Raveen R. Arora, M.D., F.A.C.C
1712 W. Medical Center Drive
Anaheim, CA 92801-1801

Phone: (714) 491-7200
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PATIENT INFORMATION FORM

Date:_____ **PLEASE PRINT CLEARLY**

PERSONAL INFORMATION

Patient Name:_____Age:_____DOB:_____
Address:_____City:_____State:_____Zip_____
Mailing Address (if different than above):_____
Home Ph#:_____Cell Ph#_____Work Ph#:_____
Social Security #:_____ Drivers License #:_____
E-Mail Address:_____ Marital Status: married [ ] single [ ]
Smoker [ ] Non Smoker [ ]

Referred by/PCP _____

EMPLOYER INFORMATION & EMERGENCY CONTACT INFO:

Name of Employer:_____ Phone#:_____Years employed:_____
Address:_____City:_____State:_____Zip:_____
Occupation:_____ SELF[ ] SPOUSE[ ] (check one)
In Case of Emergency, please notify:
Name:_____Relationship:_____Phone#:_____
Address:_____City:_____State:_____Zip:_____

INSURANCE INFORMATION

HAVE YOUR INSURANCE CARDS AND ID AVAILABLE TO COPY

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I acknowledge that I will be responsible for the full amount if the services are not covered or the services have not been otherwise pre-approved for payment by my Health Plan. I understand that it is my responsibility to make sure that all services have been pre-authorized and I authorize my insurance company to make payments directly to Raveen R. Arora, Inc. I understand that I am financially responsible to the practice for any and all services that maybe denied by my insurance company. I consent to the release of any information req by my insurance carrier with respect to the course of my medical examination or treatment. I also consent to the release of my applicable medical record information from any other or referring physician as may be requested by Raveen R. Arora, M.D. I also authorize and understand that Raveen R. Arora, M.D., is permitted to use and disclose my health informat order to make decisions about and plan for my care and treatment, refer to/or consult and coordinate with other health care providers in the course of my treatment.

Print Name:_____Signature:_____Date:_____

Patient Name _____

Patient medical history

Please list any conditions or chronic illnesses you have
(such as high blood pressure, diabetes, pregnancy, glaucoma, prostate problems, etc)

_____ _____

_____ _____

_____ _____

Please list allergies or reactions to foods or medicine

_____ _____

_____ _____

_____ _____

Please list all medications prescribed by a doctor or dentist.

_____ _____

_____ _____

_____ _____

Please list all over-the-counter medications
(such as aspirin, antacids, sleep medicine, allergy, cold medicine, vitamins, ect..)

_____ _____

_____ _____

_____ _____

5. **Do you smoke? Yes or No comment:** _____

6. **Do you drink alcoholic beverages?** _____

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 takes effect on _____ and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of 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 the 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 the use and disclosure of medical information.

2. OUR LEGAL DUTY

***Law Requires Us to*:**

- Keep your medical information private
- Give you this notice describing our legal duties, privacy practices and your rights regarding your medical information
- Follow the terms of the notice that is now in effect

We Have the Right to:

- Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law
- 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:

- Before we make an important change in our privacy practices. We will change this notice and make the new notice available upon request.

3. 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 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, technicians, medical student or other people who are taking care of you. We may also share medical information about you 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 HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care, conducting training programs and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In additions to using and disclosing your medical information for treatment, payment and health care operations we may use and disclose medical information for the following purposes:

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name, your location in our facility, your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clery or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or to refuse 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 for you.

Disaster Relief: Medical information with a public or private organization who can legally assist in disaster relief efforts.

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

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court order or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstance, such as a court order, warrant, or grand jury subpoena, we may share your information with law enforcement officials. We may share limited information with law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or local authorities charged with preventing or controlling disease, injury, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purpose of reporting adverse events associated with product defects or problems, enable product recalls, repairs or replacements, to track products, or to conduct activities required by the FDA. 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 or condition.

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 for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws(such as reporting certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS:

You Have a Right to:

- Look at or get copies of your medical information. You may request that we provide copies in a format other than Copies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may Get the form to request access by using the contact information listed at the end of this notice. You may also request access by Sending a letter to the contact person listed at the end of this notice. If you request copies we will charge you $___ for each page, And postage if you want the copies mailed to you. Contact us using the information listed.
- 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.
- Request that we place additional restricitions on our use or disclosure or your medical information. We are not required to agree to these additional restrictions, but id we do, we will abide by our agreement (except in the case of an emergency)
- Request that we communicate with you about your medical information by different means or to different locations. This request must be made in writing.
- Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you written explanation. You may respond with a statement of disagreement that will be added to the information you want changed. If we accept to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information

QUESTIONS AND COMPLAINTS: For any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

PRIVACY PRATICE ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

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

Name: _____ Birthdate: _____

Signature: _____

Raveen R. Arora, M.D., F.A.C.C.
1712 W. Medical Center Drive, Anaheim CA 92801-1801
Phone: (714) 491-7200 Fax: (714) 491-7266

PAYMENT POLICY

Thank you for choosing Dr. Arora as your healthcare provider. We are committed to providing you with quality care. As you are aware, there have been many changes in healthcare that took effect on January 1, 2014. Due to the Affordable Healthcare Act, physicians must comply with mandated policies and procedures. Accepting your insurance payment, as payment in full for services rendered, is against all contracts, including government carriers such as Medicare, therefore we are obligated to collect all co-pays and deductibles. Our billing office will send you a statement reflecting any balance due.

1. ***Proof of Insurance***: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and a current valid insurance card to provide proof of insurance coverage.

2. ***Claims Submission***: We will submit your claims and assist you in any way we reasonably can to aid in your claims being paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

3. ***Private and PPO*** patients with deductibles that have not been met, will be asked for payment at the time of your visit. Please understand that until your yearly out of pocket deductible has been met, claims that we submit on your behalf will not be paid, but will be adjudicated and applied to your deductible. We do collect the contracted rate. Also, all co-pays, which often is stated on your insurance card, will be collected at the time of your visit.

4. ***Coverage Changes***: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. Any amount that your insurance company does not pay, will be billed to you.

5. ***Nonpayment:*** If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. If this should occur, you may be notified by regular and certified mail that you have 30 days to find alternative medical care. During the 30-day period, our physician will only be able to treat you on an emergency basis.

6. ***Returned Checks***: A $25.00 returned check fee will be charged for any check paid to our office returned by your bank unpaid (NSF).

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party:_____

Print Patient Name:_____Date:_____