection will result in additional legal and/or court costs to you and may impair your credit rating.

Additionally, charges for medical care rendered by this office will be billed through this office and should not be confused with charges for care received in the hospital and/or other facility.

Should you have any questions, please feel free to contact the billing office as listed on your billing statement or our office at the telephone number listed above.

I have read and understand the Financial Responsibility Policy as outlined above.

_____ _____

Patient's or Patient's Representative's Signature Date

_____

Print Patient's Name

_____

(If Representative, Print Name and Relationship to Patient)

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GENERAL OFFICE POLICY

Please note that insurance companies generally do not cover the services and charges listed below, therefore, the patient will be responsible for the charges. Below is a list of our general fees*:

Medical Forms

Requests to fill out any patient forms or documents such as FMLA, Workers Compensation, Disability, Letter of Condition, etc. forms will be charged a **minimum** of $35.00 and payment is due in advance. Submit the form completion request well in advance of when they are needed. We will attempt to complete the forms as quickly as possible however, in order to properly address them we need adequate time to review the patient's record. You will be contacted when the form(s) have been completed with the option to pick up, fax (if applicable) or US mail.

After Hours Prescription Refill

After hours telephone calls for routine prescription re-fills may be billed at $35.00.

Telephone Calls To Discuss Issues Not Addressed by any Office Visit

Telephone calls to discuss medical issues not addressed by any office visit within the prior month may be billed $35.00, unless followed up by an office visit, if requested by the physician. However, as insurance rarely pays for communications, the patient bears full responsibility for any charges.

Medical Records Request

Request for records in the office will be charged a **minimum** of $35.00. There will be no charge for medical records if the requestor is another physician or medical group. In either case, a written medical release is required.

By signing below, I attest that I have read and understood the above policies. I have been provided a copy of this document for my records.

I have read and understand the General Policy as outlined above.

* Not all fees are listed and fees are subject to change without notice.

Patient's or Patient's Representative's Signature _____ Date _____

Print Patient's Name _____

(If Representative, Print Name and Relationship to Patient) _____

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24 HOUR CANCELLATION & "NO SHOW" FEE POLICY

Our goal is to provide you, our patient, with quality services in a timely manner. With that being said, we have implemented an appointment cancellation policy, including "no show" policy, which will enable us to provide you with quality care and the highest standards of medical care in a cost effective manner.

All appointments require a minimum 24 hour cancellation notice to avoid a cancellation fee. **For a missed appointment or cancellation with less than 24 hour notice** for an appointment scheduled, we reserves the right to charge a fee of **$50.00** for all missed appointments ("no shows"). If you are more than fifteen (15) minutes late for any appointment, you may be required to re-schedule and may be subject to the "no show" policy. **Please arrive at least 15 minutes prior to your scheduled appointment.**

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

How to Cancel Your Appointment. To cancel your appointments, please call the office that you are scheduled to be seen at the respective telephone numbers listed above.

Violation or Abuse of Cancellation Policy. If you forget to cancel or do not arrive (a "no show") for your appointment on three occasions and have not paid any and all outstanding cancellation fees, we reserve the right of discharging you from the practice with a 30 day notice and referral to other practitioners in the area.

ACKNOWLEDGEMENT OF RECEIPT OF CANCELLATION POLICY

I, the undersigned, acknowledge receipt of Comprehensive Infectious Disease Consultants cancellation policy as outlined above. If I or the patient, cancel the appointment with less than 24 hour notice, I understand that I may be billed for the amount indicated above for each appointment that I fail to cancel or show up.

_____ _____
Patient's or Patient's Representative's Signature Date

_____
Print Patient's Name

_____
(If Representative, Print Name and Relationship to Patient)

COMPREHENSIVE INFECTIOUS DISEASE CONSULTANTS

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 rights 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 Arbitrate:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician 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.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claims, 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 to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to the Code of Civil Procedure Section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration 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.

By: _____ _____

Patient's or Patient's Representative's Signature — Date

By: _____ _____ _____

Physician's or Authorized Representative's Signature — Date — Print Patient's Name

Comprehensive Infectious Disease Consultants _____

Print or Stamp Name of Physician/Medical Group Name — (If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to given to the Patient. Original is to be filled in Patient's medical records.

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ACKNOWLEDGEMENT OF
NOTICE OF PROVIDER/PATIENT PRIVACY PRACTICES

By signing this form, you acknowledge that we have provided you with our Notice of Privacy Practices which explains how your health information may be handled in various situations including your treatment, payment of your bill, and our healthcare operations. If your first date of service with us was due to an emergency, we must try to provide you with our Notice and get your written acknowledgement for the Notice as soon as we can once the emergency has passed.

☐ I have received the Notice of Privacy Practices (effective date May 1, 2015).

_____ _____
Patient's (or Legal Representative's) Signature Date

_____
Patient Name (Last, First, Middle)

_____
Relationship of Legal Representative

FOR OFFICE USE ONLY

To be completed only if Acknowledgement is not signed.

1. Was the patient given a copy of the Notice of Privacy Practices?
2. Please explain why the patient was unable to sign this Acknowledgement and our efforts to try to obtain the patient's signature:

_____
_____
_____

_____ _____ _____
Printed Name of Staff Member Signature Date