REGISTRATION FORM

PACIFIC OAKS MEDICAL GROUP

150 N. Robertson Blvd., Suite 300
Beverly Hills, CA 90211
310-652-2562

Date: _____/_____/_____

Please Print

PATIENT INFORMATION

Legal Name: _____
Last First Middle Initial

Date of Birth: _____/_____/_____ Age: _____ Sex: ___Male ___Female

Driver's License #: _____

Home Address: _____

_____
City State Zip Code

Home Phone: _____ Cell Phone: _____ Email: _____

EMPLOYMENT INFORMATION

Occupation: _____

Employer: _____

Address: _____

_____
City State Zip Code

Employer's Phone: _____Ext_____

SPOUSE INFORMATION

Relationship Status: ___ Single ___ Partnered ___ Married ___ Divorced ___ Widowed

Spouse Name: _____
Last First Middle Initial

Spouse D.O.B.: _____/_____/_____ Age: _____

Work Phone: _____ Cell Phone: _____ Email: _____

OTHER INFORMATION

Referred by: _____

Prior Doctor: _____ Phone: _____

Person Not Living With You
For Emergency Contact: _____
Relationship

Address: _____

_____
City State Zip Code

Phone: _____

Signed _____
(Insured or Authorized)

INSURANCE INFORMATION FORM

PACIFIC OAKS MEDICAL GROUP
150 N. Robertson Blvd., Suite 300
Beverly Hills, CA 90211
310-652-2562

PRIMARY INSURANCE INFORMATION

Name of Insured: _____
Last First Middle Initial Relationship to Patient

Date of Birth: _____/_____/_____ Age: _____ Sex: __ Male __ Female

Social Security number: _____

Insurance Company: _____

SECONDARY INSURANCE INFORMATION

Name of Insured: _____
Last First Middle Initial Relationship to Patient

Date of Birth: _____/_____/_____ Age: _____ Sex: __ Male __ Female

Insurance Company: _____

AUTHORIZATION & ASSIGNMENT

• AUTHORIZATION FOR TREATMENT, RELEASE OF INFORMATION, AND ASSIGNMENT OF BENEFITS. I hereby authorize Pacific Oaks Medical Group to provide medical care and treatment and to release my medical information to my insurance company(s) as necessary for the payment of benefits. I also authorize my insurance company(s) to pay benefits directly to Pacific Oaks Medical Group. These authorizations remain valid and effective from the date of signing until revoked in writing.

• FINANCIAL RESPONSIBILITY. I understand that I am financially responsible for the cost of all medical services. Pacific Oaks Medical Group will bill my insurance company strictly as a courtesy to me but any portion of my medical bill that does not get paid by my insurance including but not limited to co-payments, deductibles, and non-covered amounts will be my responsibility due at the time of service. I agree to pay collection costs and reasonable attorney fees incurred in collecting outstanding balances. I understand that invoices sent by Pacific Oaks Medical Group are due upon receipt and that failure to keep my account current may result in my being denied additional services. Payment in full is due from self-pay patients at the time of service, unless other arrangements have been made with the office. Returned checks will be subject to a $35.00 collection charge.

Pacific Oaks Medical Group is pleased to offer statements by email. If you would like this method of notification, please provide e-mail address_____

• *ASSIGNMENT OF BENEFITS DIRECT PAYMENT TO DOCTOR (Under California State Insurance Code 10133*)* I hereby authorize my Insurance Company to pay by check made out to and mailed directly to Pacific Oaks Medical Group for medical expense benefits allowable, and otherwise payable to under my current insurance policy, as payment towards charges for professional services rendered. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over-and-above this insurance payment. A photocopy of this authorization shall be considered as effective and valid as the original. * This office holds an assignment/lien on this case for services rendered. Any settlement of this claim without honoring assignment/lien will cause you to be responsible to this office for immediate payment.

• MISSING AN APPOINTMENT. Pacific Oaks Medical Group's "No Show Policy", which is posted in the waiting room, requires that at least 24-hours advance notice be given if I cancel an appointment. I hereby agree to abide by this policy and accept full responsibility for the $150.00 "No Show" fee that may be charged to my account for my failure to cancel an appointment at least 24 hours in advance.

• NON-COVERED CONVENIENCE ITEMS. I understand that Pacific Oaks Medical Group provides a variety of items and services for my convenience, which are seldom covered by medical insurance. To the extent that I want to take advantage of these items and services, I hereby agree to pay for them. These non-covered convenience items include:

Non-Emergency After-Hours Prescription Refills ($25.00)
Simple Form Completion, Single Page ($10.00)
Complex Form Completion, Multiple Pages ($50.00)
Letters ($75.00 per page)
Telephone consultations will apply to copay or deductible

Prior Authorizations – Simple form completion ($25.00)
- Complex form completion/peer-to-peer ($50.00)

- ANNUAL ADMINISTRATIVE FEE. Please note, if you are a patient of our primary care providers and have paid the $450 annual administrative fee, the above non-covered convenience items do not apply to you. If you would like information about the annual administrative fee, please speak to front office staff.

I acknowledge that I have read and understand my responsibilities and Pacific Oaks Medical Group's policies.

Patient Signature: _____ Date: _____

1.Must be completed for each visit
2.List medication that is prescribed by your primary care provider and specialists
3.List all over-the-counter medications and non-oral medications (e.g. inhalers, eye drops, creams or patches)
4.List oral contraceptives or hormone replacement therapy, or other products taken regularly such as herbal medicines or dietary supplements.

MEDICATION LIST

MEDICATION	DOSAGE	# OF TABS	TIMES PER DAY	PROVIDER
(example) Motrin	*800 mg tablets*	*1*	*twice daily*	

Pharmacy Name:_____
Telephone#:_____

MEDICAL HISTORY FORM

PACIFIC OAKS MEDICAL GROUP

150 N. Robertson Blvd., Suite 300
Beverly Hills, CA 90211
310-652-2562

Please Print Date: ____/_____/_____

GENERAL INFORMATION

Name: _____
Last First Middle Initial

Date of Birth: ____/____/____ Age:_____ Sex: _____ Height_____ Weight _____

Chief Complaint/Reason for Today's Visit: _____

_____

GENERAL MEDICAL HISTORY

Check All Items That Apply to You.

- ☐ Bleeding Problem Specify: ☐ Bleeding ☐ Blood Clots ☐ Other
- ☐ Cardiovascular/Heart Problem
- ☐ Ears, Nose, Mouth, Throat Problem
- ☐ Endocrine Problem Specify: ☐ Diabetes ☐ Thyroid Issue ☐ Liver Issue ☐ Hepatitis
- ☐ Eye Problem
- ☐ Gastrointestinal Problem Specify: ☐ Diarrhea ☐ Vomiting ☐ Irritable Bowl ☐ Other
- ☐ General Problem Specify: ☐ Fever ☐ Weight Loss ☐ Other
- ☐ Musculoskeletal Problem
- ☐ Neurological Problem Specify: ☐ Seizures ☐ Stroke ☐ Other
- ☐ Psychiatric Problem Specify: ☐ Depression ☐ Bipolar ☐ Schizophrenia ☐ Other
- ☐ Respiratory Problem Specify: ☐ Asthma ☐ Bronchitis ☐ Cough ☐ Short of Breath ☐ Other
- ☐ Skin Problem Specify: ☐ Rash ☐ Skin Ulcer ☐ Wound ☐ Other
- ☐ Urinary Problem

Check All Items That Apply to Your Close Blood Relatives (i.e., Grandparents, Parents, Siblings and Children):

- ☐ Bleeding Disease
- ☐ Cardiovascular/Heart Disease
- ☐ Cancer of the Colon, Breast or Prostate
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Neurological Disease (i.e., Stroke, Seizures)
- ☐ Rheumatoid Arthritis

LIFESTYLE HISTORY

1. Occupation? _____ Employer? _____
2. Do You Smoke Tobacco? If yes, how much per day? _____ If you quit, when did you stop? _____
3. Do You Drink Alcohol? If yes, how much per day? _____ Do you take Recreational Drugs? _____
4. When Was Your Last Physical Exam by a Doctor? _____

FAMILY HISTORY

List Allergies: _____

Mom:_____ _____

Dad:_____ _____

Siblings/Grandparents:_____ _____

PACIFIC OAKS

PRESCRIPTION REFILL POLICY

As of **September 2012**, Pacific Oaks Medical Group will implement a new Prescription Refill Policy. We realize this is a change for us both. Pacific Oaks will continue to provide the highest quality of medical care by making every effort to guarantee this is an easy transition.

- No prescriptions will be refilled by phone or fax
- Prescriptions will not be filled for unauthorized "walk-in" patients without an appointment.
- No Prescription refill requests for any 12 month period
- Non-controlled/non-narcotic prescriptions require a follow up appointment every **3-6 months**.
- Controlled-substances/narcotic prescriptions require a follow up appointment every **30-60 days**.
- If you are overdue for a follow-up visit and/or blood work (necessary for monitoring the safety or effectiveness of a medication), the provider may agree to renew only enough to last until you can schedule an appointment or up to 7 days. It is your responsibility to schedule an appointment before you run out of medication. Please schedule your next visit before you leave our office.
- New symptoms and/or events require an office visit before a prescription is given. Physicians are unable to diagnose without seeing the patient.
- Signed "Controlled-Substance Pain Management Agreement" required if using narcotic/controlled medications.
- No refills if medications are overused/abused/misused. Must follow prescription directions.
- No medication/prescription will be replaced if lost, stolen, misplaced, overused, etc.
- Medications are for the prescribed individual's use only. It is illegal to "share" your medicine.
- We will make every attempt to expedite the refill process; however the normal turnaround time is 24-48 hours due to number of requests received daily. May be up to 72 hours for mail-orders to be processed by the insurance company.

I understand and accept the protocol listed above. Failure to comply may subject immediate termination of prescriptive medications.

Patient Name: _____ Date: _____/_____/_____

Signature: _____

Name of person picking up Rx (if not same)_____

Meds: _____

Should you have any concerns about our policy, feel free to ask to speak to Management.

Thank you for choosing Pacific Oaks Medical Group. We look forward to working with you to assure the safest and highest quality medical care.

Opioid and Controlled Substances Agreement and Informed Consent

Opioid medications are used judiciously in the treatment of benign or malignant pain conditions. The following is an agreement and explanation of issues related to treatment of painful disorders through the use of opioid medications and/or other controlled substances. These medications include but are not limited to Ambien/Zolpidem, Lunesta/Eszopiclone, Dayvigo/Lemorexant, Belsomra/Suvorexant, Sonata/Zaleplon, Lyrica/Pregabalin, Tramadol, Tylenol with codeine, Testosterone, Oxandrolone, Nandrolone, Hcg, Estrogen, Adderall/dextroamphetamine and amphetamine, Vyvanse/lisdexamfetamine, Ritalin/methyphenidate, Modafanil, Xanax/alprazolam, Klonopin/clonazepam, Valium/diazepam, Restoril/temazepam, Halcion/triazolam, Ativan/lorazepam, Percocet/oxycodone, Norco/hydrocodone, phentermine, phentermine and topiramate)

Side Effects & Risks:

Because these medications are potentially dangerous, as are all medications, the side effects and risks are discussed with you at the beginning of the treatment and periodically thereafter. Side effects/risks include but are not limited to allergic reactions, sedation, somnolence, respiratory depression (i.e. slow breathing), dizziness, confusion, nausea, vomiting, urinary retention, suppression of menstrual cycle, hormonal imbalance, constipation, itching, physical dependence, tolerance, addiction, or death.

Caution:

Opioid medications may cause drowsiness. Alcoholic beverages should be avoided or be used with extreme caution and sparingly after approval of your pain physician while taking these medications. Driving a car or operating dangerous machinery may not be allowed initially until a stable dose of these medications are obtained. Usually, most side effects of opioid use disappear over time and with continued use, except for constipation. Bowel maintenance should be addressed seriously and treated if necessary. If decision is made to terminate opioid therapy, a weaning schedule rather than abrupt discontinuation of treatment should be exercised to prevent withdrawal symptoms (e.g. increased pain, agitation, nausea, diarrhea, etc.)

The following conditions must be followed and agreed upon as long as the patient is receiving treatment at Pacific Oaks Medical Group. Noncompliance with any one of these conditions may result in discharge from the practice.

1. Pacific Oaks Medical Group must be the only source for the medications that were reviewed above. The patient may not obtain these medications from any other source or physician except when it is explicitly allowed and approved by Pacific Oaks Medical Group.
2. The patient understands that the treatment goal is to improve the quality of life and ability to function and/or work. These parameters will be assessed periodically to determine benefits of opioid therapy and adjust the dosage accordingly.

3. The patient understands that he/she must take the medications as instructed and prescribed. Any change in dosing must be approved by a Pacific Oaks Medical Group physician.
4. The patient agrees to use only one pharmacy whose contact information and address the patient would provide to Pacific Oaks Medical Group. If for any reason another pharmacy is to be used (e.g. unavailability of a certain medicine), the patient should notify Pacific Oaks Medical Group.

Pharmacy: _____

Telephone: _____

5. Lost or stolen prescriptions or medications will NOT be replaced. It is the patient's responsibility to ensure that prescriptions are filled correctly at the pharmacy. If the patient realizes a medication is lost, stolen, or misplaced, a police report must be filed, and the case number should be given to Pacific Oaks Medical Group.
6. To ensure efficacy of treatment and for monitoring purposes, the patient should keep all recommended appointments.
7. *Controlled prescriptions will not be given over the phone, after hours, during the weekends, or holidays.* If there is a need to change any controlled prescription, a new appointment needs to be made.
8. Pacific Oaks Medical Group has the right to directly communicate with other healthcare providers and pharmacies regarding the patient's use of controlled substances.
9. Opioid therapy usually is only part of the overall treatment plan. The patient shall comply with all other treatments as outlined by their physician at Pacific Oaks Medical Group.
10. The patient may be asked for urine and/or blood screening tests as well as random pill count. Failure to comply with this results in immediate discharge from the practice.
11. The patient understands that sharing of medications referred to above with anyone is absolutely forbidden and is against the law.
12. Patient understands that the results of urine/blood testing can be given to the patient's other healthcare providers, insurance company, or other reimbursing agencies. The patient also authorizes any other healthcare provider, pharmacy, law enforcement, or judiciary body to release any pertinent information regarding the patient's prescription or urine/blood screen results.
13. Patient agrees that any use of illicit substances (Marijuana, Cocaine, etc.) during treatment is strictly prohibited, and if identified during a urine test may result in discharge of patient from the clinic. I, the undersigned, attest that above was discussed with me, and I fully understand and agree to all of the above requirements and instructions. I also understand that failure to comply with above can result in my discharge from Pacific Oaks Medical Group.

Patient Name: _____

Patient Signature: _____

Date: _____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS
PACIFIC OAKS MEDICAL GROUP

Your Rights

You have a right to request that communications concerning your personal health information be made through confidential channels. Pacific Oaks Medical Group will not ask you why you are making the request. Reasonable efforts to accommodate your request will be made subject to some restrictions.

- Requests cannot impede treatment, payment or day-to-day functioning of the practice.
- Requests cannot limit Pacific Oaks Medical Group's ability to submit claims to a patient's health plan.
- Requests must allow Pacific Oaks Medical Group to identify itself and the patient.

Designated Method of Contacting the Patient

I, _____, hereby request that Pacific Oaks Medical Group contact me using the following confidential channel(s) of communication related to my appointment reminders, personal health, treatment or payment for treatment. [Account balance statements will continue to be mailed to your mailing address.] *This request supercedes any prior request for confidential channel(s) of communications that I may have made.*

Include only those channels of communication that you want Pacific Oaks Medical Group to use.

Confidential Address: _____

Home: _____ Leave Message: Y N

Cell: _____ Leave Message: Y N

Cell: _____ Text Message: Y N

Work: _____ Leave Message: Y N

Other: _____ Leave Message: Y N

Email: _____

Person(s) Specifically Authorized to Receive Communications (besides the Patient):

_____

_____

Person(s) Specifically Authorized NOT to Receive Communications:

_____

Signature

Patient Name (Print) _____

Patient or Representative's Signature _____

Date _____

If Representative, Relation to Patient _____

HIPAA - Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

_____ _____

Signature of patient or patient's representative Date

_____

Printed name of patient/patient's representative

Printed Patient Name: _____ _____

_____

Relationship to the patient

Effective Date: **September 23, 2013**

PACIFIC OAKS MEDICAL GROUP

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize:_____
Physician/Healthcare Facility

To release information on _____(Patient's Name) _____(Patient's DOB) regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: _____
Name

_____
Address

_____ _____ _____
City State Zip Code

_____ _____
Telephone number Fax number

The medical information/records will be used for the following purpose:

_____

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

[ ] Limited to the following medical information:

_____

_____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____(initial)

Psychiatric/Mental Health _____(initial)

Tests for Antibodies to HIV _____(initial)

HIV Diagnosis/Treatment _____(initial)

Genetic Information _____(initial)

DURATION

This authorization shall be effective immediately and remain in effect until_____
Date

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ _____

Signature of patient *or legal/personal representative patient*

Relationship *if other than*

_____ _____

Patient's Name (PRINT)

Date

_____

Patient's Date of Birth

_____ _____

Witness name

Witness signature

PACIFIC OAKS MEDICAL GROUP

STANDARD AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (cont.)

Medical Record Payment Form

CA CIVIL CODE 123110: California Patient Access to Health Records. Inspection and copying; Paragraph (b) Additionally any patient or patient's representative shall be entitled to copies of all or any portion of the patients records that he or she has a right to inspect, upon presenting a written request to the health care provider specifying the records to be copied.

Once we receive the form, a copy of your records will be transferred/copied within 15 days, in a reasonably comprehensible format subject to copying costs of not over 25 cents per page plus reasonable clerical costs. Total cost shall not exceed $40.00 per request.

Date: _____ Medical Record #: _____

Patient Name: _____ Daytime contact #: _____

Payment Method (To Be Completed by Patient)

- o Check (payable to: POMG)
- o Credit Card (MC, Visa, AMEX)

Check #: _____
Credit Card Number: _____
Expiration Date: _____ 3 Digit Security Code: _____
Name on Credit Card: _____
Signature of credit card holder: _____
Billing Address (on card): _____

Please note: If paying by credit card, your information will be shredded upon completion.

FOR OFFICE USE ONLY

Date Received: _____ Date processed: _____ Mailed ☐ Picked Up ☐ (verify ID) Faxed ☐
Processed By: _____ ☐POMG Staff: ☐ Billing Staff ☐ Other: