

COMPREHENSIVE INFECTIOUS DISEASE CONSULTANTS

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

PATIENT REGISTRATION

PATIENT INFORMATION				Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Name (Last, First Middle)		Birth Date	Age	Social Security Number	
Address		Driver License/ID Number		Issuing State	
City	State	Zip		Ext.	
Home	Work		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widow(er) <input type="checkbox"/> Partnered <input type="checkbox"/> Separated		
Cell Phone	FAX: <input type="checkbox"/> Personal Fax <input type="checkbox"/> Work Fax		Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Retired <input type="checkbox"/> Part Time <input type="checkbox"/> Student <input type="checkbox"/> Self Employed <input type="checkbox"/> Other		
Personal E-Mail	Race:		Ethnicity:		Preferred Communication
	<input type="checkbox"/> Asian <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Japanese <input type="checkbox"/> African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> White <input type="checkbox"/> _____		<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> _____ <input type="checkbox"/> _____		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> E-Mail #1 <input type="checkbox"/> E-Mail #2 <input type="checkbox"/> Personal Fax <input type="checkbox"/> Work Fax
PRIMARY CARE PHYSICIAN NAME & PHONE NUMBER			EMERGENCY CONTACT INFORMATION		
Name (Last, First Middle) Relationship to patient _____ _____			Name (Last, First Middle) Relationship to patient _____ _____		
Name of Company _____ _____			Contact Phone _____ _____		
Address _____ _____			Referring Physician: _____ _____		City State _____ _____
City	State	Zip	Office Phone		
Work Phone	Direct Phone		_____		
PRIMARY INSURANCE COMPANY INFORMATION			SECONDARY INSURANCE COMPANY INFORMATION		
Type: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Commercial <input type="checkbox"/> EPO HMO: <input type="checkbox"/> Medicare HMO <input type="checkbox"/> Medicaid HMO <input type="checkbox"/> HMO			Type: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Commercial <input type="checkbox"/> EPO HMO: <input type="checkbox"/> Medicare HMO <input type="checkbox"/> Medicaid HMO <input type="checkbox"/> HMO		
Name of Insurance Company			Name of Insurance Company		
Subscriber Name			Subscriber Name		
Relationship To Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other			Relationship To Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other		
Subscriber Social Security Number		Subscriber Birth Date	Subscriber Social Security Number		Subscriber Birth Date
Policy #		Group #	Policy #		Group #
Provider Contact Number		Website	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		

COMPREHENSIVE INFECTIOUS DISEASE CONSULTANTS

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

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)

COMPREHENSIVE INFECTIOUS DISEASE CONSULTANTS

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

18370 Burbank Blvd Suite 412 Tarzana, CA 91356-2843

Telephone: (818) 506-3384 Fax: (818) 774-2298 (818) 699-1278

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)

COMPREHENSIVE INFECTIOUS DISEASE CONSULTANTS

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

18370 Burbank Blvd Suite 412 Tarzana, CA 91356-2843

Telephone: (818) 506-3384 Fax: (818) 774-2298 (818) 699-1278

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)

COMPREHENSIVE INFECTIOUS DISEASE CONSULTANTS

Antimicrobial Stewardship * HIV Medicine * Infection Prevention * Telemedicine & Information Technology
18370 Burbank Blvd Suite 412 Tarzana, CA 91356-2843
Telephone: (818) 506-3384 Fax: (818) 774-2298 (818) 699-1278

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 be given to the Patient. Original is to be filled in Patient's medical records.

©2012 J88818 8/12

COMPREHENSIVE INFECTIOUS DISEASE CONSULTANTS

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

18370 Burbank Blvd Suite 412 Tarzana, CA 91356-2843

Telephone: (818) 506-3384 Fax: (818) 774-2298 (818) 699-1278

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