Danielle E. Weiss, MD, FACP
Center for Hormonal Health and Well-Being
477 N. El Camino Real, Suite D200, Encinitas CA 92024

Welcome to Our Practice,

I am looking forward to meeting you and helping you attain your best health possible!

Center for Hormonal Health and Well-Being is a personalized, proactive, patient-centered medical practice with a unique focus on Integrative Endocrinology. I pride myself on spending time truly listening to your concerns and needs. I rely on a team approach to develop a holistic plan to address these issues together. Please visit http://www.centerforhormonalhealth.com as I explain the philosophy behind our practice.

Please carefully read and fill out the following forms and fax/mail/email them back to us prior to your appointment. You may email the forms to staff@centerforhormonalhealth.com but this is not HIPPA (Health Insurance Portability and Accountability Act) compliant and privacy/security of your medical information cannot be assured.

To review prior records, complete various forms, letters, refill or change prescriptions outside of the office visit, and perform prior authorization for prescription drugs require significant time and effort on the part of the physician and staff. We accept many insurance plans but it is important that you review these costs not covered by your insurance. Please sign and return all forms, including the membership agreement form where you can decide between membership savings or non-membership pricing for services not covered by insurance. If you are unsure of which option to choose, please select non-member as you can always decide to become a member at a later time. If you will be seen more than two times per year or frequently require refills or change of prescriptions outside of the office visit, we recommend you choose to become a savings member. **If you are a Medicare beneficiary, please fill out, date and sign the Advance Beneficiary Notice of Noncoverage (ABN) and please choose either billing option 1 or 2.**

If there are recent labs, imaging studies or doctor notes that may be important, *please try to have these made available to us prior to or at the time of your appointment*. Send the medical record release form enclosed (pg. 5) to your referring doctor.

Requesting, canceling or changing an online appointment via PracticeFusion is only a request. You must call the office or wait for a return call from us to confirm the appointment.

If you need to cancel or reschedule your appointment for any reason, *please give us 48 business hours notice*. **A full appointment fee may be charged for appointments not canceled within 48 business hours.** Arriving late to an appointment may be considered a missed appointment. Insurance does not cover this.

Patients using insurance plans ***will be required to have a credit card held on file*** to make payments for insurance benefits denied, deductibles not met, or inaccurate copay payments.

Once we have received an EOB (explanation of your benefits), your credit card will be charged for any of the above balances and a statement (aka EOB) from your insurance company will detail these charges. If there has been an overpayment on your co-pay or fee, your account will be refunded.

Please bring your insurance card to every appointment. If you do not bring your insurance card you will be billed as a cash patient. You are responsible for your deductible and co-payment. All co-pays are due upon check-in. If your deductible has been satisfied, we will bill your health plan. If your deductible has not been satisfied, payment is required at the time of service. Any balance carried to the next billing cycle will be subject to a monthly service charge. If it is necessary to assign your account to a collection agency and/or attorney, you will be responsible for these fees. Laboratory work charges are billed by the lab and are separate from our services. **Most HMO's and some PPO's require pre-authorization for services.** You are responsible for obtaining this. Patients are responsible to make payment within 60 days of claim submission if insurance processing is delayed or denied. If unsure of coverage, ***please contact your HMO/PPO.*** **We do not accept United Healthcare or Medi-Cal: California Medicaid welfare program. If you have an EPO plan or Medicare Advantage plan, please contact your insurance plan to determine if they will cover our services.** Credit cards, checks or cash are accepted and we will give you a receipt.

If Dr. Weiss has not seen you within one year of your last appointment, I will not be able to safely refill or prescribe your medication. Please make sure to physically see me in the office at least once a year.

If you choose to communicate with us via email, please know that this form of communication is not HIPAA compliant unless it is done within PracticeFusion's patient health record.

The first visit and subsequent follow-up visit are critical for establishing the best care possible. Please know that if Dr. Weiss orders labs, imaging or any procedure, you will need to return to the office at a follow-up visit to discuss these results and further treatment considerations in person.

Lastly, we look forward to meeting you and helping serve your health related needs. Our goal is to build a true partnership with you. If you do not understand any aspect of your health care, please let us know. We want you to be completely satisfied with the care you receive in our office.

In Best Health,

Danielle Weiss, MD, FACP

I have read and understood all of the preceding and give my consent for medical treatment.

Patient Signature: _____ **Date:** _____

Patient Name (print): _____

Thank you for choosing ***Center for Hormonal Health & Well-Being.***

**** Please be sure to sign the OFFICE POLICY & FEES AGREEMENT ON PAGE 6 ****

**** Please be sure to include your CREDIT CARD INFORMATION on Page 3 ****

Please be sure to download and save this document before filling out the form. Then save again when form has been completed. After completing and saving, print and mail to address at the top of page 1 or fax to 760-465-2332.

Patient Face Sheet (please fill out completely)

Patient Legal Last Name:			**First Name:**			**MI:**	
Age:	Birthdate:	☐M ☐F	Marital Status:		SSN:		
Home Phone:		Cell Phone:			Work Phone:		
Home Address:			City:		St:	Zip:	
Mailing Address:			City: vvv		St:	Zip:	
E-mail Address:			Driver's Lic#:			St:	
Occupation:			Employer:				
Work Address:			City:		St:	Zip:	
Pharmacy Name/Address/Phone:							
Ok to leave medical information on voicemail? Yes No			If yes, list the preferred phone number (s):				
Spouse Name:			**DOB:**		**SSN:**		
Work Phone:		Employer:			Occupation:		
Emergency contact name (other than spouse):					Phone number (s):		
Patient referred by:							
Name of responsible party for bill (if different from patient):							
Relationship to patient:			Phone:				
Mailing Address (if different from patient):							
Name of Primary Insurance:					ID #:		
Group #:	Deductible $:		Co-pay or co-insurance amount:				
Subscriber on plan:			Birthdate:				
Relationship to patient:			**If Tricare, sponsor's SSN:**				
Which Tricare? ☐ Prime* ☐ Standard ☐ Retired							
Name of Secondary Insurance Company:					ID #:		
Group #:	Deductible $:		Co-pay or Co-insurance amount:				
Subscriber on plan:			DOB:		SSN:		

***Prime requires referral from your primary care doctor.** Without this, you will be considered a cash patient. Please list your name **exactly as it appears on your insurance card**.

Please bring your insurance card(s) with you to your visit. Without them, you will be considered a cash patient.

All the information on this form is true and accurate.

Patient/Guardian Signature:	**Date:**
Credit Card No:	Zip code on billing address:

Exp.:	CVC:	Print Name Shown on Card:

Request for Release of Protected Health Information

AUTHORIZATION: I authorize the release of information pertaining to medical history, mental health, physical condition, services rendered or treatment as described below for:

Patient Name:		**Date of Birth:**	
SSN:	Phone Number:		
Release from (Record Holder):			
Street Address:	City:	St:	Zip:
Records may be released to: Center for Hormonal Health and Well-Being			
Street Address: 477 N. El Camino Real Ste D200	City: Encinitas	St: CA	Zip: 92024
Phone Number: (760) 753-ENDO (3636)	Fax Number: (760) 465- 2332		
Dates of Service: From:		To:	
Location of Treatment: ☐ Inpatient	☐ Outpatient	☐ Emergency	

TYPE OF INFORMATION:
This authorization is limited to the following medical record type of information (put x next to all that apply):

	Discharge Summary		Progress Notes
	History/Physical Exam		Laboratory Tests
	Consultation Reports		X-ray Reports
	Operative/Procedure Reports		Photographs/Digital or other imaging
	Emergency Department Reports		Other (please specify):

SPECIAL CATEGORIES OF INFORMATION: You must specifically authorize the disclosure of the following types of information (check all that apply):

	HIV (human immunodeficiency virus) test results
	Psychiatric Records
	Alcohol and/or drug abuse treatment

USE OF INFORMATION: The requestor may use the medical records and type of information authorized only for the following purposes:

	Continuing Care		Personal		Other (please explain):
	Second Opinion		Insurance Claim		

All the information on this form is true and accurate.

Printed Name:		**Date:**
Signature:		

If signed by other than patient, indicate relationship:

Witness:

Privacy Practice Acknowledgement & Release Medical Information Authorization

I hereby authorize **Center for Hormonal Health and Well-Being** to release any medical and/or billing information to my insurance company and/or referring or Consulting Health Care Providers. I understand the use of email is not a secure and private form of communication. I hereby acknowledge that I have been offered a copy of this office's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the reception area, and that any amended notice of privacy practices will be available at each appointment.

Patient Signature:
Print Name:
Date:
If NOT signed by the patient, please sign below:
Print Name:
Indicate relationship:
Guardian or conservator: ☐Yes ☐No

Annual Membership and Office Policy Acknowledgement

We will continue to bill insurance for covered medical services whether or not you enroll as a member of Center for Hormonal Health and Well-Being.

Danielle Weiss, MD, FACP Membership Agreement and Agreement for Additional Services		
	Non-member	**Member**
After hours call (emergency only)	$75	2 included, then $35
Mailed copy of results	$10	included
Prescription refills outside of a visit	$25 + $10 each additional	included
Urgent refills (less than 3 business days notice) or new prescription outside of an office visit	$50 + $10 each additional	included
Form completion: short/long	$50/$100	1 included, then $25 each
Missed appointment without 48 business hrs notice	$75	1st time waived, $50 ea. thereafter
Hourly rate for phone consultations, research, letters, review of outside records, dictated letters.	$350/hr Phone consult $60	30 minutes included, then $250/hr
Billing statement	$10	First statement included, then $10 each
Credit card or check declined	$50	$50
Insurance appeals/rebilling	$50	included
Patient Portal	$50	included
**We will continue to bill insurance for covered medical services whether you enroll as a member of Center for Hormonal Health and Well-Being or not.		

Please check one of the boxes below:

☐	I **choose to become** a Savings Member.	**$375 per year**. (Make membership check payable to Danielle Weiss, MD)
☐	I **wish to remain** a patient of Danielle Weiss MD,FACP, but choose not to save on the itemized services listed above.	

I understand the annual membership fees must be paid by check and are nonrefundable and are not prorated. I have provided my credit card information for charges for member services listed above as and when incurred. I agree to the information on these pages and the Membership Agreement and Office Policy Acknowledgement signed concurrently.

The undersigned has read, understands and agrees to the office policies on page 7, 8 and 9 that can also be found at http://www.centerforhormonalhealth.com/new_patient_forms.pdf

**Print Patient Name	Patient/Responsible Party Signature	Date
If signed by a party other than the patient, indicate the relationship by checking below (authorized representative must submit appropriate identification and necessary legal documents supporting authority).		
Parent or guardian of minor ☐	Guardian or conservator of patient ☐	

Office Policy Acknowledgement & Additional Services/Fees Information

Test Results: You will be notified of test results within a week of completion (laboratory, radiology, etc.). If you have not been notified within a week, please contact the office. An office visit will be scheduled to discuss abnormal results regardless of membership status.

Prescriptions and Refills: All refill requests must be sent to our office by your pharmacy. Please contact the pharmacy to request refills at least one week prior to running out of medication. Refills given outside of an office visit will be charged $25 and each additional refill to the same pharmacy at the same time will cost $10. If the refill is urgent (less than three business days), the fee is $50 with $10 charged for each additional refill. New prescriptions given outside of an office visit (due to traveling, change in pharmacy, medication changes based on test results or in relation with a telephone consult) will also result in a charge of $50. ***These fees are waived for members.*** All medications require monitoring and regular office visits. If I (Dr. Weiss) have not seen you within one year of your last appointment, I will not be able to safely prescribe your medication.

Patient Portal: We offer a patient portal where patients can access most lab results and send HIPAA certified secure email messages, as well as request appointments and receive appointment reminders. The fee for access to the portal is $50 per year. ***This fee is waived for members.***

Appointment Cancellation: If you cannot keep your scheduled appointment, please notify us no less than 48 business hours prior to the appointment. Arriving late to an appointment may be considered a missed/cancelled appointment. Non-members will be charged $75 for the missed/less than 48 business hours notice cancelled appointment. If you are a member, the first missed appointment is waived and a $50 charge will apply to future missed/less than 48 business hours notice cancelled appointments.

Hourly Rate: The non-member rate outside of an office visit is $350 per hour. Members have up to one-half hour included which can be applied to any service that is billed hourly such as phone consults, review of outside records/test results ordered by other physicians or letter dictations. The rate for members after one-half hour is $250 per hour.

Short form completion: The charge for a single page form (e.g., employer biometric screen) is $50 and multi-page forms (e.g., disability) is $100 for up to 10 pages. ***These fees are waived for members.***

Evening and Weekend Calls: I carry my office cell phone 24 hours a day, 7 days a week unless on vacation at which time a covering physician will be contacted. After hour calls should be used only in the case of an emergency. For non-members, the fee is $75 per call. ***These fees are waived for members for the first two occurrences.*** The member fee after that is $35 per call. Hourly rates may apply for complex coordination of care after hours.

Weekday Phone Calls: There is a $25 charge for brief requests for health information or advice during office hours. ***This fee is waived for members.*** For longer calls, see hourly rate.

Payment: Non-members and members agree to have their credit card charged at the time of service. You will be required to have an active credit card held on file to make payments for insurance benefits denied, deductibles not met, co-payments and other applicable services. Once Dr. Weiss has received an EOB (explanation of your benefits) your credit card will be charged for any of the above benefits and services. A statement (aka EOB) from your insurance company will detail these charges. If there has been an overpayment on your co-pay or fee, your account will be credited.

Please bring your insurance card to each of your appointments. If you do not bring your insurance card, you will be billed as a cash patient. You understand that your insurance eligibility and benefits may change at any time. It is your responsibility to verify insurance coverage and benefits. Insurance billing may take 2 years or more to process and you agree to remain fully responsible to pay all insurance balances and fees that may be due. You are responsible for your premiums, deductibles, co-payments and final amounts due. All co-payments and balances are due upon check-in. If your deductible has been satisfied, we will bill your health plan. If your deductible has not been satisfied, payment is required at the time of your service. Any balance carried to the next billing cycle will be subject to a monthly service charge. If it is necessary to assign your account to a collection agency, you will be responsible for these fees. Laboratory charges are billed by the lab and separate from our services. Most HMO's and some PPO's require pre-authorization for services. If this is not obtained or the HMPO/PPO refuses to cover within 60 days, the patient is responsible for services rendered. If unsure of coverage, contact your HMO/PPO. **We do not accept United Healthcare or Medi-Cal: California Medicaid welfare program. If you have an EPO plan or Medicare Advantage plan, please contact your insurance plan to determine if they will cover our services.** Credit cards, checks or cash are accepted and we will give you a receipt.

Patient Acknowledgment and Conditions of Participation: By signing below, you acknowledge that you understand and agree the benefits and services listed in the Membership Agreement and described above are not covered and are not reimbursable under your health insurance policy, health plan or government program in which you are enrolled. The membership fee and other fees payable under the Membership Agreement constitute payment for noncovered services only. You agree that you cannot and will not seek reimbursement from or under any health insurance policy, health plan or government program for the services provided under the Membership Agreement. To comply with applicable law, the list of benefits and services offered under the Membership Agreement may be amended or modified upon written notice to you. In addition to the noncovered services provided under the Membership Agreement, I (Dr. Weiss) will also provide services that are covered and reimbursable under your health plan. In such cases, I will bill and seek reimbursement from your health plan. I may also seek reimbursement from you as permitted under your health plan (e.g., deductibles, coinsurance or co-pays). By signing below, you acknowledge that you understand and agree any covered, reimbursable services are separate and distinct from the services provided under the Membership Agreement.

Term and Membership Fee: The term of the Membership Agreement shall commence on the date of your signature on the Membership Agreement and shall continue for one calendar year. The Membership Fee shall not be prorated and is not refundable. The Membership Agreement shall be renewed automatically for successive terms of one calendar year thereafter, unless written notice of termination is provided by either party to the other at least 30 days prior to the renewal date. Unless terminated as set forth above,

Center for Hormonal Health and Well-Being is authorized to charge the Membership Fee and services utilized to a credit card you will keep on file with our office.

Termination from Center for Hormonal Health and Well-Being: Our office values our relationship with you. We will only terminate this relationship with just cause. Reasons for termination include, but are not limited to: Repeated no-showing for scheduled appointments, not complying with recommended medical care, knowingly providing false or misleading information, being hostile or abusive to staff, not paying bills in a timely manner.

By signing below, you agree that my (Dr. Weiss) liability for noncompliance under the Membership Agreement shall be limited to the amount of your most recent annual fee. A photocopy of this agreement shall be considered as effective and valid as the original.

Our goal is to build a true partnership with you and we look forward to serving your health care needs.

****Printed Patient Name**	**Patient/Responsible Party**	**Date**

If signed by a party other than the patient, indicate the relationship by checking below (authorized representative must submit appropriate identification and necessary legal documents supporting authority).

☐	Parent or guardian of minor	☐	Guardian or conservator of patient

FOR MEDICARE BENEFICIARIES ONLY: Please fill out if you have Medicare

A. Notifier: *Danielle E. Weiss, MD - Center for Hormonal Health and Well-Being*
477 N. El Camino Real, Ste. D200, Encinitas, CA 92024

B. Patient Name:	**C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for ***D. CASH SERVICES*** below, you may have to pay. **Medicare does not pay for everything,** even some care that you or your health care provider have good reason to think you need. We expect **Medicare may not pay for the *D. CASH SERVICES* below**:

D. Cash Services	**E. Reason** Medicare May Not Pay	**F. Estimated Cost** (Becoming a member will reduce some of these costs.) See previous membership form.
1. Copy Records	**Noncovered Services For Medicare Part B Plan**	1. $25-$50+ (depends on size)
2. Review Records		2. $25-$75 (outside of Office Visit)
3. Prescription refills, outside of an office visit		3. $25 & $10 each additional
4. Urgent Refills, less than 3 business days notice		4. $50 & $10 each additional
5. Fill out form – short/long		5. $25 short; $50 long
6. Phone visit to discuss test results and mail copy to you		6. $70 total: $60 phone visit + $10 copy/mail records
7. Phone calls and/or emails – during office hours – uncomplicated		7. $25
8. Phone call after hours (emergency only)		8. $75
9. Missed Appointments: Reschedule 48 business hours or less		9. $75 (w/o 48 business hours notice)
10. Statement Preparation		10. $10 per month. This covers our cost for supplies, mailing and preparation costs.
11. Phone consults, research, letters, review outside records, dictated letters, coordination of care		11. $350/hourly rate
12. Returned Check or Credit Card return		12. $50
13. Insurance appeals or re-billing		13. $50
14. Patient Portal		14. $50
15. Practice Membership – Annual renewal		15. $375

WHAT YOU NEED TO DO NOW: Read this notice, so you can make an informed decision about your care. Ask us any questions that you may have after you finish reading. Choose an option below about whether to receive the **D. CASH SERVICES** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. Options: Check only one box. We cannot choose a box for you.

☐	**OPTION 1.** I want the **D. CASH SERVICES** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐	**Option 2.** I want the **D. CASH SERVICES** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
☐	**OPTION 3.** I don't want the **D. CASH SERVICES** listed above. I understand with this choice I am **not** responsible for payment, and I **cannot appeal to see if Medicare would pay**. *(Selecting this option is not advisable if you wish to remain a patient as many of these services are not considered optional. We are merely informing you of the costs in advance should you incur any of these services.)*

H. Additional Information: This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature	**J. Date**

If signed by a party other than the patient, indicate the relationship by checking below (authorized representative must submit appropriate identification and necessary legal documents supporting authority).

☐ Parent or guardian of minor ☐ Guardian or conservator of patient

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850. Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566

Danielle E. Weiss, MD, FACP
Center for Hormonal Health and Well-Being

Patient Information for Medical Records

Date:	
Acct. No.:	

Confidential Record Information contained here will not be released unless you have authorized us to do so.

Last Name:		**First Name:**			**MI:**
Home Address:		City:		St:	Zip:
Age:	Birthdate:	Sex: ☐ M ☐ F	Marital Status:	SSN:	
Home Phone:	Cell Phone:	Religion (optional):	Race (optional):		
Occupation:		Employer:			
Person to notify in case of emergency:	Address:	Phone:			
If different than above, please list family members or friends who can act as health advocate and their contact information					
Primary Care Physician	Address:	Phone:			
Referring Physician	Address:	Phone:			

Briefly describe your present medical symptoms, diagnosis and reason for your visit today:

Please list anything else you would like me to be aware of that is important for you to receive optimal and respectful care.

Family History			**If Living**		**If Deceased**	
	Sex		Age	Health	Age at Death	Cause
	M	**F**				
Father						
Mother						
Brothers/Sisters (check Sex)						
Husband/Wife						
Sons/Daughters (check Sex)						

Patient Name:
Patient Number:

Medications, Supplements, OTC (over-the-counter) non-prescription products, vitamins, minerals, nutritional supplements, homeopathic or naturopathic remedies, herbal preparations, Oriental/Chinese medicines, folk remedies: Please list the medications you are taking. Use additional sheet(s) if necessary.

MEDICATION OR SUPPLEMENT:	STRENGTH:	FREQUENCY:

Medication and food allergies: (If any allergy results in swelling around the mouth, shortness of breath, or hives please put anaphylaxis next to the medication.)

Operations (write in type and year):

Have you ever had a **transfusion**? If so, when?

Write in the names of any **diseases** you have had which required hospitalization**:**

Serious **illnesses** which you have had (not requiring hospitalization):

Serious **injuries or** accidents:

Has your weight changed in the past year? If so, by how much? **+ OR -** | How tall are you?

Do you know any blood relative who has or had:

	Check	Relationship		Check	Relationship		Check	Relationship
☐	Stroke		☐	Heart attack		☐	Asthma	
☐	Cancer		☐	Stomach Ulcers		☐	Hay fever	
☐	High blood pressure		☐	Kidney Disease		☐	Bleeding tendency	
☐	Tuberculosis		☐	Goiter		☐	Insanity	
☐	Diabetes		☐	Epilepsy		☐	Arthritis	
☐	Leukemia		☐	Suicide		☐	Colitis	
☐	Rheumatic heart		☐	Migraine		☐	Nervous breakdown	
☐	Congenital heart							

Personal Habits (enter Y for Yes or N for No):

Do you regularly smoke?		Cigarettes	Pipe	Cigars	For how long?
Do you drink caffeinated beverages?		How many per day?			
Do you have difficulty falling asleep?		Do you awaken without apparent cause?			
Do you regularly drink alcohol?		How many ounces per day?			

List dietary restrictions; gluten, lactose, vegan, paleo, Atkins, etc.			
Previous diet programs (i.e., Weight Watchers)?			
Weight 5 years ago, 2 years ago, 1 year ago, six months ago?			
Religious or personal beliefs that influence health care (i.e., Jehovah's Witness)?			
Occupational history? Any radiation or chemical exposures?			
Travel history?			
What are you passionate about?			
	Y N		**Y N**
Do you frequently have severe headaches?		(If yes, answer the following):	
Do they cause visual trouble?		Do they occur on one side of the head?	
Do they feel like a tight hat band?		Do they awaken you at night from sleep?	
Do they hurt most in the back of the head/neck?		Does aspirin relieve them?	
Have you ever fainted?		Have you ever had a convulsion?	
Spells of dizziness?		Double vision?	
Spells of weakness of an arm or leg?		Pains in the ear?	
Ringing in ears?		Nosebleeds?	
Have you ever been treated for depression?			
Have you ever been treated for anxiety?			
Have you ever seen a psychologist/psychiatrist?			
Comments:			
Do you frequently experience any of the following:			
Bleeding gums?		Sore tongue?	
Trouble swallowing?		Nausea and/or vomiting?	
Hoarseness?			
Have you ever had shortness of breath?			
Doing your usual work?		Which causes you to cough?	
Climbing a flight of stairs?		Accompanied by sneezing?	
Which awakens you at night?		Have you ever coughed up blood?	
Do you have a chronic cough?		Do you cough up much sputum?	
Have you ever had chest pain or tightness in the chest?			
When exerting yourself?		Which radiates down the arm?	
When walking against a wind?		Which disappears if you rest?	
When walking up a hill?		Which occurs only at rest?	
After a heavy meal?		When walking fast?	
When upset or excited?		When walking in cold weather?	
If you have chest pain or tightness please explain:			
Have you ever had pain in the stomach which:			
Occurs 1-2 hours after a meal?		Occurs only at rest?	
Is brought on by eating fried or gassy foods?		Awakens you at night?	
Is relieved by antacid medications?		Is relieved with milk or eating?	
Occurs while eating or immediately after?		Do you have a loss of appetite	
Is relieved by a bowel movement?			

If you have had a change in bowel habit recently answer the following:		**When or since when?**
Crampy pain in the abdomen?		
Alternating diarrhea and constipation?		
Pain during or after bowel movement?		
Mucous in the stool?		
Blood in the stool?		
Ribbon-like stools?		
Require use of strong laxatives or enemas?		
Have you had:	**Y N**	**When or since when?**
Burning when urinating?		
Loss of control of bladder?		
Blood in the urine? Dark colored urine?		
Trouble starting to urinate?		
Trouble holding the urine?		
Getting up frequently at night?		
Passed a kidney stone?		
Have you recently had:	**Y N**	**When or since when?**
Pains in calves or legs when walking?		
Cramps in legs at night?		
Pain in the big toe?		
Varicose veins?		
Phlebitis or inflamed leg veins?		
Swelling in the ankles?		
To be answered by WOMEN only:		
Do you have regular monthly menstrual periods?		Age of first menstrual cycle or "period"
Have you ever had bleeding between periods?		When?
Do you have heavy bleeding with your periods?		When?
Do you feel bloated/ irritable before your period?		When?
Do you take/have you taken the birth control pill?		When?
How many children born alive?		How many stillbirths?
How many premature births?		How many miscarriages?
How many cesarean operations?		Age at time of 1st child birth?
Any complications of pregnancy (if Yes, explain)?		
Date of last menstrual period?		Are you in menopause?
Do you regularly have pap smears?		Age at time of menopause?
Date of last test?		Was menopause spontaneous?
Have you ever had discharge from the nipple?		Menopause due to hysterectomy?
Have you taken hormones?		
To be answered by MEN only: Have you ever had:		
Loss of sexual activity?		For how long?
Treatment for genitals?		
Discharge from penis?		
Hernia (rupture)?		
Prostate trouble?		
Do you wish any further information about Advance Directives? (a written statement of a person's wishes regarding medical treatment if unable to communicate them to a doctor) ☐ Yes ☐ No		

Notice of Privacy Practices

Effective Date: April 14, 2003

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.

We understand the importance of privacy and are committed to maintain the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use the records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact our office.

How Our Office May Use or Disclose Your Health Information

Our office collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of our office, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate our office. For example, we may use and disclose this information to review and improved the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize service or referrals. We may also use and disclose this information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4 Appointment reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign in Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notifications efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We will not use or disclose your medical information without your written authorization.

8. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposed related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and

Drug Administration problems with products and reactions to medicines; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

11. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are sometimes required by law, to disclose your health information to coroners in connections with their investigations of deaths.

14. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized Government Functions. We may, and are sometimes required by law, to disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by worker's compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or worker's compensation insurer.

18. Change of Ownership. In the event that our office sells the practice or merges with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

When Our Office May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, our office will not use or disclose health information which identifies you without your written authorization. If you do authorize our office to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular P.O. Box or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want to access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request to access your child's records because we believe allowing access would be reasonably like to cause substantial harm to your child you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. Right to Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by our office, except that our office does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our office.

Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this notice. After an amendment is made, the revised Notice of Privacy Practices will apply to all protected health information that we maintain, regardless of when it was created or received. We will keeps a copy of the current notice posted in our reception are, and a copy will be available at each appointment, if requested. We will also post the current notice on our website.

Complaints

Complaints about this Notice of Privacy Practices or how our office handles your health information should be directed to our office.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Ave, SW
Room 509F HHH Bldg.
Washington, DC 20201

You will not be penalized for filing a complaint.