Beverly Hills Institute
Alex Foxman, M.D., Inc.
Internal and Preventive Medicine
9400 Brighton Way • Suite 410 • Beverly Hills • CA • 90210
Tel: 310.274.0657 • Fax: 310.274.6083 • www.bhinstitute.com

New Patient Information Form

(Please fill out all highlighted areas completely)

Mr. / Mrs. / Ms.: _____

Marital Status: ***M / S / W / D*** **Sex:** ***M / F*** **DOB:** _____

Drivers License#: _____ **SS#:** _____

Home Address: _____

City/State/Zip: _____

Home Phone #: _____ **Cell Phone #:** _____

Email Address: _____

Employed by: _____ **Work phone#:** _____

Person responsible for payment: _____ **Phone#:** _____

Address of person responsible for payment: _____
(if not the same as the Patient)

Person to notify in case of emergency:

Relation to patient: _____ **Phone #:** _____

Referred to us by: _____

INSURANCE INFORMATION

Name of Insurance: _____ ID#: _____

Subscriber: _____ DOB: _____

Relation to policyholder: Self / Spouse / Child / other: _____

AUTHORIZATION FOR TREATMENT

(No treatment will be given or surgery performed unless signed by patient/guardian)

I/We, hereby authorized ***Alex Foxman, M.D., Inc.*** and/or Staff to render whatever services deemed necessary for the care of _____, and I/we agree to assume all financial obligations incurred for care.

_____

Signature Date

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AUTHORIZATION / PATIENT RESPONSIBILITY AGREEMENT

1) I hereby authorize my insurance carrier(s) to pay ***Alex Foxman, M.D., Inc.*** directly for all medical services rendered.

2) I clearly understand that I am responsible for contacting my insurance carrier **PRIOR** to an appointment, to verify that ***Alex Foxman, M.D., Inc.*** is an approved, in-network provider of my insurance plan and to verify what my plan will and will not cover.

3) I clearly understand that ***Alex Foxman, M.D., Inc.*** is an approved provider for most PPO Insurances, and that I am responsible for any remaining balance.

4) I clearly understand that ***Alex Foxman, M.D., Inc*****. is not a Medi-Cal, HMO, or Kaiser provider.**

5) I clearly understand that ***Alex Foxman, M.D. Inc.*****, does not participate with insurances that are out of country** and that I am responsible for payment at the time of visit. ***Alex Foxman, M.D., Inc.,*** will provide the appropriate information, so that I may submit the visit to my insurance carrier directly for reimbursement.

6) I clearly understand that if I have an Office Co-Pay, per the contract with my insurance carrier, I am required to pay that Co-Pay upfront at the time of my office visit.

7) I clearly understand that if I do not have secondary insurance to Medicare, I am responsible for any outstanding balance per Medicare's Explanation of Benefits.

8) I clearly understand that I am responsible for any balance remaining after the insurance payment per my explanation of benefits (EOB) from my insurance carrier. I understand that payment is due upon receipt if I am billed by the office. I understand that if I have any questions regarding my bill that I receive from this office, I will first call my insurance carrier for explanation. I understand that should I dispute any charges or unpaid services by my insurance carrier, I will inform the office that I am disputing these charges and keep open lines of communication with the office at all times as to the status of my dispute. I understand that I will have 30 days to resolve any reimbursement disputes. If at the end of the 30 days, resolution has not yet been made, I agree to pay any/all balances, in full, to the office. I understand that I may continue to dispute charges with my insurance carrier on my own and not withhold the office of payment. If my insurance carrier reimburses the office after my payment, I understand I will be reimbursed the difference.

9) I clearly understand that ***Alex Foxman M.D.*****, Inc. requires 24 hour notice if I am unable to make my scheduled appointment for any reason**. *Please note: A fee will be billed for NO SHOWS and Cancellations/Reschedules made less than 24 hours prior to a scheduled appointment. **$200.00 for Initial / Annual Physical visits. ** $150.00 for regular follow up visits, blood work only, Ultrasound/DEXA only and X-Ray only visits (**Prices subject to change without notice).*

10) I clearly understand that ***Alex Foxman, M.D., Inc.*** requires a Credit/Debit card on file; As a new patient, I understand that I am required to provide a Credit/Debit card to schedule all visits. I understand that my Credit/Debit card will be automatically charged for all No Show appointments. A "No Show" means a pt does not show up or give any notice of cancelling or rescheduling a scheduled appt when our office has confirmed the visit with the pt. Our office will reach out to the pt when they haven't arrived, however, if there is no answer or returned phone to our office within 15 minutes after the scheduled appt, the appt will be marked a "No Show" and the No Show fee will be charged to the credit card on file.

11) I clearly understand that ***Alex Foxman, M.D., Inc.*** requires a Credit/Debit card on file; I understand that my Credit/Debit card will be charged for balances that are past due 120 days (Balances over 120 days past due will be charged only after statements are mailed, and several attempts to resolve the balance with the pt and our office by email and phone calls are not successful). I clearly understand that ***Alex Foxman, M.D., Inc.*** reserves the right to discharge a patient(s) from the practice for non-compliance of doctors' orders, repeat No Shows, repeat Cancellations/Reschedules made less than 24 hrs prior to a scheduled appt., and if a delinquent account is placed into collection status.

12) I clearly understand that if a check I write to ***Alex Foxman, M.D., Inc.*** is dishonored or returned by the bank for any reason, I may be charged the bank returned item fee charged to Alex Foxman, M.D., Inc.

Signature **Date**

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OFFICE POLICIES

1) *Alex Foxman, M.D.*, Inc. participates with numerous PPO insurance carriers and managed health care programs. It is the responsibility of each patient to ensure that this office is an in-network, provider of their insurance plan **prior** to their scheduled appointment. For patients that are members of a PPO plan, our office will submit a claim(s) for services rendered on their behalf. All patients must accurately complete the necessary forms for our records, including any special forms, before leaving the office.

2) Our office hours are Monday – Friday, 8:00 am to 4:30 pm. There is always a doctor on call after hours. Depending on the nature of the call, a doctor will call you back either the same night or the next day. **If you have an emergency after our office has closed, please call 9-1-1 without hesitation**. We are closed in observance of the following holidays: New Years Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, the day after Thanksgiving, and Christmas. The exception to this will be vacations and additional days attached before/after a holiday(s).

3) Our office will make every effort to schedule you at the time most convenient for you and in some cases, on the same day whenever possible. Arriving promptly for your appointment is not only a courtesy, but a consideration to Dr. Foxman, his staff and to the patients whose appointments are scheduled after yours. We ask that you kindly call our office if you can not make your scheduled appointment.

4) Our office requires a credit/debit card on file; All new patients will be required to provide a credit/debit card in order to schedule all visits. Please review our No Show policy and our Credit/Debit Card on File policy on page 2 for more information.

5) It is the patients' responsibility to ensure that any required referrals and/or authorizations for treatment are provided to the office of Alex Foxman, M.D., Inc. **prior** the scheduled appointment. If this information is not submitted prior to the scheduled appointment, the patient may be financially responsible if the claim is denied due to the lack of the referral/authorization. If the appointment must be rescheduled, the patient may be charged a rescheduling without 24 hours notice fee of $200.00 for Initial/Annual PX/Pre-Op visits or $150.00 for Follow up visits, Blood work only, Ultrasound only visits and DEXA/X-Ray only visits (*prices subject to change without notice).

6) If you have questions regarding your plan or what your carrier covers, please contact your insurance carrier directly. Our staff is happy to answer insurance questions regarding to how a claim was filed or regarding any additional information the carrier might need to process the claim only.

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OFFICE POLICIES Con't

7) For minors (under the age of 18), the parent(s), guardian(s), and/or adult(s) is responsible for providing current insurance information and/or payment of service including any co-pay and past due balance at the time of service. The parent(s), guardian(s), and/or adult(s) must provide all necessary insurance/subscriber information for billing and MUST accompany the minor at each appointment. Minors cannot receive medical treatment without the written consent of the parent(s) or legal guardian(s).

8) If you feel you may require financial assistance, please notify the receptionist **before** you see the physician for referral to the appropriate individual.

9) If the annual BHI Plan or your account balance is over 90 days past due, you will receive a letter stating that you have 5 days to pay the BHI Plan and/or your past due account balance. Partial payments for the BHI Plan will not be accepted. The BHI Plan can be paid in full or with a recurring monthly payment plan. For past due balances; partial payments will not be accepted unless arranged in advance and recurring monthly payment plan is in place. If the BHI Plan is not paid within the 5 days, you will be discharged from the practice as this fee is required by all patients that wish to be part of the practice. Unpaid account balances that reach 120 days past due, may be referred to an outside collection agency and may result with you and your immediate family members being discharged from this practice. If a this is to occur, a discharge letter will be mailed informing you that you have 15 days to find alternative medical care. During that 15 day period, Dr. Foxman will only be able to treat you on an emergency basis only.

10) In order for Dr. Foxman to see patients at their schedule appointment time, it may not be possible for him to return all phone calls immediately. Every effort will be made to return messages the same day, however, messages received after 3pm may not be returned until the following business day.

11) In order for Dr. Foxman to see patients at their scheduled appointment time, it may not be possible for him to respond to your email immediately. Every effort will be made to reply the same day, however, your email is urgent or you do receive a reply after 48 hours, please call the office directly.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our office policies.

By signing below, I hereby certify that I have read and understand the office policies and agree to abide by their guidelines.

_____

Signature Date

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Authorization for Use or Disclosure of Medical Information

I hereby authorize **Alex Foxman, M.D., Inc.** to use or disclose my protected health information as follows:

PATIENT IDENTIFICATION:

Patient Name:		
Social Security Number:	**Date of Birth:**	** Phone number: ( )
Note:_____O.K. to leave message with detailed information **OR _____Leave message with call back number only		

RELEASE TO:

Persons/Organizations/Patient: Name:	
Address:	
City, State, Zip:	Phone#:

INFORMATION TO BE RELEASED:

General Medical Record Information

RESTRICTIONS and RELEASE:

I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under federal privacy regulations. I herby release ***Alex Foxman, M.D., Inc.*** from all liability and all claims of any nature whatsoever pertaining to disclosure of information, or of any professional opinions, findings, or recommendations as contained in the records released to or by ***Alex Foxman, M.D., Inc.***

SIGNATURE:

Signature: *(patient, representative*, spouse*)*	**Date:**
*If signed by someone other than the patient, state your legal relationship to the patient:	

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HIPAA Privacy Rule Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I,_____understand that as part of my health care, Alex Foxman, M.D., Inc. originates and maintains health records describing my health history, symptoms, examination and test results diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the health professionals who may contribute to my health care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for routine health care operation such as assessing quality and reviewing the competence of health care professionals.

I have been provided with the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review the ***Notice of Privacy Practices*** prior to signing this authorization. I authorized the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

PHI Authorized:
Purpose Authorized:
Parties to whom my PHI is authorized to be released:

I understand that:

- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operation by other covered entities.
- I may revoke this consent in writing at any time, except to the extent that Alex Foxman, M.D., Inc. has already taken action in reliance thereon. I understand that this action may limit my future treatment options.

_____Accept _____Denied

Signature of Patient or Legal Representative Witness_____

Printed Name of Patient or Legal Representative Witness_____

Date_____

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Notice of Privacy Practices

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Provability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information for the purpose of Treatment, Payment and Health Care Operations:
Treatment – Includes sharing medical data with other providers, making referrals, and placing lab and pharmacy orders.
Payment – Includes activities involved in determining eligibility, billing of claims, and collection of charges.
Health Care Operations – Includes the necessary administrative and business functions of our office.

Uses and disclosure of your health information in certain special circumstances
The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person of organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including Veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Worker's Compensation and similar programs.

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Notice of Privacy Practices (Con't)

Your rights regarding your health information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use of disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. *You **MUST** submit your request in writing to: Alex Foxman, M.D., Inc. 9400 Brighton Way, Suite 410, Beverly Hills, CA 90210.*
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. *You **MUST** submit your request in writing to: Alex Foxman, M.D., Inc. 9400 Brighton Way, Suite 410, Beverly Hills, CA 90210.* You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist or our office manager.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our Office Administrator. All complaints must be submitted in writing to: *Alex Foxman, M.D., Inc. ATTN: Michal Morey, Office Administrator, 9400 Brighton Way, Suite 410, Beverly Hills, CA 90210.* You will in no way be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures that are not identified by this notice or permitted by applicable law.

It is our mission and continuous goal to provide you with the best care and service possible: If you have any questions regarding this notice, our health information privacy policies, or any other issue, please contact the Office Administrator at any time.

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PHYSICIAN - PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractices, 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 a 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 any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tor, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, association, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, 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 claims. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses, and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Bother parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrators fees and expenses.

Article 4: Retroactive Effect: The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, to not limited to, emergency treatment), but also before it was signed as well.

Article 5: Revocation: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed served there from and the remainder of the Agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have read and understand this agreement.

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

PRINT or Stamp Name of Physician, Medical Group or Association Name		**PRINT Patient's Name**	
Physician's or Duly Authorized Representative Signature	Date	**Patient's Signature**	**Date**
PRINT name of Translator (if applicable)		Signature of Patient's Representatives (if applicable)	Date
Signature of Translator (if applicable)	Date	PRINT name and relationship to Patient	

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Credit / Debit Card Authorization Form

I clearly understand that ***Alex Foxman, M.D., Inc.*** requires a Credit/Debit card on file; As a patient, I am required to provide a Credit/Debit card to schedule all visits.

I authorize Beverly Hills Institute/Alex Foxman, M.D., Inc. to charge the credit/debit card for conditions indicated on page 2; #10 and #11 (Rev 06282018).

I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Account Type:_____MC _____Visa ____ American Express _____Discover

Cardholder Name:_____

Credit Card Number_____

Exp Date:_____

email:_____ Phone#:_____

_____ _____

Signature Date