CLIENT INTAKE FORM

First Name _____ **Last Name** _____ **Middle Name** _____

Date of Birth _____ (MM/DD/YYYY)

Address to receive bills and correspondence:

_____

Street/Apt City State ZIP

Cell_____ Home _____E-mail: _____

Emergency Contact Information:

Name _____ Relationship _____

Emergency Contact Phone Number _____ Email _____

Medical Insurance Information

Policy ID Number _____Group Number_____

Policy Holder Name _____DOB _____Relationship_____

_____The above information is true to the best of my knowledge.

_____I hereby authorize assignment of benefits to the physician.

_____I authorize HERA Health Care to release any information required to process my medical claim(s).

Would you like to receive our electronic newsletter re: exclusive promos, time limited discounts, special events, practice updates, new services? YES_____NO_____

What services are you interested in?

- ☐ Injectables
- ☐ Non-Invasive Facial Rejuvenation
- ☐ Skin Resurfacing/Microneedling/Chemical Peels
- ☐ Sexual Health/Incontinence
- ☐ Body Contouring/Fat Removal/Weight Loss
- ☐ Sun Damage
- ☐ Hormone Replacement Therapy
- ☐ Other: _____

_____ _____

Patient Signature Date

Holistic, Esthetic, Restorative, & Anti-Aging

910 Hampshire Road, Suite A.
Westlake Village, CA, 91361
Phone #: (805)379-9110

MEDICAL HISTORY FORM

MEDICAL HISTORY – Please list all medical conditions you have been diagnosed with, or medical conditions for which you take medications

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

SURGICAL HISTORY – please list all surgeries, including cosmetic

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

FAMILY HISTORY – please list all medical conditions that your immediate family members were ever diagnosed with

MOTHER _____ _____ _____ BROTHER _____ _____ _____

MATERNAL Grandmother _____ _____ _____

MATERNAL Grandfather _____ _____ _____

FATHER _____ _____ _____ SISTER _____ _____ _____

PATERNAL Grandmother _____ _____ _____

PATERNAL Grandfather _____ _____ _____

UNCLE _____ _____ _____ AUNT _____ _____ _____

SOCIAL HISTORY Circle what applies

EXERCISE rarely ____times a week Daily

Diet NO restrictions Gluten free Food allergies _____ YES /NO

Alcohol occasional a few times a week Daily __drinks socially

Smoking YES/NO Former smoker
Tobacco quit date _____total years of smoking _____Cigarettes daily ____
Other substance abuse history YES _____ NO

BIRTH CONTROL METHOD _____

Education High School College Postgraduate

Profession _____
Special Religious Beliefs or anything else we should know _____

NAME _____Signature _____DATE _____

Name: _____

Date of Birth: _____

LIST OF CURRENT MEDICATIONS

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion.

Drug Allergies and Reactions:_____
Preferred Pharmacy:_____
Pharmacy Phone #:_____
Pharmacy Address:_____

Medication	Dose	Frequency	Reason for taking	Date Started	Prescriber

Patient Consent for the use and disclosure of Protected Health Information

We have implemented all the HIPAA (Health Insurance Portability and Accountability) guidelines recommended by the Federal Government. I hereby give my consent for the above practice to use and disclose protected health care information about me to carry out treatment, payment and healthcare operations. Your healthcare information will only be used to communicate with your insurance provider, to communicate with other healthcare professionals who may contribute to your care and for planning your care and treatment.

With this consent, the practice may call my home or alternative location and leave a message on a voice mail or in person in reference to any of the items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and calls pertaining to clinical care.

*** Please print the telephone number to where you would like to receive any phone calls from our office if other than your home: _____**

With this consent, the practice may mail or e-mail to my home or alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statement as long as they are marked personal and confidential.

*** Please print the address of where you would like any correspondence from our office to be sent if other than your home:**

_____

By signing this form, I am consenting to the above practice's use and disclosure of my protected health care information to carry out needed treatment, payment, and healthcare operations.

*** I authorize the practice to disclose my medical information to the following family members/friends:**

_____

I may revoke or limit my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the practice may decline to provide treatment to me.

_____ _____

Signature of Patient or Patients Representative Date

CONSENT FOR MEDICAL TREATMENT

Patient Name: _____

Date of Birth: _____

Knowing that I (or the patient indicated on the top of this form) desire evaluation and/or treatment at HERA Health Care, **I voluntarily consent to such care. I consent to routine diagnostic procedures, including but not limited to blood draw, collection of saliva or urine samples, other laboratory tests, administration of medication and supplements, recommendations for lifestyle changes and to medical or surgical treatment by Dr. Mirela Cernaianu.**

I acknowledge that treatment at HERA Health Care is intended to manage or heal any disease or imbalances using natural, non-invasive and conservative therapies first, however depending on the severity of my medical condition I agree that such therapies might not be sufficient or might not be the best first line of treatment.

In order to provide the best chance for successful treatment **I accept responsibility to follow the advice my treating physician including compliance with any supplements, medications, lifestyle change instructions, laboratory tests ordered or follow up appointments** with Dr. Mirela Cernaianu or other referral physicians.

I am aware that the practice of medicine is not an exact science and **I acknowledge that no guarantees have been made to me as to the results of my examination or treatment** at HERA Health Care.

I agree to return to the office or seek care with another physician or in an Emergency Department of a hospital if my condition substantially changes. I further agree to hold harmless the physicians and staff of HERA Health Care should I fail to comply with the above conditions.

Patients at HERA Health Care will be treated regardless of race, color, age, national origin, disability or religion. Notwithstanding the above criteria, HERA Health Care reserves the right to refuse care to any individual who may have an unpaid balance, exhibits rude or disruptive behavior or any other reason at the discretion of Dr. Mirela Cernaianu.

This consent shall remain in force until such time as it is specifically revoked.

_____ _____

Signature of patient or patient representative Date

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FINANCIAL POLICY AND LATE FEES

All Payments are due at check in. Please be advised that **Medical services are to be paid promptly**. Medical services provided by the physician and the trained medical staff are considered NON-refundable as soon as they have been rendered. **You have 30 days from the DUE date on your 1st billing statement to make a payment.** You will not receive a statement until your visit has been processed by your insurance. **Co-pays and cash payments due at the time of the visit are due at the time of the visit.**

New Patient Paperwork
Upon scheduling your first appointment with us, we will add you as a new patient inside of our patient portal in order for you to receive your new patient paperwork to fill out.

LATE FEES - A monthly $25 late fee will be assessed if your payment has not posted to your account 60 days from the statement date. All patient accounts that are 120 days late will be given a final 30 days to set up a payment plan. **If, after 120 days, no payment is received, we will regretfully send your account to a collection agency for the amount due plus a 40% surcharge fee.** Once your account is turned over to the collection agency, we are unable to make payment arrangements and you will need to contact the collection agency directly. Also expect the amount owed to be higher due to fees imposed by the collection agency. We encourage and support our patients' financial responsibility. We also value our relationship with you and prefer to avoid charging you any late fees. For your convenience **we offer you the option to provide us with your credit card information** and full payment due will be debited once your payment is past its due date.

PAST DUE ACCOUNTS - If your account is past due, we do not have any obligation to treat you or authorize any refills past 30 days from date of delinquency until payment is received in full (including late fees). The treating provider will provide emergency care only for 30 days at which point you will be dismissed from the practice. HRT visits and refills are not an emergency.

ARE YOUR VISITS COVERED? - HERA Health Care is NOT responsible to know whether or NOT your services at our practice are covered – that is between you and your insurance plan. We accept Medicare but not Medical - so all Medical covered services are considered patient responsibility and cash pay.

HIGH DEDUCTIBLE - All patients with a high deductible over $1000 are expected to pay for medical visits $150 if New patient or $60 for returning visits. These payments will be required as long as deductible has not been met, every time medical services are rendered.

Same Day Cancelations and NO SHOW - We respect your time and we ask you to respect ours. If you cancel without giving us the opportunity to fill in your appt, or **DO not show you will be required to pay a $50 deposit** before making another appt. This will be forfeit if you fail to cancel with 24-hour notice or do not show up again.

LATE Appointments – we reserve time in the schedule and expect you to be ready to see provider at the time scheduled. If you enter premises at the time scheduled you are already late. If you are a new patient and arrive late, you will need to be processed, that will delay your readiness to see provider and you will lose your appointment slot. We do not turn patient's away – we will gladly accommodate you but you will have to wait and be fitted into a slot that fits our patient flow, and respect other on-time patient needs. If you choose not to wait and reschedule, we will consider that a missed appointment and you will be charged $50.

PATIENT NAME_____ **SIGNATURE** _____ **DATE** _____

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HERA Health Care **ELECTRONIC MEDICAL RECORDS POLICY**

HERA Health Care uses an electronic medical record system and patient portal access.

The patient portal is completely FREE of any charge for ALL patients. You will be able to access the portal once you have been registered as a patient. Please check our website for details about how to access and use the portal.

We are required by law to provide you with a **copy of your records within 30 days of receipt of a written request.** You can **submit your request via patient portal message or by mailing a request to our practice office address**. Please do not submit your request for record by phone.

All doctor notes pertaining to your care will be routed to your portal as soon as notes is signed and closed by the physician. We strive to finish all notes same day however depending on patient flow and time, encounter notes might be available 30 days after your visit – please send us a portal message asking us for the note if you need it sooner.

Your labs and diagnostic tests will be sent to the portal after being discussed and reviewed with the doctor.

- If your results are NORMAL the office staff will be tasked to call you with normal results and the results will be available in your portal.
- If your results are OUT OF RANGE or abnormal you will be REQUIRED to make an appt to discuss results and actions that might pertain to your wellbeing. Should you wish to review your results before your appointment or you do not want to make an appt, you are going to be required to sign a Liability Release Form – assuming complete responsibility over managing results of the tests – this form is available on our website under patient forms.

You are expected to pay for your records ONLY if

- You wish a paper copy of your notes or tests – **25 cents/page**
- You wish the practice to spend time processing and faxing records to another physician's office
  - **$35 - 5 business days processing time**
  - **$50 - 1 business day processing time**
  - Keep in mind we cannot send any records without a signed HIPPA release from you
- You need a reset of your portal password more frequently that 3 times in a 12 months period
  - **Expect a charge of $5 each time you need a reset after 3 free resets in 12 months**

Patient Name _____ Signature _____ Date _____

HERA Health Care

Dr. Mirela Cernaianu

PATIENT – PHYSICIAN ARBITRATION AGREEMENT

ARTICLE 1: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2: I understand and agree that this arbitration agreement binds me and anyone else who may have a claim arising out of or related to all treatment or services provided by the physician, including any spouse or heirs of the patient and any children, whether born or unborn at the time of the occurrence giving rise to any claim. This includes, but is not limited to, all claims for monetary damages exceeding the jurisdictional limit of the small claims court, including, without limitation, suits for loss of consortium, wrongful death, emotional distress or punitive damages. I further understand and agree that if I sign this agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person(s) will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this agreement relates to claims against the physician and any consenting substitute physician, as well as the physician's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete settlement of any dispute arbitrated under this Agreement, as set forth in the CMA/CHA Medical Arbitration Rules.

ARTICLE 3: I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

ARTICLE 4: I UNDERSTAND THAT I DO NOT HAVE TO SIGN THIS AGREEMENT TO RECEIVE THE PHYSICIAN'S SERVICES, AND THAT IF I DO SIGN THE AGREEMENT AND CHANGE MY MIND WITHIN 30 DAYS OF TODAY, THEN I MAY CANCEL THIS AGREEMENT BYGIVING WRITTEN NOTICE TO THE UNDERSIGNED PHYSICIAN WITHIN THAT TIME STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT.

ARTICLE 5: On behalf of myself and all others bound by this agreement as set forth in Article 2, agreement is hereby given to be bound by the Medical Arbitration Rules of the California Healthcare Association (CHA) and the California Medical Association (CMA), as they may be amended from time to time, which are hereby incorporated into this agreement. A copy of these Rules is included in the pamphlet in which this agreement is found. Additional copies of the Rules are available from the California Medical Association, P.O. Box 7690, San Francisco, CA 94120-7690, Attention: Arbitration Rules. I understand that disputes covered by this Agreement will be covered by California law applicable to actions against health care providers, including the Medical Injury Compensation Reform Act of 1975 (including any amendments thereto).

ARTICLE 6: OPTIONAL: RETROACTIVE EFFECT If I intend this agreement to cover services rendered before the date it is signed (for example, emergency treatment), I have indicated the earlier date I intend this agreement to be effective from and initialed below.

Earlier effective date (if applicable) :_____ Patient's Initials_____

ARTICLE 7: I have read and understood all the information in this pamphlet, including the explanation of the Patient-Physician Arbitration Agreement, this Agreement, and the Rules. I understand that in the case of any pregnant woman, the term "patient" as used herein means both the mother and the mother's expected child or children.

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ Dated:_____

(Patient, Parent, Guardian or Legally Authorized Representative of Patient)

If signed by other than patient, indicate relationship:_____

PHYSICIAN'S AGREEMENT TO ARBITRATE In consideration of the foregoing execution of this Patient-Physician Arbitration Agreement, I likewise agree to be bound by the terms set forth in this agreement and in the rules specified in Article 4 above.

_____ Date:_____

(Physician or Duly Authorized Representative)

Physician

_____

Title—Partner, President, etc.

HERA Healthcare- Mirela Cernaianu, M.D.

_____

Print name of Physician, Medical Group or Association

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CREDIT Card AUTHORIZATION and AGREEMENT

I _____, agree to allow HERA Health Care to use my credit card to pay for:

- **any unpaid balances after insurance billing, when my bill goes unpaid 30 days**
- **any medical treatments that are not covered by my insurance**
- **any cancellation fees** - $50 for a medical visit or $100 for any scheduled laser treatment that requires 45 min or more
- **any supplements the practice sells, including shipping** – they can be returned for a full refund within 30 days as long as unopened with seal intact.

I understand once charged, all the above charges are **non-refundable**.

I authorize HERA Health Care to charge my card below and wish to receive notification and receipt for these charges by TEXT – Y/N or Email Y/N.

CARD TYPE _____ Credit Card no _____

EXP MM/YY _____ CVV _____

Billing ZIP CODE _____

Signature _____ Date _____

My authorization will last until credit card expires; at which time I understand I have to sign a new agreement.

I have the right to decline this authorization. As an alternative I agree to:

Option1 – keep a deposit of $150 on file at all times and will pay today

Option 2 – call my insurance company and get a representative on the line, then hand the phone to a receptionist and I will be seen after my insurance confirms no payment is owed at the time of visit. I understand this will delay my care, as I might be on hold and likely lose my appointment time - the practice will have to fit me in. I also agree to pay before the visit if my insurance states I have not met my deductible.