SHADIAR OHADI D.O., M.P.H.
Patient Information Sheet

Patient:
First Name: _____ M.I ___ Last Name: _____ DOB: _____ Age: ____
Address: _____ Apt# _____ City: _____
State: _____ Zip Code: _____ Marital Status: _____ Social Security#: _____
Home #: Cell #: Email:

Partner/Spouse:
First Name: _____ Last Name: _____ Cell#: _____

Employer Information:
Employer: _____ Occupation: _____
Work #: Extension #: Fax:

Insurance Information: Primary
Responsible party (if different from patient): _____ Insured name: _____
Relationship to Insured: _____ SSN # Insured: _____ DOB Insured: _____
Insurance company name: _____ ID #: _____ Group # _____
Address: _____ City: _____ State: _____ Zip: _____

Insurance Information: Secondary
Responsible party (if different from patient): _____ Insured name: _____
Relationship to Insured: _____ SNN # Insured: _____ DOB Insured: _____
Insurance company name: _____ ID #: _____Group # _____
Address: _____ City: _____ State: _____ Zip: _____

General Information:
Referred By: _____ Relationship: _____
Previous Physician: _____ Phone #: _____

Emergency Contact:
Name: _____ Relationship: _____ Phone #: _____

Pharmacy Information:
Name: _____ Phone #: _____

Release of Information and Assignment of Benefits

I authorize Dr. Shadiar Ohadi to disclose any and all information concerning my care and treatment as necessary to maintain continuity of treatment and care.

As a courtesy, Dr. Shadiar Ohadi will submit claims to my insurance company on my behalf and I authorize the release of medical information to insurance companies and its representatives. I understand that ultimately, I am financially responsible for all charges incurred and any balance due.

Any credit card used to pay a balance must be in (your) the patients name or if your spouse/partner is using their credit card to pay, they must sign below authorizing you to use their credit card.

A photocopy of this authorization shall be as valid as the original.

_____ _____
Patient-Parent Signature (if minor) Date

SHADIAR OHADI D.O., M.P.H.
4835 Van Nuys Blvd #203
Sherman Oaks, CA 91403

PATIENT INSURANCE RESPONSIBILITY AGREEMENT

Patient: _____

Insurance: _____

I have been advised and do understand that Dr. Shadiar Ohadi will bill my insurance company as a courtesy.

I know that I am financially responsible to pay Dr. Ohadi for any balance resulting from:

1. Non-Covered Services
2. Patient co-payments
3. Any deductibles and patient responsibility amounts
4. Covered benefits paid directly to patient instead of Dr. Ohadi

Note:
We DO NOT accept third party checks.
If my/our insurance company sends us directly any checks for services provided, I/we will deposit the check. Within 3 days of receipt of check I/we will send a personal or cashiers check.

This agreement applies to all past & future balances.

I have read and agree to abide by this written agreement. I understand that if I fail to meet my obligations, that Dr. Ohadi may take legal action to include referral to an outside Collection Agency and this may affect my credit rating.

_____ _____

Patient Signature: Date:

SHADIAR OHADI D.O., M.P.H.
Patient Medical Information Sheet

Date: _____

Patient:
First Name: _____ M.I. ____ Last Name: _____ DOB: _____ Age: _____

Do you have children? ____ Y ____ N How many? ____ Boys ____ Girls ____

Are your parents alive? ____ Y ____ N If not what was the cause of death? _____

_____

_____

Do you have brothers? ____ Y ____ N How many? ____ Sisters? ____Y ____ N How many? ____

Do you have any allergies to medicine? _____

Please list current medications you're taking? _____

_____

When was your last physical examination? _____

When was your last mammogram? _____ Last pap smear? _____

Have you ever been admitted to the hospital? ____ Y ____ N If yes, please list the reason and the dates in

chronological order? _____

_____

Do you use tobacco? ____ Y ____ N If yes, how much each day? _____ If you quit, when? _____

How long did you smoke? _____

What is the main medical problem or reason for visiting the doctor today? _____

_____

Is there any other information that you feel I should know? _____

_____

_____

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____

- **Right to consent** – Healthcare providers are required to obtain prior consent before sharing personal health information for purposes *other than* treatment, payment and healthcare operations.
- **Right to Recourse** – You have the right to file a formal complaint if you believe that violations of the regulations were made.

In general, HIPAA tries to find a balance between protecting your privacy and allowing the appropriate flow of information between healthcare providers that is necessary for you to access care and receive quality healthcare services.

Want to learn more?
For a copy of our practice privacy protections, please ask the receptionist at the front desk.

The following organizations have websites that may contain helpful information on HIPAA:

American Medical Association
American Dental Association
American Chiropractic Association
American Optometric Association
American Podiatric Medical Association
American Academy of Ophthalmology

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(Vers. M2SSS04)

Protecting Your Health Information

What you need to know about the Health Insurance Portability and Accountability Act

Identity theft. Credit card fraud. Computer viruses. Concern for the privacy and security of personal information, has never been greater. Our concern for the safety and security of your personal healthcare information has never been taken more seriously.

While we have always gone to great lengths to ensure the privacy of your personal health information, we will soon be getting additional help from the Federal Government in the form of new regulations. These regulations will help standardize privacy and security requirements across the country and across all different types of healthcare organizations.

New Regulations Passed
The regulations are part of the Health Insurance Portability and Accountability Act or HIPAA, for short. HIPAA does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange electronic health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage; although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individual health information and medical records.

HIPAA Ensures the Privacy and Security of Individual Health Information
Currently, individual state laws govern use and disclosure of this information, creating many inconsistencies and gaps in the way your health information is protected. HIPAA sets minimum security and privacy standards for healthcare organizations to follow. If a state has more stringent privacy and security laws, then those would be followed instead. In addition, HIPAA sets heavy penalties for violations of these standards and the misuse of personal health information.

Defining Individual Health Information
Every time you go to see a doctor, are admitted to a hospital, fill a prescription or send a claim to an insurance company, a record is made of your confidential health information. This type of information is referred to as individually identifiable health information and is the type of information regulated by HIPAA. It can be in any format – electronic, paper or oral.

Healthcare providers that collect and manage this type of information are therefore covered by these regulations including physicians, physical therapists, mental health professionals, dentists, chiropractors, optometrist, podiatrists and others. HIPAA also regulates this type of information in organizations such as: hospitals, health plans, employers, healthcare clearinghouses, claims processors, and others who conduct administrative and financial healthcare transactions.

Added Control Over Health Information
Under HIPAA, you have new rights to understand and control how your health information is used:

- **Right to education** – Healthcare providers and health plans are required to provide you with a clear written explanation of how they intend to use and disclose your information.
- **Right to access medical records** – You have the right to see and get copies of your medical records, request changes and receive a history of non-routine disclosures of your personal health information.

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

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