THE BEVERLY HILLS
COMPREHENSIVE
MEDICAL GROUP

PATIENT INTAKE INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security: _____-_____-_____ Gender: M F

Marital Status: S M W D DP Date of Birth: _____

Phone: Home (____) _____-_____ Work: (____) _____-_____

Cell: (____) _____-_____ Email: _____

I would like to receive Doctor's announcements from BHCMG: Y N

Referred by: _____

Employer: _____ Occupation: _____

How did you find out about our office? _____

SPOUSE OR PARENT/GUARDIAN

Name: _____ Relationship to Patient: _____

Phone: (____) _____-_____ Ext: _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Phone: (____) _____-_____ Ext: _____

Patient Signature: _____ Date: _____

NEW PATIENT QUESTIONNAIRE

Name: _____ Today's date: _____

To help us get the most out of today's visit, please answer the following questions:

1. **What is your main purpose in coming to our office today?** (If you have a new complaint, indicate how long it has been present, what it feels like, what makes it better or worse, and what you are concerned the problem might be.)

_____

_____

2. **Are you experiencing any of the following symptoms in relation to your main concern?**
   (Answer "yes" by circling the appropriate symptom.)
   Constitutional symptoms: fever, weight loss, extreme fatigue
   Eyes: double vision, sudden loss of vision, blurred vision
   Ears, nose, mouth and throat: sore throat, runny nose, ear pain
   Cardiovascular: chest pain, palpitation
   Respiratory: cough, wheezing, shortness of breath
   Gastrointestinal: nausea, vomiting, abdominal pain, constipation, diarrhea, blood in stools
   Genitourinary: irregular menses, vaginal bleeding after menopause, frequent/painful urination, bloody urine, impotence
   Skin: rash, changing mole
   Neurological: headache, persistent weakness or numbness on one side of the body, falling
   Musculoskeletal: joint pain, muscle weakness, stiffness, restricted movement
   Psychiatric: depression, anxiety, suicidal thoughts
   Endocrine: excessive thirst, cold or heat intolerance, breast mass
   Hematologic: unusual bruising or bleeding, enlarged lymph nodes
   Allergic: hay fever

3. **Do you have any other concerns?** ☐ Yes (list below) ☐ No

_____

4. **Do you have any drug allergies?** ☐ Yes (list below) ☐ No

_____

5. **List any medications/supplement you are currently taking.**

_____

6. **Do you (currently) or have you had (previously) any major medical problems?** ☐ Yes (list below) ☐ No

_____

7. **Have you had any surgeries?** ☐ Yes (list below) ☐ No

_____

8. **Does anyone in your family have a medical illness such as DM, HTN, high cholesterol, cancer or other?**
   ☐ Yes (list below) ☐ No

_____

9. **What do you do for exercise?** _____ How long? _____ How often? _____
   Note: Brisk walking for 30 minutes most days is associated with a 30% reduction in the risk of heart attacks.
10. **How much tobacco do you smoke/chew per day?** _____ **Note:** It is recommended that you stop using tobacco.
11. **How much alcohol do you consume per week?** _____
12. **How much caffeine do you consume per day?** (i.e., coffee, tea, chocolate, soda) _____
13. **What method of birth control do you use?** ☐Not Applicable ☐ The pill ☐ Vasectomy ☐ Tubal litigation
    ☐Other (specify): _____

_____

Patient Signature

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PATIENT CONSENT AND AUTHORIZATION

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician(s) and it is the responsibility of the staff to carry out the instructions of the physicians.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to BHCMG for medical benefits applicable and otherwise payable to me, but not to exceed the physician's regular charges. I specifically direct any second or third party to accept this assignment and pay the physician directly. I understand that I am financially responsible for charges that the insurance carrier declines to pay. In the case that a check is made to the patient or this office and the patient, for services rendered by this office, this document serves as a power of attorney for endorsement on the patient's behalf.

LIEN: In the event that a lien is necessary to protect and ensure payment to BHCMG, this document serves as notice of lien on any claim I may have and serves as a power of attorney for signature on my behalf on such lien form should it be needed.

RELEASE OF INFORMATION: I authorize the release of information contained in my chart to relevant insurance companies, third parties, attorneys and employers as may be needed to process and manage my case and claims.

REQUEST FOR INFORMATION: I authorize any custodian of records to release medical records and diagnostic studies (including X-Rays) to BHCMG for the purposes of case management.

HMO DISCLAIMER: I certify that I am not presently enrolled in any Health Maintenance Organization (HMO). Subsequent rejection of a claim as a result of my enrollment in an HMO will constitute responsibility for payment of claim on my part.

MINOR'S RELEASE: If the patient is a minor, my signature as parent/guardian authorizes any needed treatment and diagnostic for the minor.

PREGNANCY: There is no reason to suspect that I might be pregnant at this time. If there is a possibility that I might be pregnant, I will advise the doctor prior to any X-Ray or onset of care.

_____ _____

Printed Patient Name Date

_____ _____

Patient, Patient's Parent/Guardian Signature Date

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Office Policies

Dear Patient,

Thank you for choosing Beverly Hills Comprehensive Medical Group (BHCMG) for your healthcare needs. Our office is truly a multi-disciplinary, multi-specialty clinic. We offer Primary Medical Care, Chiropractic Care, Therapeutic Exercise, Massage Therapy, and execuSlim our medically supervised weight loss program. Our philosophy is simple; we treat the whole person and not just the symptom. Our goal is to correct the cause, not cover up the complaint. All patients receive a medical evaluation after which our medical staff decides what course of treatment, if any, will benefit you. All treatments are provided under the direction and supervision of our quality board certified medical doctors.

Financial Policies

Because we are a California Medical Corporation we follow both California State Insurance Laws as well as Federal Medicare Guidelines. All patients are responsible for their deductibles and co-payments. For the aforementioned reasons insurance billings, receipts, and statements for every procedure or treatment are billed under our group name Beverly Hills Comprehensive Medical Group (BHCMG) and the supervising medical director, Dr. Darren Boyer. We have only one set of fees, which are set by the State of California Relative Value System. Billing statements, invoices, and receipts may be sent to the email address you provide to this office.

Payment Policies

All visits not billed to insurance must be paid in full at the time of service unless prior arrangements have been made and approved by our office manager. We gladly accept cash, checks, Visa, MasterCard, Amex and most insurance policies. The only exceptions to this policy are; 1. *Medicare* patients that by law have a 24-hour payment period, 2. Approved *Worker's Compensation* patients are not required by law to pay for their own treatment, unless it is self-procured.

Appointment Policies

Most visits are on an appointment basis. If you need to change or cancel an appointment, please give us a call as soon as you can, as we are flexible with our scheduling. Emergency patients will be seen on a first come first served basis or between scheduled patients.

Please sign and date below that you have read and understand our office polices.

Name_____ Dated _____

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NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize these laws are complicated, but we must provide you with the following important information:

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES

The following circumstances may require us to use or disclose your health information:

- To other physicians or health care providers who will provide services that we do not provide.
- To obtain payment for services that we provide.
- Contact and remind our patients about appointments.
- To public health authorities and health oversight agencies that are authorized by law to collect information.
- Lawsuits and similar proceedings in response to court or administrative order.
- If required to do so by a law enforcement official.
- When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
- If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
- To Federal officials for Intelligence and National Security activities authorized by law.
- To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
- For Worker's Compensation and similar programs.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

1. Communications: You can request that our Practice communicate with you about your health and related issues in a particular manner or at a certain location. For example, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to BHCMG.

You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to BHCMG at 8530 Wilshire Boulevard, Suite 250, Beverly Hills, CA 90211. You must provide us with a reason that supports your request for amendment.

Right to a copy of this notice: You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact BHCMG at (310) 657-0366. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
Right to provide an authorization for other uses and disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

I authorize you to release any medical information about me to the people below. This release is valid until I revoke it in writing.

a._____ relationship:_____

b._____ relationship:_____

c._____ relationship:_____

If you have any questions regarding this notice or our health information privacy policies, please contact BHCMG at (310) 657-0366.

I hereby acknowledge that I have been presented with a copy of BHCMG Privacy Practices. I have personally approved the release of my medical information to those people named above in Section 8.

_____ _____

Printed Patient Name Date

_____

Patient, Patient's Parent/Guardian Signature

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CREDIT CARD AUTHORIZATION FORM

BHCMG requires that a credit card be kept on file for payment of any co-payment, co-insurance, deductible, or charge that may not be covered by your health insurance. This form will be kept confidential and only authorized staff has access to the information.

PATIENT'S NAME: _____

NAME, AS IT APPEARS ON CREDIT CARD: _____

BILLING ADDRESS: _____

_____

EMAIL ADDRESS: _____

AMEX/DISC/MC/VISA CARD # _____

EXPIRATION DATE: _____/_____ **VERIFICATION CODE (3 or 4 DIGITS)** _____

PLEASE PROVIDE THE CARDHOLDER'S DRIVER'S LICENSE

I acknowledge and authorize BHCMG to charge the above credit card account for any co-payment, co-insurance, deductible, and/or charges that may not be covered by my health insurance provider. I agree to receive billing statements, invoices, and receipts via the email I have provided to this office. If I am an uninsured patient I authorize payment at time of service. I agree to update any information regarding this credit card account.

_____ _____

Cardholder Signature Date