PRESTIGE MEDICAL GROUP

PRESTIGE MEDICAL GROUP

PATIENT INFORMATION FORM

FORMS MUST BE FILLED IN **ENTIRELY**

DATE: _____

PATIENT INFO

LAST NAME: _____ FIRST NAME: _____ MI: _____ DOB:_____

PHONE NUMBER: [H] _____ [C] _____ [W] _____

STREET ADDRESS: _____ APT #_____ CITY: _____STATE: _____ ZIP: _____

SOCIAL SECURITY #: _____ SEX: ☐M ☐F ☐T EMAIL: _____

EMPLOYER: _____ OCCUPATION: _____ ☐FULL-TIME ☐PART-TIME ☐UNEMPLOYED

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

SPOUSE'S NAME: _____ SPOUSE'S DOB: _____

DO YOU HAVE A LIVING WILL / ADVANCE DIRECTIVE? ☐YES ☐NO

ETHNICITY: ☐HISPANIC/LATINO ☐ NON-HISPANIC RACE: _____ LANGUAGE: _____

EMERGENCY CONTACT

NAME: _____ PHONE #:_____ RELATION: _____

PRIMARY CARE PHYSICIAN

NAME: _____ Phone: _____

PHARMACY

Name/City _____

☐ INSURANCE INFORMATION

☐ SELF-PAY

PRIMARY INSURANCE NAME: _____ ID #: _____

POLICY HOLDER NAME: _____ DOB: _____

SECONDARY INSURANCE NAME: _____ ID #: _____

POLICY HOLDER NAME: _____ DOB: _____

AUTHORIZATIONS – TREATMENT/MEDICAL RECORDS/BILLING CONSENT

AUTHORIZATION AND RELEASE FOR PRESTIGE MEDICAL GROUP. I VOLUNTARILY CONSENT TO THE ADMINISTRATION AND COSTS OF MEDICAL AND/OR SURGICAL PROCEDURES FOR MYSELF OR MY DEPENDENT.

ASSIGNMENT OF INSURANCE BENEFITS / GUARANTEE OF PAYMENT
I AUTHORIZE PAYMENT DIRECTLY TO PRESTIGE MEDICAL GROUP FOR ALL BENEFITS PAYABLE TO ME. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE AND AGREE TO PAY ALL CHARGES THAT ARE NOT PAID OR BILLED TO INSURANCE OR ANY THIRD PARTY PAYER. I UNDERSTAND THAT I MUST PAY IN FULL TODAY FOR ALL SERVICES RENDERED UNLESS MY INSURANCE IS ACCEPTED. I ALSO UNDERSTAND THAT IF MY INSURANCE IS ACCEPTED I UST PAY ALL APPLICABLE INSURANCE CO-PAYS, OR CO-INSURANCE, AND DEDUCTIBLE FOR SERVICES. I UNDERSTAND ALL SERVICES RENDERED ARE NON-REFUNDABLE UNDER ANY CIRCUMSTANCE. I UNDERSTAND THAT IF I DO NOT PAY WITHIN 90 DAYS UPON RECEIPT OF MY BILLING STATEMENT, MY ACCOUNT WILL BE TRANSFERRED OVER TO A CREDIT COLLECTION AGENCY.

RELEASE OF RECORDS
I AUTHORIZE PRESTIGE MEDICAL GROUP TO RELEASE (VERBAL OR WRITTEN) CONFIDENTIAL MEDICAL INFORMATION TO ANY PERSON OR ENTITY INCLUDING MY INSURANCE CARRIER, EMPLOYER (IF TREATMENT IS RELATED TO EMPLOYER PURPOSES), OR OTHER HEALTH CARE OPERATIONS WHICH MAY BE LIABLE TO ME OR MY PRACTITIONER(S) FOR CHANGES FOR THE TREATMENT AND FOR QUALITY MANAGEMENT, UTILIZATION REVIEW, TRANSFER, AND FOLLOW-UP PURPOSES. I ALSO HEREBY AUTHORIZE PRESTIGE MEDICAL GROUP TO CHECK MY EXTERNAL RX HISTORY FOR PURPOSES OF TREATMENT. I ALLOW PRESTIGE MEDICAL GROUP TO RETRIEVE, REVIEW AND SEND MY MEDICAL RECORDS VIA ELECTRONIC HEALTH RECORDS SYSTEMS.

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: _____

PRESTIGE MEDICAL GROUP

PRESTIGE MEDICAL GROUP

MEDICAL HISTORY

[PLEASE FILL IN COMPLETELY, ALL INFORMATION IS REQUIRED]

REASON FOR VISIT: _____ DATE: _____

LAST NAME: _____ FIRST: _____ MI:_____ DOB: _____/_____ /_____

GENDER: ☐M ☐F ☐T BEST PHONE NUMBER TO REACH YOU: _____ ☐HOME ☐CELL ☐WORK ☐OTHER

HOW DID YOU HEAR ABOUT US? _____

WHICH PHARMACY DO YOU USE?: _____ LOCATION: _____

CURRENT MEDICATION(S): ☐ NONE

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

MEDICATION ALLERGIES: ☐ NONE ☐YES:_____

OTHER ALLERGIES: _____

H ☐

MEDICAL HISTORY: ☐DOES NOT APPLY ☐DEPRESSION ☐KIDNEY DISEASE ☐HEART DISEASE ☐ANEMIA ☐SEIZURES ☐DIABETES
☐CANCER (TYPE) _____ ☐HIGH BLOOD PRESSURE ☐THYROID DISORDER ☐ASTHMA ☐HIGH CHOLESTEROL
OTHER(S) EXPLAIN: _____

SURGICAL HISTORY: ☐ NONE

TYPE: _____ YEAR: _____ TYPE: _____ YEAR: _____

TYPE: _____ YEAR: _____ TYPE: _____ YEAR: _____

FAMILY HISTORY: ☐NONE ☐DEPRESSION ☐KIDNEY DISEASE ☐HEART DISEASE ☐ANEMIA ☐SEIZURES ☐DIABETES

☐CANCER (TYPE) _____ ☐HIGH BLOOD PRESSURE ☐THYROID DISORDER ☐ASTHMA ☐HIGH CHOLESTEROL

OTHER(S) EXPLAIN: _____

SOCIAL HISTORY: ☐NONE SMOKER? ☐ NO ☐ YES, PACKS PER DAY?:_____ LENGTH OF USE? _____

SUBSTANCE ABUSE? ☐ NO ☐ YES IF YES, LIST SUBSTANCE(S): _____ LENGTH OF USE? _____

ALCOHOL ABUSE? ☐ NO ☐ YES IF YES, HOW MUCH? _____LENGTH OF USE? _____

CAFFEINE INTAKE? ☐ NONE ☐1-2 CUPS PER DAY ☐ 2-3 CUPS/DAY ☐ 3-4 CUPS PER DAY ☐ MORE THAN 4 CUPS PER DAY

FALL HISTORY: (PATIENTS OVER 65) HOW MANY FALLS HAVE YOU HAD IN THE **PAST YEAR**? ☐NONE ☐ONE FALL WITH INJURY ☐TWO OR MORE FALLS ☐ONE FALL WITHOUT INJURY ☐TWO OR MORE FALLS WITHOUT INJURY

LAST **MAMMOGRAM**, WHEN AND WHERE? _____ ☐NEVER ☐DOES NOT APPLY
LAST **COLONOSCOPY**, WHEN AND WHERE? _____ ☐NEVER ☐DOES NOT APPLY
LAST **INFLUENZA (FLU) VACCINE**, WHEN AND WHERE? _____ ☐NEVER
LAST **PNEUMONIA VACCINE**, WHEN AND WHERE? _____ ☐NEVER ☐DOES NOT APPLY
DIABETIC PATIENTS: LAST EYE EXAM, WHEN AND WHERE? _____ ☐NEVER ☐DOES NOT APPLY

Prestige Medical Group
18302 Irvine Blvd., Suite 200 Tustin CA 92780
720 N. Tustin Ave., Suite 104, Santa Ana CA 92705

Financial and Office Policies

* **Please do not alter this form by including additional information other than initialing as you will be asked to complete a new form.**

	Please initial next to each section to acknowledge:
	All co-pays, co-insurance, deductibles and cash payments are due at check-in on the day services are rendered. Should you have any remaining balance on your account, you will receive a billing statement in the mail due immediately upon receipt.
	For your convenience we accept cash, check, money order, Mastercard, Visa, Discover, American Express and Care Credit.
	A fee of $50.00 will be charged to your account for any returned check.
	"No Show for New Patient Appointment" – failure to keep a scheduled appointment fee. $100.00
	"No Show for Est pt OV" – Failure to keep a scheduled office visit appointment fee. $50.00
	"Cancellation"- Appointment Cancellation with less than 24 hours' notice fee. $50.00
	"Procedure Cancellation/Procedure No Show" – Procedure cancelled with less than 24 hours' notice fee. $100.00
	Surgery Deposits must be paid prior to your scheduled surgery day, usually at the time of your pre-operative appointment
	We require a 5 BUSINESS day notice for canceling surgical cases. If you do not cancel your surgery 5 business days in advance, you will be charged $200.00.
	Completion of disability forms, FMLA, Social Security or insurance forms will be assessed at $40.00 fee per form to cover the administrative overhead involved in completing these forms. This fee is not covered by insurance.
	Prior Authorizations for medications that are not covered by your insurance company- $30.00. We will notify you in advance if we believe your insurance company won't cover your medication. If you wish for us to appeal the decision, the fee will cover the manpower required to attempt the appeal. **THERE IS NO GUARANTEE THAT YOUR INSURANCE COMPANY WILL APPROVE ANY APPEAL.**
	Peer to Peer Review- $100.00. If your insurance company denies a procedure, test or medication and requests a peer to peer review, this fee will cover the time required for the Docotor to go through this process**. THERE IS NO GUARANTEE THAT YOUR INSURANCE COMPANY WILL GRANT APPROVAL.**
	Charges for copies of medical records –Forty cents per page plus postage per California law. This is to cover the manpower and supply costs of copying and mailing these records. You may access and print your records free of charge from the patient portal.
	Delinquent accounts will be turned over to a collection agency if balances due are not received within 90 days. If your account is turned over to a collection agency, you will be responsible for all collection and legal fees (small claims court)

We appreciate your trust in us and the opportunity to serve your healthcare needs.

Patient's Signature_____ Date_____

Printed Name_____

Prestige Medical Group

RESPONSIBILITY FORM
PLEASE INITIAL BESIDES EACH SECTION TO ACKNOWLEDGE

_____ 1. I acknowledge that my physician is my partner in health. As an adult, it is my responsibility to keep track of my medical conditions, medications, and all other physicians that are involved in my medical care. It is my responsibility to inform every physician or other health care provider that I encounter about any changes in my medications, medication dosages, any medical conditions or any evaluations in progress

_____ 2. I acknowledge that to help protect me from identity theft – this medical office participates in the federal regulation program titled the "Red Flags Rule." As a result, I acknowledge that I will be REQUIRED to present my photo ID and ALL insurance cards at EVERY office visit. Copies of these will be part of my medical record.

_____ 3. I acknowledge that if I fail to keep an advised follow-up appointment to go over test results, monitor treatment, or evaluate symptoms, then I am responsible if this results in harm to myself, delay in diagnosis, or failure to treat or cure.

_____ 4. I acknowledge that I am responsible for scheduling my own appointments. As a courtesy – the physician's office will attempt to contact me one or two days prior to remind me of the appointment, however I may not receive this message for various reasons.

_____ 5. I acknowledge the importance of making sure the physician's office has my current address and all phone number contacts. If my information on file is not current, then I acknowledge that my physician's office will not be able to notify me about abnormal test results, medication recalls, changes in appointment or surgery scheduling, etc.

_____ 6. I acknowledge that I am responsible to know the insurance benefits provided by my insurance carrier(s). Any questions I have regarding my insurance benefits will be directed to my Insurance carrier or Human Resources department by my guarantor or myself.

7. I understand that all telehealth appointments are billable visits, including telehealth visits scheduled to review results (such as urine drop-off results). I acknowledge that these visits will be billed to my insurance, and I am responsible for paying any patient responsibility portion (such as copay, coinsurance, or deductible) after the claim has been processed by my insurance.

Name Signature Date

PRESTIGE MEDICAL GROUP

PATIENT'S RIGHTS

- You have the right to privacy and confidentiality regarding your office visits and records.
- You have the right to adequate education and counseling regarding your medical condition.
- You have the right to have all procedures, risks, benefits, and alternatives explained arid your questions answered in lay language,
- You have the right to have medications' effectiveness and possible side effects explained to you.
- You have the right to see the results of tests arid have the meaning of the tests explained to you.
- You have the right to participate in decisions made regarding treatments, medications, procedures, and surgery.
- You have the right to refuse treatment to the extent permitted by law, and the right to receive information on alternatives and consequences of refused treatment.
- You have the right to review your medical records and have them explained.
- You have the right to decide whether to participate in clinical research studies.

PATIENT'S RESPONSIBILITIES

- Patients have the responsibility to give honest, accurate •and complete medical history information.
- Patients are responsible for ensuring they understand what the doctor is saying and, if not, ask questions for clarification.
- Patients have the responsibility to follow their doctor's medical advice and instructions.
- Patients should report any significant changes in their health to their doctor.
- Patients should keep appointments or cancel in advance because failure to do so prevents patients from being seen:
- Patients are responsible for understanding their own insurance benefits, coverage, co-payment responsibilities and obtaining referrals and authorizations.

ASSIGNMENT OF BENEFITS

I hereby assign to Prestige Medical Groiup Practice any insurance or other third-party benefits available for healthcare services provided to me. I understand that Prestige Medical Group Practice has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Prestige Medical Group Practice, I agree to forward the Practice all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.

Signature of Patient/Legal Guardian **Date:**

PRESTIGE MEDICAL GROUP

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Patient Signature / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship_____ Phone_____

Name: _____ Relationship: _____ Phone_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation Phone_____
☐ Work Phone Confirmation ☐ **Any of the Above** Cell Phone_____

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA: Email:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation
☐ Email Confirmation ☐ Work Phone Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ Clinical Research ☐ **Opt Out**
☐ Email ☐ Any of the Above

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

PRESTIGE MEDICAL GROUP

RECORDS RELEASE FORM

From:

Address_____

I Hereby authorize and request the
Release of copies of the following information:

☐ Complete ☐ Medical Records ☐ Imaging

☐ Laboratory Records ☐ Procedure Reports ☐ Other Records_____

INCLUDING CURRENT AND PREVIOUS MEDICAL RECORDS FROM OTHER PRACTICES AND PRACTICIONERS, HOSPITALS, AND/OR CLINIC WHICH ARE A PART OF MY MEDICAL RECORDS.

To: Lamia L. Gabal, MD or Jill Byers MD, or Hari Sawkar, MD
18302 Irvine Blvd, Suite 200. Tustin, CA 92780 or 720 N. Tustin Ave., Suite 104, Santa Ana, CA 92705

Phone: 949-825-7650 Fax: 877-473-1042

This information has been released to you specifically with the consent of the patient of his/her authorized representative. It is strictly confidential, and no further release or use of the information is authorized without the consent of the patient or authorized representative. I hereby release the facility from any Liability which may arise as a result of the use of the information contained in the records released.

Patient Name:_____ Date of Birth_____

Social Security#:_____ Phone #:_____

Signature:_____Date:_____

☐ Signature Disclosure ☐ Continuing disclosure for 90 days ☐ Expiration Date_____

PRESTIGE MEDICAL GROUP

☐ I consent to a pelvic and/or rectal exam by Dr. Gabal, Dr. Byers, Dr. Sawkar, or one of our qualified Physician Assistants. I understand this is important to evaluate my urological health and plan care. I also understand that a chaperone can be provided upon request.

☐ I decline to a pelvic and/or rectal exam.

Name: _____ Date: _____

Signature:_____

18302 Irvine Blvd., Suite
200 Tustin, CA 92780

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Santa Ana, CA 92705