HEAL
Medical Clinic
PATIENT REGISTRATION FORM

Today's Date:______________________**PCP: Dr. Sara Shokouhi () Dr. Farrokh Alemzadeh ( )**
Preferred Pharmacy:______________________ **Phone:**______________________

Last Name:______________________**First Name:**______________________Date Of Birth:______________

Middle:______________________**Preferred Language:** English () Spanish () Farsi () Other:______________

Race: American Indian/Native () Asian () Black () White () Declined to disclose () Other:______________________

Ethnicity: Hispanic/Latino () Not Hispanic/Latino () Unknown () Declined to disclose () Other:______________________

Mr. () **Marital Status (check one)**
Mrs() Single () Married () Divorced ()
Miss() Separated ( ) Widowed ()
Ms.()

Is this your exact name on the insurance card? Yes () No()
If not, what is the EXACT name?______________________
____

Street Address:______________________ **Home Phone(**_______)______________________

______________________**Cell Phone:** (_______)______________________

City:______________________**State:**______________**Zip code:**______________________

Social Security:______________________**Email Address:**______________________

How where you referred to our office? (please check one) Doctor () Internet () Insurance () Friend/Family () Yellow pgs ()

Other ()______________________

Occupation:______________Employer:______________Work Phone: (_______)______________

Can we contact you by e-mail and send you confidential laboratory or health information through the internet?
Yes () No () Initials:_______

INSURANCE INFORMATION
(Please give yor insurance card to the receptionist)

Person responsible for bill:______________________DOB:______________Phone:______________

Insurance: PPO() HMO() other:______________________Phone Number: (_______)______________

Insurance ID #:______________________Group #:______________________

IN CASE OF EMERGENCY

Name of local friend or relative(not living at same address):______________________

Relationship to patient:______________Home Number: (______)______________Cell: (_____)______________

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 HEAL Medical Clinic or insurance company to realease any information required to process my claims.
I accept responsibility for all charges incurred in the medical evaluation and health care of the above named patient.
I understand that ongoing primary medical care is the responsibility of the patient: it is not the responsibility of HEAL Medical Clinic.

Patient/Guardian signature:______________________Date:______________________

Printed Name:______________________

HEAL Medical Clinic

Office Visits
We require that all PPO and HMO co-payments be made at the time of the visit.

Insurance Cards
We ask that you bring your insurance card with you each time you visit our office. If applicable, be sure to bring cards for your secondary insurance as well. If you don not have your insurance cards, you may be asked to pay at the time of service and sign a waiver.

Changes in Insurance Coverage
If there is any change in insurance, it is your responsibility to bring that to our attention immediately(even if you don't have your new insurance card with you.) Delays in communicating these insurance changes may result in the balance being uncollectible from the insurance company and the full responsibility for payment falling upon the patient.

HMO Insurances
Dr. Alemzadeh and Dr. Shokouhi coverage on the Monarch Healthcare Network. If you have coverage through any other HMO plans (Kaiser, Bristol Park, Greater Newport, Arta etc) It is your responsibility to bring that to our attention and you should be prepared to pay for the vist at the time of service. Failure of our office staff to identify this information on your insurance card at check in will not waive your responsibility for the payment of these services.

Credit Cards
For your convenience we accept visa mastercard, american express and discover. Payments by credit card may also be made over the phone directly with our business office.

Return Check Fee
Checks that are returned to our office will carry a 25.00 return check-handling fee. It is expected that the patients will pay the amount of the returned check and fee with either cash or credit card as soon as the situation is brought to their attention.

Medicare
All of our physicians are participating with Medicare. Please be aware that some office visits or procedures are not covered by Medicare on an annual basis. Please check with your local Medicare carrier for specific benefit guidelines.

Medi-Cal
All of our physicians are participating with Monarch-Medi-cal Patients.

Medical Record Copies
There is a fee for medical record copies and filling out of disability and off work forms. Please check with the office regarding these.

Suspension of Services with HEAL Medical Clinic
Failure to keep an account current may result in a patient being suspended from services. In many cases, this action is merely the result of us not having the most current information-insurance changes, address changes, name changes, etc. Please make every effort to communicate demographic changes to our office in order to avoid this situation.

Non-Payment
If your account is turned over to collections for non-payment you will be billed the total amount plus an 18% collection fee.

Statement of Financial Responsibility
It is the policy of the practice to collect payment for services as they are rendered . This allows us to control our

cost and keep fees at a reasonable level.

This office will assist you by billing your insurance company. However, the services can not be rendered on the assumption that your charge will be paid by your insurance company. You are responsible for fees that your insurance does not pay.
Patient Initials: ____________

PLEASE BE ADVISED
For the courtesy of ALL our patients

Billing Inquires
If you have any questions or concerns about the financial aspects of your account with us, please feel free to contact our billing office at (949)461-1056

CANCELLATION POLICY& APPOINTMENT REMINDERS

In our everyday lives unplanned issues come up for all of us. We recognize this fact. When things come up that interfere with a set appointments at our office, we respectfully request that you cancel you schedules appointment by phone with a miniumum 24 hours in advance. This will enable us to fill your spot with someone needing an appointment. If our office is not notified according to these terms, you will be susceptible to a **$35.00** missed appointment fee. If you are more than 15 minutes late to your scheduled appointment, it may be re-scheduled. This fee is not covered by your insurance carriers and will be your responsibility. As a courtesy to our patients, we will call to remind you one day in advance of your appointment. We will call between 8:00am and 4:30pm at your primary contact number to remind you or your upcoming appointment.

I understand that by signing I agree to the terms written above. I have been given the opportunity to ask questions and have had my questions answered.

Patient Signature:________________________ Date:________________________________

Print Name:_____________________________

Heal Medical Clinic

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.

Uses and Disclosures Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other third party payors, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of HEAL Medical Clinic.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable disease to the state's public health department.

Appointment reminders. Your health information will be used by our staff to send you appointment reminders. We utilize an automated phone system and you may be called the day prior to your appointment as a reminder. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of our information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Individual Rights You have certain rights under the federal privacy standards. These include: • The right to request restrictions on the use and disclosure of your protected health information • The right to receive confidential communications concerning your medical condition and treatment The right to inspect and copy your protected health information • The right to amend or submit corrections to your protected health information • The right to receive an accounting of how and to whom your protected health information has been disclosed. • The right to receive a printed copy of this notice

Right to Revise Privacy Practices As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the front office receptionist. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services

I hereby acknowledge receipt of the Notice of Privacy Practices:

Print Name:______________________ Patient Signature:_____________________ Date:__________

HEAL MEDICAL CLINIC
HIPPA DISCLOSURE CONSENT

To protect your privacy we need your permission to leave a message on your answering machine.

YES________ You may leave a message at this/these number(s): (____)______-____________
(____)______-____________

NO________ You may not leave messages on the voicemail/answering machine.

PLEASE CHECK ALL THAT APPLY
( ) All Medical Information

( ) Birth Control , Drug Alcohol, STD Results

( ) All Lab Results

( ) Medications

( ) Appointments

( ) Other:______________________________

To protect your privacy we need your permission to whom we may speak to in the event you're unavailable.

First Name:___________________________________Last Name:_______________________________________
Phone:____

Relationship: Mother ( ) Father( ) Spouse ( ) Daughter ( ) Son ( ) Other:____________________________

I allowed HEAL Medical to disclose the following medical records with the person above regarding the following:

PLEASE CHECK ALL THAT APPLY
( ) All Medical Information

( ) Birth Control , Drug Alcohol, STD Results

( ) All Lab Results

( ) Medications

( ) Appointments

( ) Other:______________________________

( ) ONLY DISCLOSE MEDICAL INFORMATION WITH ME.

Patient Signature:_________________________ Date:________________________________

Print Name:_____________________________

HEALTH QUESTIONAIRE

Name:______________________________ DOB:________________ Age:________ Date:____________________

PAST MEDICAL HISTORY: Approx. Weight:____________ ___Approx. Height:______________________

PREFERRED PHARMACY Location/Phone:____

Measles	Yes	No	Seizure	Yes	No	Peptic Ulcers	Yes	No
Mumps	Yes	NO	Heart Disease	Yes	No	Kidney Disease	Yes	No
Chicken Pox	Yes	No	Hypertension	Yes	No	Diabetes	Yes	No
Polio	Yes	No	Tuberculosis	Yes	No	Thyroid Disease	Yes	No
Rheumatic Fever	Yes	No	Pneumonia	Yes	No	Veneral Disease	Yes	No
Cancer	Yes	No	Asthma	Yes	No	Anemia	Yes	No
Stroke	Yes	No	Hepetatis	Yes	No	Blood Clots	Yes	No
Scarlet Fever	Yes	No	Liver Disease	Yes	No	Gout	Yes	No

Past Surgical History: Any other significant illnesses, injuries or hospitalizations:

Year:__________ Illness:____________________________Year:_________ Surgery:____________________________
Year:__________ Illness:____________________________Year:_________ Surgery:____________________________
Year:__________ Illness:____________________________Year:_________ Surgery:____________________________
Year:__________ Illness:____________________________Year:_________ Surgery:____________________________

Allergies(Medication & Food) ....( ) NONE
1.________________Reaction:__________________
2.________________Reaction:__________________
3.________________Reaction:__________________
4.________________Reaction:__________________

Current Medications: (medication& strenght) ( ) NONE
1.____________________5.____________________
2.____________________6.____________________
3.____________________7____________________
4.____________________8____________________

Immunizations:
Vaccine: Year
Influenza ______
Tetanus ______
Pneumococcol ______
Shingles ______

Social History:
Marital Status: Single Married Seperated Divorced Widowed
\# of children: ______ Occupation:____________________
Smoker: Yes No Pack/day:#_________ Years: #______
Caffeine: Yes No Cups/drinks________ day
Alcohol(kind, amount, frequency)______________________
Recreational Drugs:__________________________________

Family History:

Relative	Age	Health Condition(living)	Age(at death)	Cause of death
Father	____	________________	________	______________________
Mother	____	________________	________	______________________
Brother	____	________________	________	______________________
Sister	____	________________	________	______________________
Husband	____	________________	________	______________________
Wife	____	________________	________	______________________
Son	____	________________	________	______________________
Daughter	____	________________	________	______________________

Has any blood Relative ever had:

Cancer	Yes	No	Tuberculosis	Yes	No	Diabetes	Yes	No
Heart Trouble	Yes	No	High Blood Pressure	Yes	No	Stroke	Yes	No
Stroke	Yes	No	Convulsion	Yes	No	Suicide	Yes	No
Mental Illness	Yes	No	Bleeding Tendency	Yes	No	Gout	Yes	No
Hereditary Def.	Yes	No						

System Review

GENERAL:

Question		
Do you eat a well balanced diet?	Yes	No
Approx. Weight Now_______ l yr ago________		
Maximum Weight_______________________		
Exercise? Frequency/Wk_________________		
Activities___________________________		
Any sexual Concerns:	Yes	No
Last Complete Physical:________________		
Headaches:	Yes	No
Glasses/Contacts	Yes	No
Double Vision	Yes	No
Eye disease or injury	Yes	No
Last Glucoma check:__________________		
Itching eyes/nose/hay fever	Yes	No
Septal Deviation/Polys	Yes	No
Nose Bleeds	Yes	No
Sinus Trouble	Yes	No
Ear Disease	Yes	No
Impaired Hearing	Yes	No
Ringing in ears	Yes	No
Hoarsness	Yes	No

NECK:

Stiffness	Yes	No
Enlarged Glands	Yes	No
Injury	Yes	No

RESPIRATORY:

Coughing up blood	Yes	No
Chronic Cough	Yes	No
Wheezing	Yes	No
Shortness of breath	Yes	No
Night Sweats	Yes	No
Skin Test for TB	Yes	No
If yes, Year_______		
Year of last chest x ray________		

CARDIOVASCULAR:

Chest pain or angina pectoris	Yes	No
Shortness of breath when laying	Yes	No
Pain in legs after walking	Yes	No
Varicose Veins	Yes	No
Ankle Swelling	Yes	No
Heart Murmur	Yes	No
Rapid hand or skipped heart beats	Yes	No
Year last EKG______________		
Have you had stress test? Year_____________		

GASTROINTESTINAL:

Change in appetite	Yes	No
Heartburn	Yes	No
Sour taste in mouth	Yes	No
Intolerance to Spicy fodd	Yes	No
Vomitted blood?	Yes	No
Gallbladder trouble	Yes	No
Intolerance to milk products	Yes	No
Pancreatitis	Yes	No
Crampy/abdominal pain	Yes	No
Chronic Constipation	Yes	No
Frequent diarrhea	Yes	No
Change in Bowel Movements	Yes	No

Genitorurinary:

Loss of urine when coughing or sneeze	Yes	No
Kidney or bladder infection	Yes	No
Burning or frequent urination	Yes	No
Feeling must go immediately	Yes	No
Do you have to get up at night to urinate	Yes	No
Blood in urine	Yes	No
Swelling of hands and feet	Yes	No
Difficulty starting urination	Yes	No
Decreased in strength of stream	Yes	No
Penile Discharge	Yes	No
Date of last Prostate Exam:____________________		

MUSCULOSKELETAL:

Significant arthritis	Yes	No
Low Back Pain	Yes	No
Muscle Weakness	Yes	No
Difficulty Walking	Yes	No
Fractures(list)______________________________		

SKIN:

Skin Disorders	Yes	No

NEUROLOGIC/PSYCHIATRIC

Numbness/paralysis	Yes	No
Fainting Spells	Yes	No
Memory Loss	Yes	No
Diziness	Yes	No
Do you have trouble sleeping?	Yes	No
Are often depressed?	Yes	No
Are you often anxious or nervous	Yes	No
Do you ever wish you were dead?	Yes	No
Do you often worry?	Yes	No
Have you ever been under psychiatric care	Yes	No

ENDOCRINE:

Crave large amount of fluids	Yes	No
Intolerance to slightly warm rooms	Yes	No
Intolerance to slightly cool rooms	Yes	No
Change in textures of hair or skin	Yes	No
Change in voice(as an adult)	Yes	No
Hair Loss	Yes	No
Diminished Sex Drive	Yes	No
Darkening of Skin	Yes	No

GYNECOLOGICAL(WOMEN ONLY)

Age when you started period:__________ years old

Frequency:_________Days Last Period:________________

Are you abnormal or irregular?	Yes	No
Menopausal_________ Age_________	Yes	No

Number of Pregnancies:____________C-sections:__________

Term Deliveries:_________________Premature:__________

Miscarriages:____________________Abortions:__________

Pelvic Inflammatory disease	Yes	No
Pain with intercourse	Yes	No
Date of last pap smear?_______Normal?	Yes	No
Breast masses/lumps/cysts(circle)	Yes	No
Nipple Discharge	Yes	No
Skin Discoloration	Yes	No
Family history breast cancer?	Yes	No

Last Mammogram?__________

Patient Signature:_______________________________

Reviewing Physician:______________________________

HEAL MEDICAL
CLINIC

Lab/Radiology Result Policy

Heal Medical Clinic wants to ensure **EVERY** patient to be aware of **ALL** results. We have invested in a software called **Patient Ally** that will allow you to easily access your results from your computer or mobile phone.

This office does not have "No News is Good News" policy. We encourage **ALL** our patients to enroll. If you don't hear from us in 2-3 weeks. Please give us a call or schedule an appointment to follow up.

Patient Last Name:____________________**First Name:**________________________________

Patient Signature:______________________ **Date:**_____________________________________

Prescription Refill Policy

Heal Medical Clinic wants to inform all our patients that all prescription refills need to be requested through your pharmacy. Please allow **2 business days** to process your request.

Please be aware that all prescription refills are done as a courtesy to our patients and if you have not been seen in the last 6 months; please schedule an appointment.

Patient Last Name:____________________**First Name:**________________________________

Patient Signature:________________________**Date:**__________________________________