REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's Last name: First: Middle:			☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Marital status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner ☐	
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Birth date:	Age:	Social Security Number:	Sex: ☐ M ☐ F
Preferred Language:			Race:		Ethnicity:
Street address:			Cell phone: ( )		Home phone: ( )
City:	State:	ZIP Code:	Driver's License:	Email address:	
Occupation:	Employer & Employer Address:				Employer phone: ( )
Who referred you to this office? (Please check one box):	☐ Referred by Doctor - Dr.'s Name:				
☐ Family – Name:	☐ Friend - Name:	☐ Internet	☐ Hospital – Name:		
How would you like us to contact you for appointment reminder: ☐ Home Phone ☐ Cell Phone					
PHARMACY: Name, address, and phone number of pharmacy you would like medications called in to:					

INSURANCE INFORMATION

(Please give your insurance card to the front desk.)

Person responsible for bill:	Birth date:	Address (if different):			Home phone: ( )
Is this person a patient here? ☐ Yes ☐ No	Is this injury: ☐ Work Related ☐ Auto ☐ Personal Injury				
Is this patient covered by insurance? ☐ Yes ☐ No					
Please indicate primary insurance	☐ Blue Cross	☐ Blue Shield	☐ Aetna	☐ Cigna	☐ HealthNet
☐ SAG	☐ PacifiCare	☐ Medicare	☐ Medicare / Medi-Cal	☐ Other	
Subscriber's name:	Subscriber's S.S. number:	Birth date:	Group number:	Policy number:	Co-payment: $
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group number:	Policy number:	
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

IN CASE OF EMERGENCY

Name of local friend or relative :	Relationship to patient:	Home phone: ( )	Work phone: ( )

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 Neil Ghodadra, M.D., Inc., or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Neil S. Ghodadra, M.D.

HISTORY FORM - NEW PATIENT

PATIENT NAME: _____TODAY'S DATE_____

Who referred you to this office? _____ Internist/Family MD_____

CHIEF COMPLAINT

1) What is the main reason for your visit today? _____Right / Left / Both

HISTORY OF PRESENT ILLNESS

Age_____ Height_____ Weight_____ Right/Left Handed_____ Occupation_____

1) What was the date your symptoms started/were injured?_____

2) Explain Injury: _____

_____

3) Was this a work related accident? ☐ Yes ☐ No
If yes, are you still working? ☐ Yes ☐ No
If yes, are you working: ☐ Full ☐ Light duty

4) Was this an auto accident? ☐ Yes ☐ No
If so, were you driving? ☐ Yes ☐ No
Did airbags inflate? ☐ Yes ☐ No

5) Recreational or athletic injury? ☐ Yes ☐ No

6) Accident in your home? ☐ Yes ☐ No

7) On a scale of 1 (least) to 10 (greatest), what level is your pain today? 1 2 3 4 5 6 7 8 9 10

8) Describe symptoms you are having (check all that apply):

☐Aching ☐ Gives way ☐ Sharp ☐ Stabbing ☐Wakes you up
☐Clicking ☐ Locking ☐ Snapping ☐ Throbbing ☐ Weakness
☐Dull ☐ Numbness ☐ Sore ☐ Tingling ☐

9) How long does problem last? ☐ Constant ☐ Comes and goes ☐ Other:_____

10) Does anything make it better? ☐ Yes ☐ No Explain:_____
(eg: ice, rest, standing, sitting, meds, etc)

11) Does anything make it worse? ☐ Yes ☐ No Explain:_____
(eg: standing, sitting, bending, lifting, etc)

12) Does it radiate anywhere? ☐ Yes ☐ No If so, where:_____

13) List any other doctors you have seen for this problem:

_____

14) List any previous tests, procedures, treatments (injections, physical therapy, medications) for this problem:

Physical Therapy: _____# of visits per week x _____weeks/months

Injections: How many?_____Date of last injection_____/_____/_____Type of injection_____

Medications you have tried:_____

Chiropractic/Acupuncture:_____# of visits

MEDICATIONS

Are you sensitive or allergic to any medications? ☐ Yes ☐ No

If yes, please mark all that apply: ☐ Penicillin ☐ Keflex ☐ Aspirin ☐ Codeine ☐ Tetracycline
☐ Erythromycin ☐ Valium ☐ Demerol ☐ Barbituates ☐ Epinephrine
☐ Iodine ☐ Latex ☐ Naproxen ☐ Other_____

Are you currently taking:

Any cortisone-type medication (e.g. Prednisone)? ☐ Yes ☐ No
Any blood thinning medication (e.g. Coumadin, Warfarin, ASA, Plavix, etc)? ☐ Yes ☐ No
Family member ever had major adverse reaction to anesthesia? ☐ Yes ☐ No

If yes, Explain_____

Please list all the medications you are currently taking and the dosages:

_____
_____
_____
_____

PAST MEDICAL HISTORY

Serious Childhood Illnesses:_____

Adult Illnesses: List and document hospital stays if any_____

_____

Surgeries: List date, procedure, surgeon, and hospital_____

_____

Major accidents/Injuries with dates:_____

_____

FAMILY HISTORY

Father: Age if alive_____ Age/death and cause_____

Mother: Age if alive_____ Age/death and cause_____

Siblings: Age/health status_____

Children: Age/health status_____

Family Disease: (Hypertension, Diabetes, Tuberculosis, Gout, Cancer, etc)_____

_____

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No If yes, how much?_____How long?_____

If no, did you ever smoke? ☐ Yes ☐ No If yes, how much?_____How long?_____Year quit_____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much?_____How often?_____

Do you take any drugs? ☐ Yes ☐ No If yes, what drugs?_____

How often?_____

Have you been or are you addicted? _____Detoxed? _____

REVIEW OF SYSTEMS
Please circle those that apply or check the "none" box

GENERAL
Fever, Night Sweats
Marked Weight gain/loss
None☐

HEAD, EYES, EARS, NOSE
Frequent headaches
Neck pain/stiffness
Glaucoma
Blurring/vision
Dizziness
Hearing problems
Sinus problems
None☐

CHEST/RESPIRATORY
Asthma
Sputum production from cough
Cough up blood
Chronic cough
Positive TB skin test
Abnormal Chest X-ray
None☐

CARDIAC
High Blood Pressure
History of Heart attack
Chest Pain
Rapid/Abnormal Pulse
Ankle Swelling
None☐

VASCULAR
Previous phlebitis
Leg cramps on exercise
Varicose veins
Poor circulation
None☐

GASTROINTESTINAL
Ulcers/gastritis
Severe/frequent abdominal pain
Tarry/Black bowel movements
Yellow/Jaundice
Vomit blood, Hepatitis
None☐

GYNECOLOGICAL/WOMEN
Pregnant now? _____
Abnormal/irregular periods
Date last period_____
Age periods stopped___
None☐

MUSCULOSKELETAL
General joint pain/arthritis
Joint swelling
Spinal pain
None☐

ENDOCRINE
Diabetes
Thyroid abnormality
Gout
Osteoporosis
None☐

NEUROLOGICAL
Fainting
Convulsions
Dizziness
Shakiness/trembling
Diffuse muscle weakness
Tingling in extremities
None☐

URINARY
Kidney Stones
Blood in your urine
Frequent/Painful urination
Recurrent Kidney/Bladder infections
None☐

PSYCHIATRIC
Psychiatric Hospitalization
Depression
Frequent Mood Swings
History of substance abuse
None☐

OTHER
AIDS/HIV
Tested positive for HIV? Yes☐ No☐ When? _____

***I attest that the above information is true and correct to the best of my knowledge and recollection*.**

Signature of Patient or Legal Representative_____Date_____

Insurance Liability Waiver

Pursuant to insurance guidelines, I have been informed that Neil Ghodadra, M.D., Inc. is **OUT-OF-NETWORK** with **Covered California** insurance plans.

Although I have medical insurance coverage, the office visit and/or procedure I am going to receive may or may not be covered by my insurance policy and may be classified as "investigational and/or experimental" or not covered due to the medical practice being Out-of-Network. Under these cases, I will be financially liable for all charges for this office visit/procedure. Depending on my insurance coverage, I may have a deductible, co-insurance, and/or out-of-pocket maximum that I will be liable to pay prior to my visit/surgery date.

Having been fully informed of this possibility, I have the right to accept these conditions and proceed with the procedure and/or office visit or I have the option to decline treatment. If I am an Out-of-Network patient, I also understand that there may be an upfront payment that is required by Neil Ghodadra, M.D., INC., such as co-pay.

I further understand that Neil Ghodadra, M.D., INC. will bill my insurance carrier as a courtesy for amounts above my deductible, co-insurance, and out-of-pocket maximum. However, if these are not paid by my insurance carrier, I am liable for all services provided to me.

Please check **one (1)** of the following boxes:

☐ I understand and **accept these conditions** and have decided to **proceed** with the office visit and/or procedure.

☐ I understand but **do not accept these conditions** and have decided **not to proceed** with the office visit and/or procedure.

_____	_____	_____
Patient's Name (Please Print)	Patient's Signature	Date

Cancellation Policy

Cancellation of an Appointment

Appointments are in high demand, and thus, in order to best serve the needs our patients, please promptly call our office if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. We would appreciate a minimum of 24 hours advanced notice for cancellations.

How to Cancel Your Appointment

Please call (310) 929-4748 to cancel your appointment.

Late Cancellations

Late cancellations or failure to show up at scheduled time will be considered a "no show."

No Show Policy

A "no show" is when a patient misses an appointment without contacting the office to cancel in advance. No shows inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in our appointment system as a "no show." The first time there is a "no show," the patient will be sent a letter alerting them to the fact that they have failed to show up for an appointment and did not cancel the appointment. If there is a second "no show" within 1 year, a fee of $25.00 will be billed to the patient. This fee is to be paid prior to scheduling the patient's next appointment. Three "no shows" in 1 year will result in the termination from our practice.

Thank you in advance for your cooperation. Please sign and date below to acknowledge that you read and understand this information.

_____ _____

Signature Date

Office Policy
Disability Form Processing

Due to the very high volume of patients who require disability paperwork to be completed and signed by the doctor, we have adopted the following guidelines to assist in rapid processing of those important and necessary forms.

Please note that any paperwork processed by this office will take 5-7 business days (from the date received) to complete and mail. If you would like us to fax it to your Employer/Insurance Company/Outside Agency, please provide their fax number.

Paper work cannot be processed unless you have completed all portions of the document that are to be filled out by the patient. NO EXCEPTIONS. This will not apply if the paperwork does not require signature.

A copy of your paperwork will be placed in your chart after the doctor signs it and will remain a part of your permanent record. This applies to ALL forms.

When we send the original document out to the employer/insurance company/other agency, a copy will be sent to you at your home. If another facility or office requires a copy of this, it is your responsibility to forward it to that party.

ALL Private Insurance Disability forms, Life Insurance forms and Worker's Compensation forms **will require a $100 fee due at the time** forms are submitted to our office. The fee determined based upon the length of the forms. You will be notified of the exact fee when you present the forms to us for completion. **Paperwork will not be processed without payment in advance.** We accept cash, checks and credit cards. Please make checks payable to Neil Ghodadra, M.D., Inc.

We appreciate your assistance in completing your portion of the forms. We feel that this will allow us to better serve you, the patient. Please sign and date below to acknowledge that you read and understand this information. If you have any questions or concerns feel free to contact our office.

_____ _____

Signature Date

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 (PHI) to carry out treatment, payment or health care operations (TPO) 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 condition and related health care services.

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 that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

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 a third party. 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.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare 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, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

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 and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. 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. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. 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 alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – 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.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

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 Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Office of Civil Rights
U.S. Department of Health and Human Services
50 United Nations Plaza – Room 322
San Francisco, CA 94102

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying “Acknowledgment” form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.Parts 160 and 164)

1. Authorization

I authorize _____Neil Ghodadra, M.D._____ (healthcare provider) to use and disclose the protected health information described below to the follow person(s) _____(individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from the below dates:

_____ to _____ OR ☐ all past, present, and future periods.

3. Extent of Authorization

□ I authorize the release of my complete health record (including records relating to mental healthcare, and treatment of
alcohol or drug abuse).
□ I authorize the release of my complete health record with the exception of the following:

□ Mental health records
□ Alcohol/drug abuse treatment
□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effective until date listed in item (2) above, at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____	_____	_____
Printed name of patient/guardian	Signature of patient/guardian	Date

If all categories declined above, please check below

☐ Acknowledgement of Receipt of Notice of Privacy Practices

Signature
I have received a copy of the Privacy Practices.

_____	_____	_____
Printed name of patient/guardian	Signature of patient/guardian	Date