Jonathan Oheb, M.D.

GENERAL INFORMATION - Please take a moment to fill the information below.

Name: _____ Date: _____

Home Phone: _____ Cell Phone: _____

Address: _____ City: _____

State: _____ Zip: _____

Email: _____

Date of Birth: _____ Age: _____ Handed (circle one): Right/Left

Sex (circle): M F Date of Injury: _____ Social Security: _____

Please initial if we may leave messages on your answering machine or voicemail: _____

Employer: _____ Occupation: _____

Primary Care Doctor: _____ Phone #: _____

**Do you have health insurance? (circle) YES NO

Insurance: _____ ID #: _____

Were you involved in a personal injury? (Please answer questions below)

** Do you have auto insurance? (circle) YES NO

Insurance: _____ ID #: _____

Attorney (If applicable) _____

Address: _____

City: _____ State: _____ Zip: _____

Attorney's Number: _____ Fax: _____

DISCLOSURE TO FAMILIES AND LOVED ONES (Emergency Contacts)

I authorize Jonathan Oheb MD to disclose my health care information and to discuss my health care needs to those that I designate. I further authorize the release of my billing information and give these individuals the ability to pick

up prescriptions and/or medications on my behalf. These individuals will be considered my emergency contacts. Without authorization, no information may be shared. I authorize Jonathan Oheb MD to disclose my health information with the following people: PLEASE PRINT

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE AND THAT ALL INFORMATION GIVEN IS TRUE AND CORRECT.

Signature of Patient or Patient Representative: _____ Date: _____

NAME:_____ DATE:_____

NATURE OF PROBLEM:_____

_____

_____

_____

DATE OF INJURY OR DATE SYMPTOMS OCCURRED:_____

_____

WHERE AND HOW INJURY OR ACCIDENT OCCURRED:_____

_____

_____

_____

_____

NAME OF DOCTOR OR FACILITY FIRST TREATED YOU:_____

_____

_____

NATURE OF TREATMENT:_____

_____

_____

_____

_____

DO YOU OR IS THERE ANY FAMILY HISTORY OF THE FOLLOWING AND WHICH FAMILY MEMBERS:

TUBERCULOSIS_____ ARTHRITIS_____

HIGH BLOOD PRESSURE_____ CANCER_____

DIABETES_____ HEART DISEASE_____

OTHER_____

NEXT PAGE

NAME:_____ DATE:_____

DO YOU HAVE ANY OR HAVE YOU HAD ANY ILLNESSES, ACCIDENTS, SURGERIES OR HOSPITALIZATION? IF SO PLEASE INCLUDE DATES:

_____

_____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS?:_____

WHAT TYPE OF REACTION?:_____

ARE YOU ON ANY MEDICATIONS? IF SO, GIVE NAMES:_____

_____

GENERAL HEALTH:

HEIGHT_____WEIGHT_____RIGHT HANDED____LEFT HANDED_____

ARE YOU CHRONICALLY BOTHERED WITH ANY OF THE FOLLOWING:

_____HEADACHES	_____DIARREA
_____DIZZINESS OR FAINTING SPELL	_____ CONSTIPATION
_____TROUBLE WITH VISION	_____ULCERS
_____BREATHING	_____INDIGESTION
_____COUGH OR SPUTUM	_____PALPITATION
_____CHEST PAIN	_____OTHERS

DO YOU HAVE PROBLEMS URINATING?_____

DO YOU SMOKE?:_____DO YOU DRINK ALCOHOLIC BEVERAGES?_____

DO YOU USE ANY KIND OF RECREATIONAL DRUGS?:_____

FEMALE PATIENTS:MENSTRUAL IRREGULARITY OR PROBLEMS?_____

HOW MANY PREGNANCIES?____HOW MANY LIVING CHILDREN?_____

MALE PATIENTS: HAVE YOU HAD ANY PROSTATE TROUBLE?_____

ADDITIONAL INFORMATION:_____

JONATHAN OHEB, M.D.

AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name: _____ SS#: _____

I authorize the following person, or facility to release my health information:

Name of Person or Facility: _____

Street Address; _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

To be received by:

[ ] Dr. Jonathan Oheb, M.D.

This will authorize you to permit the bearer to review, inspect, copy, and/or photocopy any of the following your possession or control:

1. X-rays- films and reports
2. Medical Reports, records, chart, and notes
3. Personal, attendance (work or school)

Photocopies of this authorization will be considered as valid as the original This is not

an authorization to discuss this case with any insurance company representative.

Patient Signature: _____ Date: _____

5363 Balboa Blvd Suite 445
Encino, CA 91316
Tel: (818) 946-8424 Fax: (818) 946-8429

JONATHAN OHEB, M.D.
Financial Policy

The following is an explanation of our policies and procedures. We will be happy to answer any questions you have regarding our **Policy, your account, and your insurance coverage.**

Payments

Your health care needs are our primary concern. We do not want finances to get in the way of you getting the health care that you need. Policies are in place in an attempt to assist you in meeting your financial obligations without increasing stress in your life.

If you do not have insurance ALL payments are expected at the time of service.

If you have insurance ALL COPAYS AND/OR CO-INSURANCE are due at the time of service. If you have a deductible it must be satisfied before any coinsurance/copay take into effect. There will be a $25.00 charge on all returned checks.

Insurance Coverage/ Verification

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule bearing no relationship to the current standard of care in this area. If your carrier has not paid a claim within (60) days of submission, you agree to take active part in the recovery of your claim. If your insurance carrier has not paid within (90) days of submission, you accept responsibility for payment in full of any outstanding balance. As a courtesy to our patients, our office will attempt to pre-verify your primary insurance coverage. It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance. Please be advised that the information provided by your insurance is not a guarantee of payment.

Initial _____

Personal/ Auto Injury

In the nature of a personal/auto injury, payments of medical bills can go months or sometimes years until the case settles and satisfies our charges. We must ask you to provide any/or all of the following benefits that apply:

1. Automobile Insurance- Medical Pay
2. Health Insurance
3. Lien- signed by you and your attorney

*Initial*_____

Appointment/ Treatment

We require that you give us a 24 hour cancellation notice if you need to miss your appointment. For personal/auto injury cases **appointments missed are to be made up within the same week to assist you in reaching your maximum therapeutic benefit.**

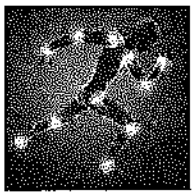
*Initial*_____

Patient Health Information Consent

By signing you agree to allow this office to use your Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As a patient you have the right to obtain a copy of your health records at any time. For your security, all staff has been trained in the area of patient record privacy. If you refuse to sign this consent for the purpose of **treatment, payment, and health care Operations our office has the right to refuse to give care.**

_____ _____

Patient/Parent/Guardian Signature **Date**



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Fax: (818)946-8429

Encino	***Mission Hills***	***Beverly Hills***
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Encino, CA 91316	Mission Hills, CA 91345	Beverly Hills, CA 90211

Patient Name: _____ **DOB:** _____

Cash patient: Payment is due full when service are rendered.

Co- payment and deductibles are due when service are rendered: Insured patient are responsible for all charges not covered by the insurance company. Payment arrangements can be made on an individual basis AT OUR DISCRETION.

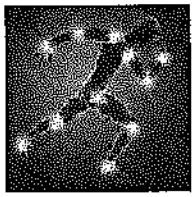
Insurance Policy: We will bill your insurance company as a courtesy provided, we are provided with all the current necessary information. It is the patient's responsibility to verify with your insurance company as to whether you are covered for medical services provided to you. If you require an authorization for services that we are recommending, we will forward that request to your insurance company.

No Show: Patients who fail to cancel an appointment within 24 hours of the appointment time may be charged $25 for visit.

I acknowledge that I was informed by the office whether or not they are in or out of network for my medical service. It is my right to choose among these options as well as my financial responsibilities for both in and out of network services.

Given the choices and considering my medical needs and the quality of care that may be offered, I have made my own informed decisions and choices for medical services.

Patient Signature: _____ **Date:** _____



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QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have question or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or your disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.

Contact Officer: _____

Telephone: _____ Fax: _____

Address: _____

I HAVE READ THE NOTICE OF PRIVACY PRACTICE

PRINT PATIENT'S NAME: _____

SIGNATURE OF PATIENT: _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN: _____

DATE: _____

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HIPAA-ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have reviewed/received a copy of HIPAA NOTICE OF PRIVACY PRACTICES documents

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____

OR

Signature of Personal Representative: _____

Authority of Personal Representative to Sign for Patient (check one)

Parent_____Guardian._____Power of Attorney _____Other____

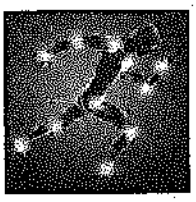
Please Note: It is your right to refuse to sign this Acknowledgement.

Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of HIPAA NOTICE OF PRIVACY PRACTICES, but it could not be obtained because:

_An emergency prevented us from obtaining acknowledgement.
_A communication barrier prevented us from obtaining acknowledgement.
_The individual was unwilling to sign.
_Other

Staff Member Signature: _____ Date: _____



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PATIENT NAME: _____ **DOB:** _____ **DATE:** _____

WHO REFERRED YOU TO OUR OFFICE?

- PHYSICIAN _____
- FRIEND _____
- INSURANCE _____
- INTERNET:
  - YELP
  - GOOGLE
  - HEALTH GRADES
  - WED MD
  - ZOCDOC
  - VITALS.COM
  - OTHER: _____

Consent to Use Telemedicine

Patient's Name_____ My Doctor's Name_____

CONSENT TO USE TELEMEDICINE

I am physically located in California. At the beginning of each telemedicine session, I will help my doctor to complete a check-in to assess the suitability of using telemedicine services by verifying my full name, my current location, my readiness to proceed, and whether I am in a situation conducive to private, uninterrupted communication. By signing this consent, I understand and agree:

1. My doctor is located in and licensed by the State of California. My doctor may not be able to prescribe medications for me and/or may not be able to assist me in an emergency situation when I am located in any other state or country. If I require medication, I may contact my doctor. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help.

2. I submit to the exclusive jurisdiction of the California state superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by my doctor and my doctor's staff will be brought solely and exclusively in California state superior courts. I also agree that the interpretation of this consent will be exclusively governed by and construed in accordance with the laws of California.

3. My doctor believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use despite its risks and limitations. While I may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.

4. If my doctor believes at any time that another form of services (for example, a traditional in-person consultation) would be appropriate, my doctor may discontinue telemedicine services and schedule an in-person consultation with my doctor or refer me to a healthcare provider in my area who can provide such services.

5. I have the right to withdraw consent to the use of telemedicine services at any time and receive inperson healthcare services with my doctor.

6. I received an explanation of how the electronic communications technology will be used for the telemedicine services. I am comfortable with using electronic communications technology to communicate with my doctor and understand there are limitations to the technology which may require an in-person consultation.

7. I agree to have the necessary computer, equipment and internet access for my telemedicine communications. I also agree to arrange for a location with sufficient lighting and privacy and is free from distractions and intrusions during my telemedicine communications.

8. The laws that protect privacy and the confidentiality of my medical information also apply to telemedicine. The medical information that is transmitted electronically by my doctor to me will be encrypted during transmission and will be stored only by my doctor or a service provider selected by my doctor. I understand the dissemination of any personally-identifiable images or information from the telemedicine communication to researchers or other healthcare providers will not occur except as required by federal or California state law.

9. I understand my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to "autoremember" usernames and passwords, or use my work computer for personal communications. I also understand it is my responsibility to encrypt medical information I transmit electronically to my doctor and my failure to use technical safeguards, such as encryption, increases my risks of a privacy violation.

10. [I agree to be videotaped and recorded during the telemedicine services. I understand the resulting images and audio will become part of my medical record.] OR [No part of the encounter will be recorded without my written consent.]

11. I have the right to access my medical information and obtain copies of my medical records in accordance with California law.

12. I understand that the telemedicine services provided to me will be billed to my health insurance company and that I will be billed for any patient responsibility as per my insurance.

I read and understand the information provided in this Consent to Use of Telemedicine. I discussed any questions I had with my doctor and all of my questions were answered to my satisfaction.

Date _____ Patient's Signature _____

About Telemedicine

WHAT IS TELEMEDICINE?

Telemedicine (also sometimes called telehealth) services are a way to deliver healthcare services locally to a patient when the healthcare provider is located at a distant site. Telemedicine is generally defined as the use of electronic information and communications technology to exchange medical information from one site to another site to provide medical or surgical treatment to a patient and/or to participate in the medical diagnosis of, or medical opinion or medical advice to, a patient.

When a healthcare provider believes a patient may benefit from the use of telemedicine services, telemedicine can maintain a continuity of care with the provider and facilitate patient self-management and caregiver support of the patient. Telemedicine services often provides a broader access to medical care, eliminates transportation concerns, and increases comfort and familiarity for patients and their families when located in their own homes or other local environments.

However, telemedicine uses new communications technology for which there is little research supporting its effectiveness. For example, telemedicine services may not be as complete as in-person healthcare services because the healthcare provider will not always be able to observe subtle non-verbal communications such as a patient's posture, facial expression, gestures, and tone of voice.

Telemedicine may transfer medical information through the use of interactive, real-time audio/visual technology (for example, video conferencing) or electronic data interchange (for example, computer-to-computer exchanges), or it may transfer medical information through the use of store-and-forward technology (for example, emails). While precautions are taken to secure the confidentiality of telemedicine services, the electronic transmission of medical information can be incomplete, lost or otherwise disrupted by technical failures. Additionally, despite such measures, the transmission and storage of medical information can be accessed by unauthorized persons, causing a breach of the patient's privacy.

I read and understand the information provided in this document. I discussed any question I had with my doctor and all of my questions were answered to my satisfaction.

_____ _____

Date Patient's Signature