New Beginnings Healthcare ~ Dr. Patricia Deckert ~8911 La Mesa Blvd. #101, La Mesa CA 91942

REQUIRED PATIENT INFORMATION FOR INSURANCE BILLING

(PATIENT)
LAST NAME: _____FIRST:_____ MI: _____DOB:_____/_____/_____ SEX: M ____F____

STREET: _____APT #:_____CITY: _____ST:_____ZIP:_____

SS# _____H. PHONE: _____/_____WK PHONE: _____/_____ CELL PHONE: _____/_____

MARRIED: ___ SINGLE: ___ DIV: ___ OTHER: ___ SPOUSE'S NAME_____SPOUSE'S WK PH #____/_____

SPOUSE'S CELL PH # _____/_____ EMAIL ADDRESS: _____REFERRED TO THIS OFFICE BY: _____

_____ EMERGENCY CONTACT NOT LIVING WITH YOU: _____PH #: _____/_____

PRIMARY INSURANCE INFORMATION

(INSURED)
(IF PRIMARY INSURED IS NOT THE PATIENT, LIST SPOUSE, PARENT OR OTHER INFORMATION OF PRIMARY INSURED BELOW)

INSURED NAME: _____DOB: _____/_____/_____SS# _____ SEX: M____F____

INSURANCE CO: _____ID#_____ GROUP #_____

PATIENT'S RELATIONSHIP TO INSURED_____
(Please include the social security number and date of birth of the primary insured for your insurance to be billed.)

SECONDARY INSURANCE INFORMATION

(INSURED)
(IF SECONDARY INSURED IS NOT THE PATIENT, LIST SPOUSE, PARENT OR OTHER INFORMATION OF SECONDARY INSURED BELOW)

INSURED NAME: _____DOB: _____/_____/_____SS# _____ SEX: M____F____

INSURANCE CO: _____ ID#_____ GROUP #_____

PATIENT'S RELATIONSHIP TO INSURED_____

PAYMENT POLICIES

You are responsible for anything your insurance does not cover. All Co-Pays are due and payable at each visit. These fees may apply, please review & initial in the boxes:

- ☐ $5 FEE FOR CO-PAYS NOT PAID AT TIME OF SERVICE.
- ☐ $50 NO SHOW FEE FOR ANY MISSED APPOINTMENT THAT WAS NOT CANCELLED OR RESCHEDULED 24 HOURS PRIOR TO THE APPOINTMENT. PLEASE BE CONSIDERATE AND CALL AT LEAST 24 HOURS BEFORE YOUR APPOINTMENT IF YOU CANNOT COME IN.
- ☐ $35 NSF CHARGE FOR ANY RETURNED CHECK FROM THE BANK

If you are a private pay patient without insurance, all charges are due at the time of visit. We do not send statements to private pay patients.

PRESCRIPTION POLICY

Please do not wait until your last pill to call for a refill. There is a 48 hour turn around for prescription refills. If you have not seen the Physician in six months, the prescription will be denied. Assignment of benefits are payable to the doctors.

PLEASE SIGN AND DATE THIS DOCUMENT SHOWING THAT YOU HAVE READ AND UNDERSTAND OUR POLICIES.

SIGNATURE _____DATE: _____

Revised 2-19-18

PREFERRED PHARMACY

Pharmacy Name _____

Address _____ City _____ State _____ Zip _____

Phone (_____)_____ Fax (_____)_____

MISCELLANEOUS INFO

Race (census bureau categorization)

□ American Indian & Alaskan Native
□ Asian
□ Black or African American
□ Black Hispanic or Latino
□ Native Hawaiian & Other Pacific Islander
□ White Hispanic or Latino
□ White
□ *Decline to state*

Language Preference

□ English □ Chinese □ French □ German
□ Italian □ Japanese □ Korean □ Portuguese
□ Russian □ Spanish □ *Decline to state*

How did you find us? _____

I hereby give lifetime authorization for payment or insurance benefits to be made directly to the physician and any assisting physicians for services rendered. I understand that I am financially responsible for all charges, whether they are covered or not covered by my insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

_____ _____ _____

Signature of Responsible Party Print Patient's Name Date

HEALTH HISTORY

(Confidential)

Your answers on this form will help your health care provider better understand your medical concerns, conditions and health goals. This form will not be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. Thank you!

Name _____ Today's Date _____ Age _____

Date of Birth _____/_____/_____ Date of Last Physical Exam _____/_____/_____

What is the reason for your visit? _____

SYMPTOMS (Please check any current symptoms you have)

GENERAL
- □ Chills
- □ Depression
- □ Dizziness
- □ Fainting
- □ Fever
- □ Forgetfulness
- □ Headache
- □ Lack of sleep
- □ Loss of weight
- □ Nervousness
- □ Numbness
- □ Sweats

MUSCLE/JOINT/BONE
- □ Pain, weakness, numbness in:
  - □ Arms
  - □ Hips
  - □ Back
  - □ Legs
  - □ Feet
  - □ Hands
  - □ Neck
  - □ Shoulders

GENITO-URINARY
- □ Blood in urine
- □ Frequent urination
- □ Painful urination

GASTROINSTESTINAL
- □ Poor appetite
- □ Bloating
- □ Bowel changes
- □ Constipation
- □ Diarrhea
- □ Excessive hunger
- □ Excessive thirst
- □ Gas
- □ Hemorrhoids
- □ Indigestion
- □ Nausea
- □ Rectal bleeding
- □ Stomach pain
- □ Vomiting
- □ Vomiting blood

CARDIOVASCULAR
- □ Chest pain
- □ High blood pressure
- □ Irregular heart beat
- □ Low blood pressure
- □ Poor circulation
- □ Rapid heart beat
- □ Swelling of ankles
- □ Varicose veins

EYES, EARS NOSE, THROAT
- □ Bleeding gums
- □ Blurred vision
- □ Crossed eyes
- □ Difficulty swallowing
- □ Double vision
- □ Ear ache
- □ Ear discharge
- □ Hoarseness
- □ Loss of hearing
- □ Nosebleeds
- □ Persistent cough
- □ Ringing in ears
- □ Sinus problems
- □ Vision-flashes
- □ Vision-halos

SKIN
- □ Bruise easily
- □ Hives
- □ Itching
- □ Change in moles
- □ Rash
- □ Scars
- □ Sore that won't heal

MEN ONLY
- □ Breast lump
- □ Erection difficulties
- □ Lump in testicles
- □ Penis discharge
- □ Sore on penis
- □ Other:

WOMAN ONLY
- □ Abnormal PAP smear
- □ Bleeding between periods
- □ Breast lump
- □ Extreme menstrual pain
- □ Hot flashes
- □ Nipple discharge
- □ Painful intercourse
- □ Vaginal discharge
- □ Other:

Date of last menstrual period:

_____/_____/_____

Date of last PAP:

_____/_____/_____

Date of last mammogram:

_____/_____/_____

Are you pregnant?
□ Yes □ No

Number of children: _____

CONDITIONS (Check conditions you have or have had in the past)

□ Aids	□ Chemical dependency	□ High cholesterol	□ Prostate problem
□ Alcoholism	□ Chicken pox	□ HIV positive	□ Psychiatric care
□ Anemia	□ Diabetes	□ Kidney disease	□ Rheumatic fever
□ Anorexia	□ Emphysema	□ Liver disease	□ Scarlet fever
□ Appendicitis	□ Glaucoma	□ Measles	□ Stroke
□ Arthritis	□ Goiter	□ Migraine headaches	□ Suicide attempt
□ Asthma	□ Gonorrhea	□ Miscarriage	□ Thyroid problems
□ Bleeding disorders	□ Gout	□ Mononucleosis	□ Tonsillitis
□ Breast lump	□ Heart disease	□ Multiple sclerosis	□ Tuberculosis
□ Bronchitis	□ Hepatitis	□ Mumps	□ Ulcers
□ Bulimia	□ Hernia	□ Pacemaker	□ Vaginal infections

MEDICATIONS YOU ARE CURRENTLY TAKING	***ALLERGIES TO MEDICATIONS OR SUBSTANCES***

HEALTH HABITS (Check which substances you use and describe how much/how often)

□ Caffeine _____

□ Tobacco _____

□ Drugs _____

□ Other _____

OCCUPATIONAL CONCERNS (Check if your work exposes you to the following):

□ Stress
□ Hazardous substance
□ Heavy lifting
□ Other _____

Your Occupation: _____

HOSPITALIZATIONS			***PREGNANCY HISTORY***		
Year	Hospital	Reason for Hospitalization	Year	Sex of child	Complications, if any

FAMILY HISTORY

CHECK IF ANY OF YOUR BLOOD RELATIVES HAD ANY OF THE FOLLOWING	***RELATIONSHIP***
□ Diseases:	
□ Arthritis Gout	
□ Asthma, Hay fever	
□ Cancer: Breast	
□ Cancer: Colon	
□ Cancer: Prostate	
□ Chemical Dependency	
□ Diabetes	
□ Heart Disease	
□ High Blood Pressure	
□ High Cholesterol	
□ Kidney Disease	
□ Stoke	
□ Tuberculosis	
□ Other	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of their staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature of Responsible Party Date

New Beginnings Health Care
A Professional Medical Corporation
8911 La Mesa Boulevard, Suite 101
La Mesa, CA 91942
Phone: (619) 713-5540 Fax: (619) 401-3273

OFFICE POLICIES AND PROCEDURES

Thank you for choosing our office for your health care needs. We are committed to your treatment being successful. The following is a statement of our office policies and procedures which sets for the terms and conditions upon which our services are rendered. Please let us know if you have any questions.

APPOINTMENTS: I understand that appointments are pre-arranged and that it is my responsibility to keep my appointment with a minimum of **24 hours notice**. Failure to cancel with less than 24 hour notice will result in a $50 charge to my account. I will arrive for my appointment on time, understanding that if I am more than 15 minutes late, my appointment may be rescheduled.

BILLING/INSURANCE:

Co-pays: All co-pays must be paid at the time of service; this arrangement is part of your contract with your insurance company. Failure on our part to collect co-pays can be considered fraud. Please help us in upholding the law by paying your co-pay at each visit. If you have two insurances, your primary insurance co-pay is applicable; co-pays are not billable to any secondary/supplemental insurance plans.

Deductibles/Co-Insurance: Deductibles are provisions that require the member to accumulate a specific amount of medical bills before benefits are provided. After deductibles are met, the plan begins paying a percentage of covered services. The member owes the remaining amount, called co-insurance.

Non-Payment of Account: Please be aware that if a balance remains unpaid over 90 days, we may place your account in pre-collection status or refer your account to a collection agency. These actions can possibly jeopardize any future appointments or result in discharge from this practice. There will be a $25 charge in addition to any additional bank fees for checks returned by the bank for insufficient funds, stop-payment, etc.

RECORDS: Records will be kept for seven years, as per legal requirements. Copies of records can be transferred to other physicians upon receipt of written notification from the patient. We request the patient provide the office with at least 72 hours notice when requesting records.

MEDICATIONS: Medication refills will be considered during office hours only. This is to conform to California Pharmacy statutes and to prevent people from acting or posing as patients. This also prevents the possibility of people obtaining medications by illegal means. Patients should contact their pharmacy **2-3 days prior** to the needed refill, as the prescribing physician may not be immediately available the same day the medication runs out. It also permits accurate records of medicine consumption to be maintained in the patient's chart for review by the State Pharmacy Review Board, if necessary.

REFILLS CANNOT BE PROVIDED TO ANY PATIENT WHO HAS NOT BEEN SEEN IN THIS OFFICE IN OVER 6 MONTHS.

I understand and agree to the above policies and procedures.

_____ _____

Signature of Responsible Party Date

New Beginnings Health Care
A Professional Medical Corporation
8911 La Mesa Boulevard, Suite 101
La Mesa, CA 91942
Phone: (619) 713-5540 Fax: (619) 401-3273

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Date _____

Patient Name _____ Date of Birth _____/_____/_____

I authorize Dr. Patricia Deckert or her authorized representative to discuss my medical history or anything related to my health records with the following persons:

_____

Full Name of 1st Individual

_____ _____

Relationship Phone Number

_____

Full Name of 2nd Individual

_____ _____

Relationship Phone Number

_____

***Full Name* of 3rd Individual**

_____ _____

Relationship Phone Number

_____

***Full Name* of 4th Individual**

_____ _____

Relationship Phone Number

_____ _____

Signature of Responsible Party Date

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.

Our pledge regarding your medical information: This privacy your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding these and disclosure of medical information.

Our Legal Duty/The Law requires us to:
1. Follow the terms of the notice that is now in effect.
2. Keep your medical information private.
3. Give you this notice describing our legal duties, privacy practices, and your rights regarding medical information.

We Have the Right to:
1. Change our privacy practices and the terms of this notice at any time, provided that the law permits the changes.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of change to privacy practices:
1. Before we make an important change in our privacy practice, we will change this notice and make the new notice available upon request.

Use and Disclosure of Your Medical Information: The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, medical assistants, technicians, medical students, or other people who are taking care of you. We may also share medical information to your other health care providers to assist them in treating you.

For Payment: We may use and disclose your medical information for payment purposes.

For Business Operations: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses, and credentials we need to serve you.

Notification: Medical information to notify: a family member, your personal representative or another person responsible for your care. We will get your permission before we share medical information, or give you the opportunity to refuse permission. In case of emergency, and you are unable to give permission we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information about you.

Appointment Reminders and Health-Related Information: Covered entity may contact the individual to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may be of interest of the individual.

Limited Research: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to insure the privacy of medical information.

USES AND DISCLOSURES FOR WHICH NO PERMISSION IS REQUIRED:
Public Health Reporting: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposed of reporting adverse events associated with product defects or problems to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight activities authorized by law, including audits, civil, administrative or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities, court orders and judicial and administrative proceedings. We may disclose medical information in response to court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, w may share your medical information with law enforcement officials. We may share limited information with law enforcement officials concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person.

Your Individual Rights/You have a right to:
1. Look at or get copies of your medical information. You may also request copies by filling out a release for from our office which will be handled by the medical record department. If you request copies, there will be a per-page charge and a postage charge. Contact our medical records department for a bill explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restriction on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the medical records department.

Questions and Complaints:
If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact our business operations manager. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

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

Patient Name: _____ Signature: _____ Date: _____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** 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 any 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 tort, 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, associations, 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 claim. 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. Both 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 arbitrator's 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, but 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 severed and the remainder of the Agreement will be 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 received a copy.

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.

By: _____

Physicians or Duly Authorized Representative Signature — Date

New Beginnings Health Care

Print or Stamp Name of Physician, Medical Group or Association Name

By: _____

Signature of Translator (if applicable) — Date

_____

Print Name of Translator

By: _____

Patients Signature — Date

_____

Print Patient's Name

By: _____

Signature of Patient's Representative (if applicable) — Date

_____

Print Name & Relationship to Patient