HERA Health Care
910 Hampshire Road, Suite A
Westlake Village, Ca, 91361
805-379-9110

A Holistic Esthetic Restorative and Anti-Aging Medical Practice

Seek your Inner Goddess!

Driving Directions to our Office!

From 101 - going SOUTH *towards L.A.*

- **Exit Westlake Blvd**
- Turn Right at the end of the ramp

From 101 - going NORTH *towards Ventura*

- **Exit Westlake Blvd**
- Turn Left at the end of the ramp

Then . . .

- Make a Right onto Hampshire Rd. (2nd traffic light)
- Make a Right onto Wild Rose (1st street on right)
- Make a Left into the 2nd driveway on left
  (Were located on the backside of the complex so our address is not visible from the road, but if you see "Bolderdash" to your left when you turn into the driveway your on the right track)
- Drive until you see building 910 (almost to the end)
- Park directly outside Suite A, in the 910 building. You will see a sign with our name on it directly over the door.
- Reception is to the right when you enter the suite.

If you have any questions or need further directions feel free to call us 805.379.9110

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=Todays Date_____

Patient Demographic Information

Name:_____
Last First MI

Address:_____
Street City State Zip Code

Contacts: Cell:_____ Home:_____ Work:_____

E-mail:_____

Please circle how you wish to be contacted: Cell - Home – Work - E-mail - Text

Best time frame to contact: _____ Ok to leave a Voicemail? _____

SSN:_____ DOB:_____ Age:_____

Reason for visit:_____

Primary Care Provider:_____ PCP Phone #: _____

Primary Insurance Company:_____ Co-pay Amount: _____

Policy/ID #:_____ Group #:_____

Policy Holder Name:_____ Policy Holder DOB:_____

Patient Relationship to Insured: ___Self ___Spouse ___Child ___Other Insurance Phone#:_____

Emergency Contact:_____ Phone #:_____

Relationship to Patient: _____ Address: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize HERA Health Care or insurance company to release any information required to process my claims.

_____ _____
Patient/Guardian Signature Date

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Please be advised that as of October 1st, 2014 our financial policy is the following:

Medical services are expected to be paid promptly. If you choose to be billed for your insurance visits, you have 30 days from the date on your 1st statement to make a payment. You will not receive a statement until your visit has been processed by your insurance.
A monthly $25 late fee will be assessed if your payment has not posted to your account 30 days from the statement date. All patient accounts that are 90 days late will be given a final 30 days to set up a payment plan. After 120 days of no payment received, we will regretfully send your account to a collection agency.

We encourage and support our patients' financial responsibility. We also value our relationship with you and prefer to avoid charging you any late fees.

For your convenience we offer you the option to provide us with a credit card that can be charged, and full payment debited once your payment becomes past due. Before we charge your credit card we will call you. Please provide us with a phone number where you can be reached. We will leave you a voice message with the amount and the date your credit card will be charged, if we are unable to reach you at the number you provided. You will receive a statement reflecting your credit card payment.

If your account is past due, you will not be able to make an appointment until payment in full (including late fees) has been received, unless the treating physician decides that the reason for your visit constitutes a medical emergency. Also, if your account is past due and you require a refill on your medications, a one-time 30 day refill would be granted, giving you plenty of time to either make your account current or find another physician.

Providing us with a credit card will not compromise your ability to dispute a charge or question your insurance company's determination of payment. Co-pays and cash payments due at the time of the visit will, of course, still be due at the time of the visit.

Your credit card information will be held securely in your electronic medical record, along with your demographic information. It is your responsibility to update us of any changes to your credit card information, including credit card number, address and phone number.

If you have any questions about our financial policy, please do not hesitate to ask.

I authorize HERA Health Care, to charge outstanding balances on my account to the following credit card:

Visa Mastercard American Express DisOther: _____

Account number _____

Expiration Date _____

Security number _____

Billing address for the card: _____

_____

Phone number _____E-mail _____

By signing below I agree with the terms specified in this document, and I give HERA Health Care permission to use my card for paying any outstanding balances as they become past due, so I can avoid late fees and becoming delinquent.

Printed Name _____

Signature _____

Date _____

Supplement purchase REFUND POLICY

If you decide to purchase any supplements sold through out practice please be aware that we accept ***unopened bottles within 30 days from date of purchase for a full refund***.
If bottles are opened no refund will be paid.

Also supplements are not included in the cost of your visit and are considered not reimbursable by your medical insurance - however IF you have an HSA you can use your card to purchase them and we can provide the diagnostic codes to help you submit it through the insurance.

I have read this policy and I agree to it without reservations.

Name _____ Signature _____ Date_____

HERA Health Care

Dr. Mirela Cernaianu

PATIENT – PHYSICIAN ARBITRATION AGREEMENT

ARTICLE 1: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2:I understand and agree that this arbitration agreement binds me and anyone else who may have a claim arising out of or related to all treatment or services provided by the physician, including any spouse or heirs of the patient and any children, whether born or unborn at the time of the occurrence giving rise to any claim. This includes, but is not limited to, all claims for monetary damages exceeding the jurisdictional limit of the small claims court, including, without limitation, suits for loss of consortium, wrongful death, emotional distress or punitive damages. I further understand and agree that if I sign this agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person(s) will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this agreement relates to claims against the physician and any consenting substitute physician, as well as the physician's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete settlement of any dispute arbitrated under this Agreement, as set forth in the CMA/CHA Medical Arbitration Rules.

ARTICLE 3: I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

ARTICLE 4: I UNDERSTAND THAT I DO NOT HAVE TO SIGN THIS AGREEMENT TO RECEIVE THE PHYSICIAN'S SERVICES, AND THAT IF I DO SIGN THE AGREEMENT AND CHANGE MY MIND WITHIN 30 DAYS OF TODAY, THEN I MAY CANCEL THIS AGREEMENT BYGIVING WRITTEN NOTICE TO THE UNDERSIGNED PHYSICIAN WITHIN THAT TIME STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT.

ARTICLE 5: On behalf of myself and all others bound by this agreement as set forth in Article 2, agreement is hereby given to be bound by the Medical Arbitration Rules of the California Healthcare Association (CHA) and the California Medical Association (CMA), as they may be amended from time to time, which are hereby incorporated into this agreement. A copy of these Rules is included in the pamphlet in which this agreement is found. Additional copies of the Rules are available from the California Medical Association, P.O. Box 7690, San Francisco, CA 94120-7690, Attention: Arbitration Rules. I understand that disputes covered by this Agreement will be covered by California law applicable to actions against health care providers, including the

Medical Injury Compensation Reform Act of 1975 (including any amendments thereto).

ARTICLE 6: OPTIONAL: RETROACTIVE EFFECT If I intend this agreement to cover services rendered before the date it is signed (for example, emergency treatment), I have indicated the earlier date I intend this agreement to be effective from and initialed below.

Earlier effective date (if applicable) :_____ Patient's Initials_____

ARTICLE 7: I have read and understood all the information in this pamphlet, including the explanation of the Patient-Physician Arbitration Agreement, this Agreement, and the Rules. I understand that in the case of any pregnant woman, the term "patient" as used herein means both the mother and the mother's expected child or children.

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ Dated:_____

(Patient, Parent, Guardian or Legally Authorized Representative of Patient)

If signed by other than patient, indicate relationship:_____

PHYSICIAN'S AGREEMENT TO ARBITRATEIn consideration of the foregoing execution of this Patient-Physician Arbitration Agreement, I likewise agree to be bound by the terms set forth in this agreement and in the rules specified in Article 4 above.

_____ Date:_____

(Physician or Duly Authorized Representative)

Physician

_____

Title—Partner, President, etc.

HERA Healthcare- Mirela Cernaianu, M.D.

_____

Print name of Physician, Medical Group or Association

HERA HEALTH CARE
Mirela Cernaianu, M.D.
910 Hampshire Road, Suite A
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Patient Consent for the use and disclosure of Protected Health Information

We have implemented all the HIPAA (Health Insurance Portability and Accountability) guidelines recommended by the Federal Government. I hereby give my consent for the above practice to use and disclose protected health care information about me to carry out treatment, payment and healthcare operations. Your healthcare information will only be used to communicate with your insurance provider, to communicate with other healthcare professionals who may contribute to your care and for planning your care and treatment.

With this consent, the practice may call my home or alternative location and leave a message on a voice mail or in person in reference to any of the items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and calls pertaining to clinical care.

*** Please print the telephone number to where you would like to receive any phone calls from our office if other than your home:** _____

With this consent, the practice may mail or e-mail to my home or alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statement as long as they are marked Personal and Confidential.

*** Please print the address of where you would like any correspondence from out office to be sent if other than your home:**

_____

By signing this form, I am consenting to the above practice's use and disclosure of my protected health care information to carry out needed treatment, payment and healthcare operations.

* **I authorize the Practice to disclose my medical information to the following family members/friends:**

_____

I may revoke or limit my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the practice may decline to provide treatment to me.

_____ _____

Signature of Patient or Patients Representative Date

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CONSENT FOR MEDICAL TREATMENT

PATIENT NAME: _____

Date of Birth: _____

Knowing that I (or the patient indicated on the top of this form) desire evaluation and/or treatment at HERA Health Care, I voluntarily consent to such care. I consent to routine diagnostic procedures, including but no limited to x-rays, blood draw, collection of saliva or urine samples, other laboratory tests, administration of medication and supplements, recommendations for lifestyle changes and to medical or surgical treatment b Dr. Mirela Cernaianu.

I acknowledge that treatment at HERA Health Care is intended to manage or heal any disease or imbalances using natural, non-invasive and conservative therapies first, however depending on the severity of my medical condition I agree that such therapies might not be sufficient or might not be the best first line of treatment.

In order to provide the best chance for successful treatment I accept responsibility to follow the advice of m treating physician including compliance with any supplements, medications, lifestyle change instructions, laboratory tests ordered or follow up appointments with Dr. Mirela Cernaianu or other referral physicians.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guaranties hav been made to me as to the results of my examination or treatment at HERA Health Care.

I agree to return to the office or seek care with another physician or in an Emergency Department of a hospital if my condition substantially changes. I further agree to hold harmless the physicians and staff of HERA Health Care should I fail to comply with the above conditions.

Patients at HERA Health Care will be treated regardless of race, color, age, national origin, disability or religion. Notwithstanding the above criteria, HERA Health Care reserves the right to refuse care to any individual who may have an unpaid balance, exhibits rude or disruptive behavior or any other reason at the discretion of Dr. Mirela Cernaianu.

This consent shall remain in force until such time as it is specifically revoked.

_____Date:_____

Signature of patient or patient representative

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Medical Cancellation Policy/No Show Policy

Dear Patient,

Thank you for trusting your medical care to HERA Health Care. We strive to render excellent medical care to you and all of our patients. In order to be consistent with this philosophy, HERA Health Care uses an appointment system that sets aside ample time for a patient dependent on the patient's current needs.

If you do not show up for your appointment, or notify us of your inability to keep your appointment by phone at least 24 hours in advance, the time that has been allotted for your visit cannot be used to treat another patient and is time lost to our office. Missed appointments can also cause the doctor to wait at the office when she could be at the hospital or some other healthcare facility. With that in mind and in order to keep costs as low as possible, a Medical Appointment Cancellation Policy has been put into place.

Our policy is as follows:

1. We request that you please give our office a **24-hour notice** in the event that you need to reschedule your appointment. This will make the appointment time available to someone else. Our scheduling number is (805) 379-9110.

2. If you miss an appointment and do not contact us with at least 24 hours prior notice, we will consider this to be a missed appointment and a **$50.00** will be assessed to you.

3. If you are late for an appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length.

4. As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive your reminder call or message, the cancellation policy will still remain in effect.

If you have any questions regarding this policy, please contact HERA Health Care at the above address or phone number and we will be glad to clarify any questions you may have.

We thank you for your patronage.

_____ _____

Signature (Parent / Legal Guardian) Date of Birth

_____ _____

Printed Name Date

Name: _____

Date of Birth: _____

LIST OF CURRENT MEDICATIONS

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion.

Drug Allergies: _____
Preferred Pharmacy:_____
Pharmacy Phone #:_____
Pharmacy Address:_____

Medication	Dose	Frequency	Reason for taking	Date Started	Prescriber

Patient Portal Instructions

For Office Use Only

E-Mail: _____

Username: _____

Temporary Password: _____welcome123_____

Patients Password: _____

- You will receive an email from Portal@Sevocity.com
  - (Check spam mailbox if you cannot find the email)

- In the email will be a link to the portal. Click on it.
  https://www.medicalofficeconnect.com:8444/PatientPortal
- Enter log in information (see above)
  - Log in is case sensitive, no capital letters and no spaces.

- When prompted, create your own password
  - (Write it in the space provided above and keep in a safe place)

You will now have access to the Patient Portal! You can send us messages with any questions you may have. We will send any labs or reports to you through this secure portal. Please just ask the front desk to do