

JEFFREY P. BLOCK, M.D.
A PROFESSIONAL CORPORATION
2220 Lynn Road Suite 302
Thousand Oaks, CA 91360

PATIENT INFORMATION

Date: ____ - ____ - ____ Who referred you to us? _____

Name: _____ Birth date: ____ - ____ - ____ Age ____ Sex: M/F

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone# () _____ Work Phone# () _____ Cell Phone# _____

Social Security# ____ - ____ - ____ Marital Status: (circle one) Single Married Divorced Widowed

Employer: _____ Address: _____

Patient's Occupation: _____

Name of Spouse: _____ Spouse SS#: ____ - ____ - ____ Birth date: ____ - ____ - ____

Spouse Employer: _____ Address: _____

Spouse's Occupation: _____

Spouse Work Phone#: _____ Spouse Cell Phone#: _____

Emergency Contact: _____ Relationship: _____ Phone#: _____

Reason for Office Visit: _____

Primary Insurance: _____

Insured's Name: _____ Birth date: ____ - ____ - ____

Claim Form Address: _____ City: _____ State: _____ ZIP: _____

Insured's ID#: _____ Group#: _____ Phone#: _____

Secondary Insurance: _____

Insured's Name: _____ Birth date: ____ - ____ - ____

Address: _____ City: _____ State: _____ ZIP: _____

Insured's ID#: _____ Group#: _____ Phone#: _____

I understand that if any of the insurance information I have provided is incorrect or if I fail to notify the office of any insurance changes, that I am responsible for all physician charges and non-covered medical services.

I hereby authorize the release of any medical information necessary for the process of insurance. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to JEFFREY P. BLOCK a Professional Corporation This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I have received the Notice of Privacy Practices.

Patient's Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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 Pharmacy is covered by the medical information privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (generally called "HIPAA") and its Regulations. As a result, we are required to comply with HIPAA and the Regulations in the use and disclosure of health information by which our patients can be individually identified. This health information is referred to as "Protected Health Information" or "PHI" for short. We are also required under Section 164.520 to give our patients this notice (in paper or electronically as the patient wishes) of our legal duties and privacy practices concerning their Protected Health Information, and also to tell our patients about their rights under HIPAA and the Regulations.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

There are two categories for the use and disclosure of our patients' Protected Health Information: (1) information that we can use and disclose without the patient's prior consent; and (2) information that we cannot use or disclose without the patient's prior authorization.

A. PATIENTS' PRIOR CONSENT NOT REQUIRED

- (1). Treatment. In the first category, we are permitted to use and disclose our patients' Protected Health Information in connection with their medical treatment in situations such as allowing a family member or other relative or a close personal friend or other person involved in the patient's health care to pick up the patient's prescriptions and to receive Protected Health Information that is directly related to the patient's care. In doing so, we are to use our professional judgment and experience with common practice in determining what is in the patient's best interest. Other examples include sending information about a patient's prescriptions to the patient's family doctor or to a specialist who is treating the patient or to a hospital where the patient is receiving care, particularly if the patient has suffered a health emergency.
- (2). Payment. If a patient is covered by a pharmacy benefit plan, we are entitled to send Protected Health Care Information to the plan or to another business entity involved in our billing system describing the medication or health care equipment we have dispensed so that we can be paid.
- (3). Health Care Operations. In addition, we can provide Protected Health Information for health care operations such as evaluations of the quality of our patients' health care in order to improve the success of treatment programs. Other examples include reviews of health care professionals, insurance premium rating, legal and auditing functions, and business planning and management.
- (4). Other Permitted Uses and Disclosures. There are a number of other specified purposes for which we may disclose a patient's Protected Health Information without the patient's prior consent (but with certain restrictions). Examples include public health activities; situations where there may be abuse, neglect or domestic violence; in connection with health oversight activities; in the course of judicial or administrative proceedings; in response to law enforcement inquiries; in the event of death; where organ donations are involved; in support of research studies; where there is a serious threat to health and safety; in cases of military or veterans' activities; where national security is involved; for determinations of medical suitability; for government programs for public benefit; for workers' compensation proceedings; when our records are being audited; when medical emergencies occur; and when we communicate with our patients orally or in writing about refilling prescriptions, about generic drugs that may be appropriate for a patient's treatment, or about alternative therapies.

B. PATIENT'S PRIOR AUTHORIZATION REQUIRED

For purposes other than those mentioned above, we are required to ask for our patients' written authorizations before using or disclosing any of their Protected Health Information. If we request an authorization, any of our

patients may decline to agree, and if a patient gives us an authorization, the patient has the right to revoke the authorization and by doing so, stop any future uses and disclosures of the patient's health information that the authorization covered. An example of a situation where the patient's prior authorization would be required would be if we wish to conduct a marketing program that would involve the use of Protected Health Information.

2. PATIENTS' RIGHTS

HIPAA and the Regulations provide our patients with rights concerning their Protected Health Information. With limited exceptions (which are subject to review), each patient has the right to the following:

- (a). Patient's Record. Each patient can obtain a copy of his or her Protected Health Information by completing our request form. The only charge will be based on our cost in responding to the request. The amount of the charge will vary depending on the format the patient requests and whether the patient wants the record or a summary, and whether it is to be delivered by mail or otherwise. The patient will be told of the fee when the patient's request is received.
- (b). Accounting for Disclosures. By completing our request form, each patient is entitled to obtain a list of the disclosures of the patient's Protected Health Information that have occurred within a period of 6 years after April 14, 2003, except for disclosures made for the purposes of treatment, payment or health care operations, and certain others. There will be no charge for the first request in any 12-month period, but we are entitled to charge a reasonable cost-based fee for additional requests made in the same period of time.
- (c). Amendments. Each patient may ask to change the record of his or her own Protected Health Information by completing our request form, explaining why the change should be made. We will review the request, but may decline to make the change if, in our professional judgment, we conclude that the record should not be changed.
- (d). Communications. By completing our request form, each patient can ask us to communicate with him or her about their own Protected Health Information in a confidential manner such as by sending mail to an address other than the home address or using a particular telephone number.
- (e). Special Restrictions. By completing our request form, each patient can ask us to adopt special restrictions that further limit our use and disclosure of the patient's Protected Health Information (except where use and disclosure are required of us by law or in emergency circumstances). We will consider the request; but in accordance with HIPAA and the Regulations, we are not required to agree to with the request.
- (f). Complaints. If a patient believes that we have violated the patient's rights as to the patient's Protected Health Information under HIPAA and the Regulations, or if a patient disagrees with a decision we made about access to the patient's Protected Health Information, the patient has the right to complete our complaint form and deliver it to our Contact Person listed below. Our Contact Person is required to investigate, and if possible, to resolve each such complaint, and to advise the patient accordingly. The patient also has the right to send a written complaint to the U.S. Department of Health and Human Services at the addresses shown on the complaint form. Under no circumstances will any patient be retaliated against by this Pharmacy for filing a complaint.

We are required by law to protect the privacy of our patients' Protected Health Information, to provide this notice about our privacy practices, and follow the privacy practices that are described in this notice. We reserve the right to make changes in our privacy practices that will apply to all the Protected Health Information we maintain. A new notice will be available on request before any significant change is made.

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Consent for Medical Treatment

I, the undersigned, the patient (or the patient's duly authorized representative) do hereby voluntarily consent to and authorize medical care encompassing all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician, his assistants or designees.

I am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guaranties have been made to me as to the result of treatment or examinations performed.

I authorize or staff to retain, preserve and use for scientific or teaching purposes, or dispose of at their convenience and in their sole discretion any specimens or tissues removed and I waive any interest I may have had in such specimen tissues.

This form has been fully explained to me and I certify that I understand and accept its contents.

All the above will be discussed with me, by the attending physician prior to any proposed testing or any type of surgical procedures to be scheduled.

Patient's signature: _____

Date: _____

Dear Patient,

Our office is pleased to have the opportunity to serve you. Our primary mission is to provide you with quality, cost effective, medical care. Together, we (patients and physicians) are trying to adapt to the changing way that healthcare is financed and delivered. The following letter outlines some of the financial and procedural steps required by your insurance or managed care plan.

Payment Guidelines:

- We must collect any co-payments, co-insurance, and/or deductibles at the time of service, unless other arrangements have been made in advance with our office.
- We accept **Cash, Checks, Money Orders**.
- The remainder of your bill will be sent to your insurance company for payment to our office.
- If, by mistake, your insurance company remits this payment back to you, please send it to us along with all paperwork sent to you. **Please do not send payment back to the insurance company.**

When to Present Insurance Card?

Please present your insurance card at EACH VISIT. Specifically bring to our attention any changes (new card, new group #, etc.) since your last visit. This protects you from paying a bill because we had the wrong insurance information. There is a narrow window (30-45 days) to present an accurate claim to the correct insurance company. Failure to do so could mean the claim may be denied. In addition, if you have secondary insurance, it will be filed on your behalf as a courtesy. However, if we have not received payment from your secondary insurance in a timely manner, the balance will become your responsibility.

Insurance Company Denies Payment?

Sometimes your insurance company will refuse payment of a claim for some of the following reasons:

1. This is a pre-existing illness or condition that they do not cover.
2. You have not met your full calendar year deductible.
3. The type of medical service required is not covered.
4. The insurance was not in effect at the time of service.
5. You have other insurance which must be filed first.
6. You have exceeded your maximum dollar/visit amount.
7. You did not have a referral # for your visit/service.

If your insurance company denies your claim for any of the above reasons or for any other reasons, our office cannot be responsible for this bill. It is your responsibility to pay the denied amounts in full.

We value you as a patient and are eager to serve you! Our first priority is to provide you with the best possible care. If you would like to contact our billing office, you may reach them at (214) 689-3829 or (800) 425-3759.

Sincerely,

I have read and understand my financial obligations. I understand that this office will file an insurance claim on my behalf. I assign the proceeds of such insurance claim to . Both and I will receive an Explanation of Benefits (EOB) from my insurance company that will detail all payments, deductions, and adjustments per my plan's guidelines.

I understand that I will be fully responsible for payment of any and all medical services denied by my insurance company, as applicable by state and/or federal law.

Patient Signature

Date

7.30 Patient Authorization for Personal Representative

Please print all information, then sign and date form at bottom.

Type of Authorization: Personal Representative

Patient's name (Please print): _____ **Date of Birth:** _____

Purpose of request: I authorize JPB M.D. to disclose or provide my protected health information (PHI) to the following individual who is authorized to act as my personal representative for the purposes of receiving all PHI about myself. As my designated personal representative, they may exercise my right to inspect copy and correct my PHI. They may also consent or authorize the use or disclosure of my PHI:

Name of Personal Representative and Relationship (i.e. Spouse, family member, etc)

Address

City, State, Zip

Phone

Description of information to be disclosed – I authorize JPB M.D. to disclose all of my PHI to my designated personal representative.

Circle one: Procedure & Biopsy Labs All Information

Expiration or termination of authorization – This authorization will remain in effect until terminated by patient, the patient's personal representative, or another individual of legal entity authorized to do so by court order of law.

Right to revoke or terminate – As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in person or by mailing a request to:

JP B M.D.

ATTN: _____

Redisclosure – We have no control over the person (s) you have listed as your personal representative. Therefore, your PHI disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Digestive Health Assoc. of Texas, P.A.

7.34 Patient Authorization for Disclosure of Protected Health Information via telephone.

Type of Authorization: Telephone Contact

Patient's name (Please print): _____ **Date of Birth:** _____

Purpose of request – I authorize JP B M.D. to disclose my PHI in the following manner:
(Check the box that applies)

- Leave detailed messages on my answering machine/ voice mail
- Leave messages with only call-back number (includes staff member name and doctor's office) on my answering machine/voice mail
- Home Telephone: _____ Cell Number: _____
- Work Telephone _____

Expiration or termination of authorization – This authorization will remain in effect until terminated by patient, the patient's personal representative, or another individual of legal entity authorized to do so by court order of law.

Right to revoke or terminate – As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in person or by mailing a request to:

JP B M.D.

ATTN: _____

X

Patients Signature

Date

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ Medical Record # _____

Date of Birth _____ Social Security # _____ (optional)

I authorize the following individual or organization to disclose the above named individual's health information:

_____ Address: _____

This information may be disclosed TO and used by the following individual or organization:

JEFFREY P. BLOCK M.D. Address: _____

For the purpose of: _____

Please release the following:

- Problem List
- Progress Notes
- History/Physical Exam
- Medication List
- Immunization Record
- List of Allergies
- X-Ray/Imaging Reports-from (date) _____ to (date) _____
- X-Ray Films
- Laboratory Results-from (date) _____ to (date) _____
- EKG Reports
- Genetic Testing Information
- Other Diagnostic Reports (Specify) _____
- Other (Specify) _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Yes, I consent to the release of this information. **No**, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact _____:

Signature of Patient or Legal Representative

Date

Relationship to Patient (If Legal Representative)

Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold _____ liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative

Date

Relationship to Patient (If Legal Representative)

Witness

Date request completed _____ # pages copied _____ Reviewed only _____
Charges \$ _____ Cash _____ Check # _____ Initials _____