Ashim Arora, A Medical Corporation

PATIENT REGISTRATION SHEET

PATIENT INFORMATION:

Patient Last Name: _____ First Name: _____ MI: ____

Street Address: _____ City: _____

State _____ Zip _____ EMAIL Address: _____

Primary Phone (____) _____ Secondary Phone (____) _____

Date of Birth: ____/____/_____ Sex: M ☐ F ☐ Social Security #: _____

Patient Driver's License #: _____ State of Issue: _____ Hispanic/Latino descent: Y / N

Marital Status: S ☐ M ☐ D ☐ W ☐ Spouse's Name (if applicable): _____

Occupation: _____ Employer: _____

EMERGENCY CONTACT: _____ Relationship to Patient: _____

Primary Phone (____) _____ Secondary Phone (____) _____

INSURANCE INFORMATION:

Primary Insurance: _____ *Secondary Insurance:* _____

Patient is Subscriber/Policy Holder: YES ☐ NO ☐ Patient is Subscriber/Policy Holder: YES ☐ NO ☐

Primary Policy ID #: _____ *Secondary Policy ID:* _____

Primary Group #: _____ *Secondary Group #:* _____

Insurance Subscriber/Policy Holder Name (if different from patient): _____

Relationship to Patient: _____ Date of Birth: ____/____/_____ Sex: M ☐ F ☐

The above information is true to the best of my knowledge. I hereby authorize Ashim Arora, A Medical Corporation to provide medical care and direct my insurance carrier to pay directly to this provider any benefits payable under my insurance plan. I understand that I am responsible for any balance not paid under this plan. I also authorize Ashim Arora, A Medical Corporation to release any information required to process my claims. If I am uninsured, I am fully responsible for all charges. I further agree that a photocopy of this agreement will be as valid as the original.

I agree to be evaluated and treated by the Physician and/or the Physician Assistant (PA-C). Both are licensed and governed by the California State Board of Medical Examiners. A Physician Assistant provides an additional level of access to high quality patient care in our office.

Patient Signature _____ Date _____

Ashim Arora, A Medical Corporation

PATIENT HEALTH and HISTORY

PATIENT NAME _____ Date of Birth _____

CURRENT PHYSICIANS:

Physician Name	City	Specialty

SOCIAL HISTORY:

Occupation (current or prior): _____ Employer: _____
(circle one if applicable) retired / unemployed / leave of absence / disabled

Marital Status: (circle one) single / married / widowed

Spouse/Partner Name: _____ Number of children: _____

Who lives at home with you? _____ What pets do you have at home? _____

Do you Have a POLST (Physican Order for Life Sustaining Treatment)? YES/NO

Advanced Directive? YES/NO Name of Medical Power of Attourney? _____

_____

TOBACCO USE:

Smokes Cigarettes:	☐Currently	☐Formerly	☐Never

Former Smoker:

Quit Date/Year: _____ Years Smoked: _____ Packs/Day Smoked: _____

Current Smoker:

Packs/Day: _____ Years Smoked: _____ Other Tobacco: ☐Pipe ☐Cigar ☐Snuff ☐Chew

Illegal Drug Use: ☐Past ☐Present Type _____ Frequency _____

ALCOHOL USE:

Drink Alcohol:	☐Daily	☐Occasionally	☐Rarely	☐Never

EXERCISE:

How many days/week? _____ Duration: _____ minutes

PATIENT NAME _____ Date of Birth _____

PREVIOUS SURGERIES:

FOR WHAT REASON?	WHICH HOSPITAL/CITY?	YEAR:

PAST MEDICAL HISTORY:

Pulmonology: ☐Asthma ☐Bronchitis ☐COPD (chronic bronchitis/emphysema) ☐Blood Clots ☐Pneumonia ☐History of abnormal chest x-ray/CT scan

Sleep: ☐Sleep Apnea ☐Snoring ☐Insomnia ☐Excessive Daytime Sleepiness ☐CPaP

Ear/Nose/Throat: ☐Allergies ☐Sinusitis ☐Glaucoma ☐Cataract

Cardiovascular: ☐High Blood Pressure ☐Coronary Artery Disease ☐Heart Attack ☐Heart Murmur ☐History of Stent Placement ☐Abnormal Heart Beat

Gastrointestinal: ☐GERD (acid reflux) ☐GI Bleed ☐Liver Disease ☐Abnormal Liver Function Tests ☐Colon Polyps ☐Stomach Ulcer ☐Colonoscopy, Yr_____ ☐Upper Endoscopy, Yr_____

Endocrinology: ☐Diabetes ☐Low Thyroid ☐High Thyroid ☐High Cholesterol ☐Kidney Problems

Neurology: ☐Headache/Migraine ☐Stroke ☐TIA ☐Nerve Pain ☐Seizures

Hematology: ☐Anemia ☐Bleeding Problems ☐Blood Transfusion

Oncology: ☐Cancer If yes, what type _____ Year _____

Urology: ☐Renal Stone ☐Blood in Urine ☐Recurrent Urinary Tract Infections ☐Urinary Frequency ☐Burning with Urination

Musculoskeletal: ☐Arthritis ☐Osteoporosis ☐Neck Pain ☐Back Pain

Psychiatry: ☐Depression ☐Anxiety ☐ADD/ADHD ☐Other

FAMILY MEDICAL HISTORY:

RELATIVE	ALIVE / DECEASED	AGE	MAIN MEDICAL PROBLEMS
Mother			
Father			
Sibling			
Sibling			
Child			
Child			

Ashim Arora, A Medical Corporation

MEDICATION/ALLERGIES SHEET

Patient Name _____ Date of Birth _____

*** *LATEX ALLERGY:* *Yes* ☐ *No* ☐

Current PRESCRIPTION Medications	Dosage/Strength	Frequency

Current OVER-THE-COUNTER Medications/Vitamins	Dosage/Strength	Frequency

Current HERBAL Medications	Dosage/Strength	Frequency

ALLERGIES TO MEDICATIONS (including anesthesia)	REACTION:

VACCINE HISTORY/RECORD	DATE/YEAR RECEIVED
Influenza Vaccine	
Pneumonia Vaccine (Pneumococcal23 and Prevnar13)	
Tetanus	
Tdap	

ASHIM ARORA, M.D., F.C.C.P.
158 Macaw Lane
Simi Valley, CA 93065
Tel: (805) 584-1930 · Fax: (805) 584-1932

PATIENT NAME _____ YOUR DATE OF BIRTH ____/____/_____
(Please Print)

PERMISSIONS

1) My designated emergency contact is:

NAME _____ PHONE # _____
(Please Print)

2) You may leave a message regarding any of my appointments with the person listed above.

YES ☐ NO ☐

3) You may leave a message regarding my test results/medications, etc., with the person listed above.

YES ☐ NO ☐

4) You may discuss my health information with the person listed above.

YES ☐ NO ☐

5) May we release you medical information to a government agency to assist in community reportings?

YES ☐ NO ☐

6) May we release pertinent records to other Physicians that our provider may refer you to?

YES ☐ NO ☐

SIGN _____ DATE ____/____/_____

Our Financial Policy

We are dedicated to providing the best possible care for you. We want you to completely understand our financial policies.

1. ☐ **Payment is due at the time of service**
   We accept major credit cards, cash, and checks. There will be a charge of $25 for all returned checks.

2. **Fees**
   There is a fee for medical care. Fees are posted in the office and may be requested prior to services being performed.

3. ☐ **Procedures** beyond the physician/staff consultant/office visit are charged separately for each procedure performed (i.e. EKG's, Spirometry, Pulmonary Function Tests, etc.) in addition to the office visit fee. Procedures may also be subject to different insurance benefits than the office visit. Your annual deductible and co-insurance charges may apply. You may request to discuss any fees beyond your office visit co-pay or co-insurance in advance of your treatment.

4. **If you have medical insurance**
   As a service to you, we will file your insurance claim if you assign benefits to the doctor- in other words, if you agree to have your insurance carrier pay the doctor directly.

5. ☐ **Any copayments, co-insurance and deductibles are due at the time of your visit** (up to the amount we can reasonably estimate will be due according to your insurance policy). You will be billed for all outstanding balances. FEDERAL AND STATE LAWS AND MANAGED CARE CONTRACTS MANDATE THAT WE COLLECT ALL APPLICABLE CO-PAYS AND DEDUCTIBLES. You may request to discuss your fees before your treatment.

6. If you have not met your deductible or if your deductible applies to office visits, we may collect the full amount applicable towards your services on the day of your visit and before any procedures are performed.

7. If we are unable to verify your insurance coverage at the time of your visit, we will ask you to pay for all services at the time of your visit. If we later receive a payment from your insurer, we will refund overpayment to you in a timely manner. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive payment from your insurer, we will refund overpayment to you.

8. We have made prior arrangements with many insurance companies to accept an assignment of benefits. If we are listed as participating providers in your plan, you will only be responsible for any amounts not paid by your policy, including co-payment, co-insurance and deductible amounts. If we do not have prior arrangements with your insurance carrier, we will prepare the claim and submit it to your insurance, however, you may be responsible for the entire bill.

9. **Provider Participation**
   It is your responsibility to determine if the doctor is a participating provider under your insurance plan. As a service to you, we will assist in the determination of participation in your insurance plan to the best of our ability

10. ☐ **Not all insurance plans cover all services**
    In the event that your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon the receipt of a statement from our office.

11. **Please notify us immediately if your insurance has changed**. Failure to notify us may result in no payment of services and thus transfer the financial responsibility to you.

12. IF YOU HAVE AN HMO - Please note that we do not DIRECTLY participate with any HMO plans.

13. If you are insured with Covered California, please note that we are not participating providers with these plans. You will be responsible for payment for all services at our private pay rates.

14. ☐ CANCELLATION POLICY
    - 24-hour notice is required to cancel or reschedule an appointment
    - A fee of $50 may be assessed if you fail to keep a new patient appointment.
    - A fee of *$25 for a 2nd missed appointment up to $75 for 3 or more missed appointments* may be assessed if you fail to keep your follow up appointment.

15. We reserve the right to refuse service to anyone. You may be discharged from our practice for non-payment of outstanding balances or other reasons.

Patient Signature _____ Date _____

NO SHOW/MISSED APPOINTMENT POLICY

We, at ASHIM ARORA, A MEDICAL CORPORATION, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice).You can cancel appointments by calling the following number: 805-584-1930.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see the clinician's at ASHIM ARORA, A MEDICAL CORPORATION and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients in need of medical care.

2. If less than a 24-hour cancellation is given this will be documented as a "No-Show" appointment.

3. If you do not present to the office for your appointment, this will be documented as a "No-Show"appointment.

4. After the first "No-Show/Missed" appointment, you will receive a phone call or letter informing you that you have broken our "No-Show" policy. Staff at ASHIM ARORA, A MEDICAL CORPORATION will assist you to reschedule this appointment if needed.

5. If you more than 2 "No-Show/Missed" appointments incur, you will receive a warning letter from our office and will be assessed a $25.00 no show fee.

I have read and understand ASHIM ARORA, A MEDICAL CORPORATION'S No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify ASHIM ARORA, A MEDICAL CORPORATION appropriately if I have difficulty keeping my scheduled appointments.

Patient Name	Date of Birth	Date
Patient Signature or Parent/Guardian if minor	Relationship to Patient	

Ashim Arora, A Medical Corporation

ACKNOWLEDGMENT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge having received Notice of Privacy Practices from Ashim Arora, A Medical Corporation. I have been informed that I have the right to review Notice of Privacy Practices at any time. The Notice of Privacy Practices may change in accordance with updated laws.

Patient Signature _____ **Date** _____

Printed Patient Name _____

HIPAA NOTICE OF PRIVACY PRACTICES

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital may may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization:
Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object:

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate your care and disclosures to family or other individuals involved in your health care.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice use for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact your doctor if you have any other questions about privacy practices.